STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215112	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Health Systems - Columbia	6334 Cedar Lane Columbia, MD 21044

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 43096 Based on observation and interviews with residents, it was determined that the facility staff failed to treat residents with dignity and respect by leaving residents who needed assistance with dressing undressed. This was evident for 1 (Resident #61) of 4 residents reviewed for dignity during the survey. The findings include: On 6/20/24 at 9:40 AM, two surveyors entered Resident #61's room for an interview while the room door was wide open, and the curtain was not applied. Surveyors observed that the resident was not appropriately dressed; no gown or clothes worn, a gown placed on the top of his/her chest. Resident #61 reported, I messed up my clothes. Waiting for staff to bathe me. No one helped me for 40 minutes. The resident also mentioned that he/she preferred to have clothes on, but it was okay as long as no [opposite gender resident] came into his/her room. While surveyors were interviewing Resident #61 on 6/20/24 at 10:11 AM, an opposite-gender resident opened the door and tried to come in. On 6/24/24 at 12:59 PM, a second observation of Resident #61 noted that he/she was lying in bed without any clothes or gown. His/her body was just covered with a sheet and towel. The surveyor asked Resident #61 why he/she was not wearing any clothes. The resident said that he/she wanted to wear them, but nobody came to help. Resident #61 requested that the surveyor tell staff that he/she wanted to be dressed. A review of Resident #61's medical record on 7/03/24 at 11:28 AM revealed that the resident's BIM score (Brief Interview for Mental Status: is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) was 14/15 dated 11/07/23. Also, the MDS (Minimum Data Set: a federally mandated process for assessing residents' clinical needs and functional capabilities in Medicare and Medicaid certified nursing homes) dated 6/02/24 coded upper and lower body dressing as dependent. (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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 7/03/24 at 12:54 PM, he was asked about ensuring residents' privacy and dignity. The DON said, This is the resident's home. Staff should knock at the door and introduce themselves. If staff is doing ADL (Activities of Daily Living) care, they should explain the procedure. Also, staff should close the curtain for their privacy. Surveyors shared the privacy concerns for Resident #61 with details of observations. The DON said he would go to the unit to talk to the staff.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50458 Based on observation and interview with the facility staff, it was determined that the facility failed to provide an environment that was safe, clean and in good repair. This was evident in one room during the initial observation of the Renaissance 1 Medical Surgical Unit (MSU). The findings include: On 6/20/24 at 2:35 PM it was observed that in the bathroom of room [ROOM NUMBER], 2 ceiling tiles above the shower were falling down. One tile had brown discoloration over 75% of the tile around the ceiling fan. On 7/03/24 at 8:51 AM an interview and observation was conducted with the Maintenance Director (Staff #10) of the ceiling tile above the shower in room [ROOM NUMBER] on the Renaissance 1 Unit (MSU). Staff #10 looked at the ceiling tiles and stated that it might have been a water leak from the shower above (2nd floor). He stated that he will repair the ceiling tiles and will check the room/shower on the floor directly above to ensure there was no leak now. He was informed that this was found on the initial observation on 6/20/24. On 7/03/24 at 9:06 AM the Director of Nursing (DON) was asked to inspect the falling/discolored ceiling tile in the shower of room [ROOM NUMBER] on the Renaissance 1 unit. The DON observed the maintenance staff in the bathroom removing the discolored tile and the DON said he was not aware that the tile was falling and discolored. He was informed that this was observed on the first day of the survey and he validated the concern.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **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 4 (Resident #49, #74, #99, #131) of 6 residents reviewed for hospitalization during a recertification/complaint survey. The findings include: 1) During an initial screen of Resident #131 on 6/21/2024 at 2:54 PM by a surveyor, the resident stated that s/he was sent to the hospital for infection and saying crazy stuff last November/December. On 7/1/2024 at 11:50 AM, the surveyor went to interview the resident, but they were not in their room. On 7/1/2024 at 11:57 AM, an interview was completed with Licensed Practical Nurse (LPN #3) who stated that Resident #131 was sent out to the hospital a few days ago for a change in mental status. Regarding transferring residents out to the hospital, LPN #3 stated that she has never given a resident/resident representative (RP) anything in writing regarding the reason for transfer out. LPN #3 further stated that the reason for transfer was written in the transfer sheet placed in packet sent to the hospital. LPN #3 added that the residents and/or their families were told verbally why the residents were transferred to the hospital and they (staff) documented in SBAR (change in condition form) and progress notes that RP was notified. On 7/1/2024 at 12:23 PM, an interview was completed with 2 [NAME] Unit Manager (UM #4). UM #4 confirmed that she has never given residents/their RPs in writing the reason for transfer to the hospital. She 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. She confirmed that Resident #131 and/or their RP were not notified in writing reason for transfer/discharge to hospital. On 7/1/2024 at 1:50 PM, Surveyor reviewed a Notice of Emergency Transfer and Bed hold policy dated 6/27/2024 addressed to [name of hospital]. There was no documentation to indicate that the resident and/or their RP was notified in writing reason for transfer/discharge to the hospital. On 7/1/2024 at 2:19 PM, in an interview with the Director of Nursing (DON), he confirmed that he could not find any documentation that Resident #131 and/or their RP was given any written notification of the reason for transfer to the hospital on 6/27/2024. However, DON stated that the reason for transfer was documented on the change in condition form (SBAR) including that family/RP was notified. He confirmed that the family were notified verbally and not in writing: We don't give them anything in writing, we tell them verbally why the resident was transferred. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/2024 at 9:03 AM, a review of change in condition documentation (SBAR) dated 6/27/2024 revealed Resident #131 was transferred to the hospital for change in mental status . However, there was no documentation and/or evidence in the record indicating that the facility staff notified the resident/resident's representative (RP) in writing of the reason for the transfer to the hospital. 2) On 6/27/2024 at 2:28 PM, a review of nurses' progress notes revealed a change in condition documentation (SBAR) dated 1/30/2024 at 12:41 PM that revealed Resident #49 was transferred to the hospital. Further review of Resident #49's medical record documentation revealed the responsible party was notified. However, there was no written documentation that the responsible party was notified in writing of the hospital transfer. In an initial interview with Resident #49 on 7/1/2024 at 11:12 AM, the resident stated that s/he has been sent to the hospital several times. When asked if s/he was notified in writing the reason for the transfer, Resident #49 state s/he was told verbally about the reason for the transfer but was not given anything in writing. On 7/1/2024 at 1:58 PM, in a follow up interview with 2 [NAME] Unit Manager (UM #4), surveyor received and reviewed the facility to hospital transfer form dated 1/30/2024. There was no documentation to indicate that the resident and/or their RP was notified in writing reason for transfer/discharge to the hospital. UM #4 confirmed that she has never given the resident and/or their RP in writing the reason for transfer to the hospital. She stated that the resident and/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. On 7/12/2024 at 9:21 AM, in an interview with the Director of Nursing (DON) and VP of Clinical Services (Staff #44), 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 #49 and/or their RP was notified in writing the reason for the transfer to the hospital on 1/30/2024. 44441 3) On 6/21/24 at 12:29 PM a review of resident #74's medical records revealed that resident was hospitalized on [DATE] and 12/4/23 for a medical condition. Further review did not show that a written notice of transfer/discharge was given to the resident's representative. On 6/24/24 at 2;20 PM during an initial tour of the facility, resident #99 indicated in an interview that he was hospitalized recently for a medical condition. Resident stated that s/he was prepared for hospitalization but not sure if a written notification of transfer/discharge was given to him or his family. A review of Resident #99 medical records on 7/01/24 at 8:57 AM documented that resident was sent out to the hospital on numerous occasions for medical issues on these dates: 3/19/24, 3/27/24, 6/13/24 and 6/27/24. Further review did not show that a notice of transfer was given to the resident or their responsible party. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/1/24 at 1:12 PM in an interview with Staff #49 a Licensed Practical Nurse (LPN), she was asked about the process for transferring residents to the hospital. She stated that they call the physician first to get transfer orders, then complete the transfer forms, notify the resident if alert and oriented and or the resident's family before sending them out. She was asked about written notification of transfer. She stated that they do verbal notification only and do not send written notifications of transfer. On 7/1/24 at 2:53 PM The Director of Nursing (DON) was asked about the written notice of transfer, and he said that the admission director follows up with residents and their families with a call, but they do not email anything to the residents or their families and that written notifications are not sent. He was made aware that this was a concern.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative in writing of the bed-hold policy upon transfer of a resident to an acute care facility. This was evident for 4 (Resident #49, #74, #99, #131) of 6 residents reviewed for hospitalization during a recertification/complaint survey. The findings include: The bed-hold policy describes the facility's policy of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . 1) During an initial screen of Resident # 131 on 6/21/2024 at 2:54 PM by a surveyor, the resident stated that s/he was sent to the hospital for infection and saying crazy stuff last November/December. On 7/1/2024 at 11:50 AM, surveyor went to interview the resident, but they were not in their room. On 7/1/2024 at 11:57 AM, an interview was completed with Licensed Practical Nurse (LPN #3) who stated that Resident #131 was sent out to the hospital a few days ago for a change in mental status. Regarding bed hold, LPN #3 stated that the facility's bed hold policy was included in the Transfer packet when a resident was sent out to the hospital. She stated that the Transfer packet was given to EMT (Emergency Medical Technicians) who transported the resident to the hospital. LPN #3 confirmed that s/he has never given any written bed hold policy notification to a resident and/or their representative (RP) upon transfer to the hospital. On 7/1/2024 at 12:32 PM, an interview was completed with 2 [NAME] Unit Manager (UM #4) who confirmed that Resident #131 was sent out on 6/27/2024. Regarding bed hold notification, UM #4 stated that she has never given residents/their RPs a copy of the bed hold notification upon transfer to the hospital. UM #4 stated that the bed hold policy was included in the transfer packet sent to the hospital upon transfer but not given to the resident and/or their RP. UM #4 further stated that the resident and RP were notified verbally of the bed hold policy. She added that the family were normally not present at the time of transfer, so staff contacted them by phone and told them verbally that the resident was being sent out, reason why and where EMT was taking the resident to. She confirmed that Resident #131 and/or their RP were not given a copy of the bed hold policy. On 7/1/2024 at 2:19 PM, in an interview with the Director of Nursing (DON), he stated that staff verbally explain to residents/family about bed hold policy. DON added that when going to the hospital most of the time the residents have a change of mental status, so bed hold policy is included in the transfer packet given to the EMS (Emergency Medical Services) staff. He stated that Nurses don't give a copy of the bed hold to the resident and/or RP upon transfer/discharge to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/2024 at 9:03 AM, a review of nurses' progress notes revealed a change in condition documentation (SBAR) dated 6/27/2024 at 01:26 (1:26 AM) that noted Resident #131 was transferred to the hospital and the resident's representative (RP) notified of the transfer. It revealed documentation that Notice of Bed-Hold Policy and Care plan goals were placed in the Transfer Packet. However, there was no documentation that the resident/responsible party was notified in writing of the bed-hold policy. 2) On 6/27/2024 at 2:28 PM, a review of nurses' progress notes revealed a change in condition documentation (SBAR) dated 1/30/2024 at 12:41 PM that revealed Resident #49 was transferred to the hospital. However, there was no documentation and/or evidence in the record indicating that the facility staff notified the resident/resident's representative (RP) in writing of the facility's bed hold policy. In an initial interview with Resident # 49 on 7/1/2024 at 11:12 AM, the resident stated that s/he has been sent to the hospital several times. Regarding hospitalization s and notifications, Resident #49 stated that s/he was told verbally why she was sent to hospital but did not remember if s/he was given a written notification of the bed hold policy. On 7/1/2024 at 11:57 AM, in an interview with Licensed Practical Nurse (LPN #3), she stated that the facility's bed hold policy was included in the Transfer packet when a resident was sent out to the hospital. She stated that the Transfer packet was given to EMT (Emergency Medical Technicians) who transported the resident to the hospital. LPN #3 confirmed that s/he never gave written bed hold policy notification to Resident #49 and/or their representative (RP) upon transfer to the hospital. On 7/1/2024 at 1:58 PM, in an interview with 2 [NAME] Unit Manager (UM #4), surveyor received and reviewed the facility to hospital transfer form dated 1/30/2024 for Resident #49: Bed hold was checked as attached to the transfer form/packet sent with the resident to the hospital. Surveyor further reviewed a Notice of Emergency Transfer and Bed hold policy dated 1/30/2024 but addressed to [name of hospital] Resident #49 was sent to. However, there was no documentation that the resident and/or their RP was given the bed hold policy notice in writing. UM #4 confirmed that she has never given the resident and/or their RP a copy of the bed hold notification upon transfer to the hospital. UM #4 stated that the bed hold policy was included in the transfer packet sent to the hospital upon transfer but not given to the resident and/or their RP. On 7/1/2024 at 2:53 PM, in a follow up interview with the DON, he confirmed that facility staff did not give the residents and/or their RPs written notice of the facility bed hold policy upon transfer of a resident to the hospital. DON stated that Admissions director followed up with a call when residents were transferred out but did not send any notification in writing to them nor their RPs. DON added that they (admissions) did not mail and/or send emails to the RPs regarding bed hold policy upon transfer/discharge of a resident to the hospital. On 7/12/2024 at 9:21 AM, in an interview with the Director of Nursing (DON) and VP of Clinical Services (Staff #44), surveyor shared concerns regarding bed hold notification. They did not provide any further documentation. 44441 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 6/21/24 at 12:29 PM a review of resident #74's medical records revealed that resident was hospitalized on [DATE] and 12/4/23 for a medical condition. Further review did not show that a written notification of the bed hold policy was given to the resident's representative on transfer to the hospital. On 6/24/24 at 2:20 PM during an initial tour of the facility, resident #99 indicated in an interview that he was hospitalized recently for a medical condition. Resident stated that s/he was prepared for hospitalization but not sure if a written notification of bed hold was given to them or their family members. A review of Resident #99's medical records on 7/1/24 at 8:57 AM documented that resident was sent out to the hospital on numerous occasions for medical issues on these dates: 3/19/24, 3/27/24, 6/13/24 and 6/27/24. Further review did not show that a written notice of bed hold was given to the resident or their responsible party. On 7/1/24 at 1:12 PM in an interview with Staff #49 a Licensed Practical Nurse (LPN), she was asked about the process for transferring residents to the hospital. She stated that the nurse would call the physician to get transfer orders, then completes the transfer forms and notify the resident if alert and oriented and or the resident's family. She was asked about written notification of bed hold, and she stated that they call the families and let them know about the bed hold policy and send a copy with the resident to the hospital. That a written copy of the bed hold was not mailed to residents or their responsible parties. On 7/1/24 at 1:32 PM staff #52 was asked about the process for hospital transfer, she stated that they would first get an order to send the resident out. That they have a sheet with a guideline on the transfer packet on what documents goes with the resident to the hospital. The nurse would notify the resident and/or resident's family to let them know they are sending the resident out. She was asked about the bed hold policy and if they give it to the resident or their families on transfer to the hospital and she stated that the bed hold policy is a form in the packet that they send with the resident to the hospital, they do not review it with the resident and do not mail it out to the resident's family.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50458 Based on record review and interview with the facility staff, it was determined that the facility failed to provide a baseline care plan to the resident or the resident representative. This was evident for one (Resident # 6) out of 6 residents reviewed for dental services during the annual survey, and one (Resident #186) out of 3 closed records reviewed during the recertification survey. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. 1) On 6/26/24 at 10:10 AM a record review of Resident #6's baseline care plans dated 8/21/23, 12/11/23 and 6/19/24 revealed that there was no documentation that the information was provided to the resident or the resident's representative. On 06/27/24 at 1:30 PM an interview was conducted with the Director of Nursing (DON) regarding Resident #6's baseline care plans. He was asked about the baseline care plans dated 8/21/2023, 12/11/2023, and 6/19/2024 that have no documentation that Resident #6 and/or representative received a written summary of the baseline care plan. He stated that he will provide documentation. On 07/01/24 at 2:19 PM in an interview with the DON, he confirmed that there was no evidence that the resident and/or representative were given the baseline care plan. 48168 2) On 7/11/24 at 10:39 AM a review of Resident #186's clinical record revealed that the resident was admitted to the facility on [DATE] but the baseline care plan did not contain any indication that it was provided to the resident or the resident's representative (RP). On 7/11/24 at 10:58 AM an interview with the Director of Nursing (DON) was conducted to review the printed baseline care plan on the resident's closed record that has a blank space where documentation should indicate that the resident or RP received a copy. The DON was asked to provide evidence that the baseline care plan was provided to the resident or the RP. On 7/11/24 at 11:30 AM another interview with the DON was conducted. He said that he reviewed the resident's record but did not find any documented evidence that the baseline care plan was provided to the resident or the RP. On 7/11/24 at 11:33 AM an interview with the [NAME] President of Clinical Services (Staff #44) was conducted to inform her that the baseline care plan was not provided to the resident or RP and she acknowledged understanding.

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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 observation, medical record review, and staff interview, it was determined the facility staff failed to develop and initiate comprehensive person-centered care plans for residents residing in the facility. This was evident for 1 (# 131) of 2 residents reviewed for dialysis, 1 (Resident #163) out of 9 residents reviewed for unnecessary medications, 1 resident (Resident #83) of 1 residents reviewed for Rehabilitation and Restorative care during the recertification survey, and 1 (Resident #109) out of one resident reviewed for hospice during the facility's recertification 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. Hemodialysis or simply dialysis is a process of filtering the blood of a person whose kidneys are not working normally. An arteriovenous (AV) fistula is a connection that's made between an artery and a vein for dialysis access. A surgical procedure, done in the operating room, is required to stitch together two vessels to create an AV fistula. A contracture is a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff. This prevents normal movement of a joint or other body part. Contractures may be caused by injury, scarring, and nerve damage, or by not using the muscles. 1) On 7/2/2024 at 9:46 AM, a review of Resident #131's clinical records revealed the resident was initially admitted to the facility on [DATE] with medical diagnoses that included but not limited to End Stage Renal Disease (ESRD), Kidney transplant status, and dependence on Renal Dialysis. During a review of Resident #131's medical record conducted on 7/2/2024 at 10:27 AM, surveyor noted active physician orders for: ARM FISTULA: Left upper arm. MONITOR FOR BRUIT AND THRILL EVERY SHIFT, every shift for MONITORING DOCUMENT PRESENCE OF BRUIT/THRILL dated 12/10/2023, and DIALYSIS AT LORIEN [NAME] EVERY T, T, S 3RD SHIFTevery day shift every Tue, Thu, Sat dated 12/12/2023. On 7/2/2024 at 11:19 AM a review of Resident #131's care plan revealed a focus for I need hemodialysis r/t ESRD with the initiation date of 12/11/2023. The associated goal for this focus was I will have no s/sx of complications from dialysis through the review date. The following interventions were listed, all dated 12/11/2023: - Monitor labs and report to doctor as needed. - Monitor/document for peripheral edema. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Monitor/document/report to MD PRN any s/sx of infection to access site: Redness, Swelling, warmth or drainage. - Monitor/document/report to MD PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. The care plan interventions were not comprehensive, and resident centered: It did not mention the type of dialysis access (AV fistula) nor location of the access site. No mention of dialysis days (Tuesday, Thursday, Saturday), nor access site check for bruit/thrill as per physician orders. The care plan lacked any care instructions for dialysis access site care such as: no blood draws and/or use of tourniquets/blood pressure cuff on extremity with access site, and/or weight monitoring before and after dialysis, etc. On 7/2/2024 at 1:15 PM, an interview was conducted with the 2 [NAME] Unit Manager (UM #4). The surveyor reviewed Resident #131's care plan with UM #4 who verified and confirmed that the resident's care plan for hemodialysis r/t ESRD was not comprehensive and needed more interventions. UM #4 stated she was going to revise the resident's care plan. On 7/12/2024 at 8:55 AM, in an interview with the Director of Nursing (DON) and VP of Clinical Services (Staff #44), surveyor reviewed the above findings with them. They reviewed and confirmed that the interventions did not reflect the orders for hemodialysis: no indication of dialysis access site, no monitoring of bruit/thrill, no weight monitoring etc. DON stated that their major focus was on infection control which was part of the interventions listed on the care plan focus for hemodialysis. 47200 2) On 7/5/24 at 1:11PM the surveyor conducted a review of the medical record for Resident #163 which revealed active medical orders for several psychotropic medications including Lorazepam and Seroquel, however, no medical orders for monitoring of medication side effects, or behavioral monitoring of the resident could be found. On 7/9/24 at 10:24AM the surveyor conducted an interview with the Resident's assigned nurse, Licensed Practical Nurse (LPN) #51. When the surveyor inquired as to the monitoring for side effects and behavior monitoring for psychotropic medication use for Resident #163, they reviewed the medical record with the surveyor present, and they responded: It should be ordered. On 7/9/24 at 10:37AM the surveyor conducted an interview with the facility Administrator. During the interview, the Administrator reviewed the resident's medical record and confirmed that side effect and behavior monitoring should be in place via a medical order and was not currently ordered for the resident. At this time, the surveyor shared their concerns and the Administrator acknowledged and confirmed understanding of the concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/9/24 at 11:08AM the surveyor reviewed the care plan of Resident #163 which revealed the following documented current interventions dated as beginning on 5/21/24: Administer medications as ordered. Monitor for therapeutic/adverse effects and notify MD/NP as indicated and Monitor/document side effects and effectiveness. Anti anxiety side effects: drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Paradoxical side effects: mania, hostility and rage, aggressive or impulsive behavior, hallucinations. 48168 3) On 6/20/24 at 2:45 PM in an observation of Resident #83, the resident was lying in bed with both hands visible above the covers and both hands were noted to have contractures. Both hands were empty. On 7/05/24 at 8:55 AM a review of Resident #83's clinical record revealed a task list for the daily placement of a hand splint and palm protector in the resident's hands. A review of the resident's care plan revealed no problem for any contracture or limited mobility, and no interventions the use of a hand splint or palm protector. On 7/05/24 at 10:50 AM an interview with the Director of Nursing (DON) was conducted and Resident #83's task list and care plan were reviewed. The DON confirmed that there were no problems, goals, or interventions found on the resident's care plan regarding contractures and the use of a splint and palm protector. He said that there should be and that the resident's care plan was incomplete. 50502 4) On 7/10/24 at 9:30 AM, a review of Resident #109's paper chart showed the hospice election on file dated 3/22/24. On 7/10/24 at 11:09 AM, a review of the hospice order dated 3/22/24 indicated, Admit to Hospice with terminal diagnosis: Senile degeneration of the brain. On 7/10/24 at 10:14 AM, a review of the Minimum Data Set (MDS: is a standardized assessment tool that is required by federal law to evaluate the health needs and functional capabilities of residents in Medicare or Medicaid certified nursing homes) with an Assessment Reference Date (ARD) of 3/28/24 for significant change, confirmed coding of Hospice. On 7/10/24 at 12:29 PM, the surveyor reviewed Resident #109's care plan and revealed that the hospice care plan had never been developed since (March 22, 2024) the start of hospice care. On 7/10/24 at 11:29 AM, an interview with a Registered Nurse (RN #8), revealed that the staff collaborated with the hospice nurse during resident visits. The hospice nurse wrote the order in the chart using the physician order sheet, and then the facility nurse entered the order into the system. RN #8 stated, We communicate with the attending physician by sending an e-medical alert through the facility's electronic charting system. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/10/24 at 11:44 AM, during an interview with the unit manager (RN # 9), she was asked how the facility collaborate with hospice nurse, RN #9 stated, If there are issues with hospice residents, the hospice nurse will talk to the facility nurse, if there are any new orders, the hospice nurse will notify the facility nurse. RN # 9 confirmed that she initiated the resident's care plan when there was a change in condition/ status. She confirmed that she initiated the care plan of Resident #109 when he/she was admitted to Hospice on 3/22/24. The surveyors asked RN #9 to verify the care plan on her computer. After checking the electronic charting system for over 3 minutes, RN #9 verified that the facility failed to develop a hospice care plan. On 7/10/24 at 1:58 PM, during an interview with the Director of Nursing (DON), he/she confirmed that the residents' care plan should be developed for any change of condition and is initiated by the Unit Manager. The DON was informed that the hospice care plan of Resident #109 had not been initiated since March 2024. The DON stated, I'm shocked.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50502 Based on record review, observation, and interview, it was determined that the facility failed to update/revise care plans after an episode of fall and elopement attempt. This was evident for 1 (Resident #154) of 5 residents reviewed for care plans, and 1 (Resident #89) out of 2 residents reviewed for elopement during the annual and complaint survey. The findings include: 1) On 6/26/24 at 8:03 AM, a review of Resident #154's admission/discharge record revealed that the resident was initially admitted to the facility in December 2023. The resident was transferred to the hospital on 3/21/24 due to a fall incident. The resident was readmitted back to the facility on [DATE]. On 6/24/24 at 8:21 AM, Resident #154 was observed inside his/her room sitting in a geriatric chair. The resident appeared anxious and kept getting up. The second observation on 6/24/24 at 9:47 AM noted that Resident #154 was sitting in the geriatric chair in the nurse's station. He/she tried to get out of the chair multiple times and was repositioned by the nurse. On 6/24/24 at 11:11 AM, during an interview with Resident #154's responsible party, he/she stated that he/she had not heard any episodes of a fall since April of 2024. On 6/26/24 at 8:26 AM, a review of Resident #154's care plan revealed that the resident had care plans regarding fall risk, high risk for falls r/t unaware of safety needs, educate resident/family/caregivers about safety reminders and what to do if a fall occurs, upon his/her admission. However, the facility did not revise and/or apply additional interventions after the fall incident on 3/21/24. On 6/26/24 at 10:58 AM, an interview with Registered Nurse (RN #8), he/she stated that if a resident had a fall, they documented the incident in the electronic charting system and updated the care plan to prevent further incidents. On 6/27/24 at 9:22 AM, an interview with RN #5 revealed that she updated care plans after falls and placed interventions such as the bed in the lowest position and the call light within reach. On 6/28/24 at 8:00 AM, during an interview with the Unit manager RN #32, he/she confirmed that nurse managers update the care plan when residents have a fall. On 6/28/24 at 8:15 AM, during an interview with the Director of Nursing (DON), he confirmed that the unit managers updated the care plans, and nurses put in immediate interventions. He further stated, As the DON, I expect that the care plan is updated, the nurse will put in some interventions, and we come back and review what works best. The DON was notified that the fall care plan of Resident #154 was never updated/ revised upon return from the hospital. 42886 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of Resident #89's medical records on 7/01/24 at 11:16am revealed the resident attempted to elope from the facility on 10/31/22. Continued review of medical records revealed that the facility failed to update resident #89's elopement care plan interventions after the 10/31/22 elopement attempt. The last update on the resident's elopement care plan was on 7/19/22. Interview with the Director of Nursing (DON) on 7/02/24 at 12:45pm confirmed that the last update on the resident #89's elopement care plan was on 7/19/22. The updated intervention was to engage the resident in a purposeful activity to reorient the resident to his/her surroundings. The DON also explained that the resident had prior attempts to elope from the facility when the resident returned to the facility after a leave of absence. The surveyor expressed concerns regarding the status of the resident's care plan on 7/02/24 at 1:00pm. The DON understood and provided no other information on the deficient practice.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 47200 Based on observation, interview, and medical record review it was determined the facility failed to: ensure a medical order was followed, ensure a medical order was present for a care intervention, and ensure a resident's call device was within reach. This was evident for 1 (resident #393) out of 7 residents reviewed for pressure injuries during the facility's recertification survey. The findings include: On 6/21/24 at 9:47AM the surveyor observed intact gauze wrapped dressings on each of Resident #393's feet with both feet resting directly on the surface of the bed. During an interview with Resident #393 on 6/21/24 at 9:55AM they reported to the surveyor that their call bell was not in reach and they needed assistance with repositioning. At this time, the surveyor observed a wedge pillow situated between the resident's right side of their body and the bed rail on their right side, with the call bell dangling onto the floor out of reach of the resident. At this time, the surveyor reported the concern to Licensed Practical Nurse (LPN) #51 who offered the following response: I have to go find their nurse because of the sign on the door, it's not my patient. At this time, the surveyor further noted the signage on the door to the room which indicated that enhanced barrier precautions were to be followed for this resident room. LPN #51 further reported to the surveyor that Resident #393 was on contact precautions because of the wound on their leg. On 6/21/24 at 9:57AM the surveyor observed LPN #51 put on a gown and assist the resident by retrieving their call bell. Resident #393 appeared concerned and asked LPN #51 why they had to put a gown on. LPN #51 replied to the resident: because of the wound on your leg if I have to do something to the wound. Resident #393 stated the following to LPN #51: You're the only one who has put that gown on. Both Resident #393 and their roommate, Resident #176, reported to the surveyor that the enhanced barrier precautions sign on the door had just gone up yesterday and they had not received communication as to why. Resident #393 and Resident #176 reported to LPN #51 that they were concerned about why the gown was just put on by them, and wanted to know if someone was sick. Resident #393 asked LPN #51 why the sign went on the door the day prior, but no one had utilized the gown and gloves prior to this time. The surveyor noted that the resident's initial need for repositioning was not addressed. On 6/26/24 at 9:17AM the surveyor conducted a review of the medical record for Resident #393 which revealed the following active medical order: Elevate/float heels while in bed every shift for prevention of skin breakdown dated as beginning on 6/16/24. Additionally, several active medical orders were observed dated as beginning on 6/15/24 for daily wound dressing changes to occur. The surveyor noted that the resident was admitted to the facility with wounds, and their date of admission was 6/14/24. The medical order for enhanced barrier precautions was observed as having began on 6/23/24, approximately 9 days later, instead of upon admission. On 6/26/24 at 9:26AM the surveyor reviewed the hospital physician discharge summary for Resident #393 dated 6/14/24 at 7:17AM which included their recommendation for the resident to have heel protectors. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:23AM the surveyor entered the room of Resident #393 and observed the enhanced barrier precaution signage posted on the door the room, and LPN #59 was observed at the bedside performing the resident's wound dressing change on their right foot with a mask and gloves on, and no gown on. On 6/26/24 at 11:24AM the surveyor observed the intact gauze dressing to the resident's left foot which had not been changed yet, and noted the date and time written on this dressing in permanent marker was 6/24/24 at 10:15AM with LPN #60's initials, which was approximately two days earlier despite the active medical order in place for the dressings to be changed daily. On 6/26/24 at 11:31AM the surveyor observed LPN #59 enter the room again, with no gown on. On 6/26/24 at 11:33AM the surveyor observed two heel protector boots sitting at the resident's bedside. LPN #59 was observed changing the resident's left foot dressing with no gown on and offered application of the heel protector boots to the resident, although no active medical order was in place for this intervention. At this time, the surveyor observed another dressing on the resident's neck area which was dated 6/24/24. When the surveyor inquired to LPN #59 as to the date on the dressings, they acknowledged and confirmed that the dressings were expected to be changed daily. On 6/26/24 at 11:40AM the surveyor conducted an interview with LPN #59 regarding their understanding of what personal protective equipment needed to be worn for the resident on enhanced barrier precautions. LPN #59 reported to the surveyor that they have to wear gloves, a gown and a mask during dressing changes and acknowledged that they did not wear the gown to perform the dressing changes. At this time the surveyor shared their concerns with LPN #59 who confirmed understanding of the concerns. On 6/26/24 at 12:02PM the surveyor observed LPN #59 and GNA #24 standing at the bedside of Resident #393, moving the resident up in bed with their bed sheet, and no gowns were being worn. On 6/26/24 at 12:03PM the surveyor conducted an additional interview with LPN #59 who reported the following information to the surveyor regarding why they did not have gowns on: We have to wear a mask, gloves, and gown if we are doing invasive procedures, but right now we are just moving him/her up in bed. On 6/26/24 at 12:39PM the surveyor conducted an interview with the facility's Wound Nurse, LPN #61 who confirmed that heel protectors require a medical order, no medical order for this had been obtained, and they reported being unaware the resident had heel protector boots. During the interview, when the surveyor inquired as to the hospital discharge recommendation, LPN #61 stated that a medical order should have been placed on admission for the heel protector boots. When the surveyor inquired as to the facility's expectation for personal protective equipment to be utilized for enhanced barrier precautions, LPN #61 reported the following: Staff need a gown and gloves on, no mask, when doing wound care, and yes, the same for repositioning someone in bed. On 6/27/24 at 9:56AM the surveyor reviewed the medical record for resident #393 which revealed the weekly skin assessment note dated 6/26/24, documented by Wound Nurse LPN #61 stated the following information: Wound evaluation completed today due to resident was in hemodialysis yesterday . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 12:02PM the surveyor conducted an interview with LPN #60, who reported that Wound Nurse LPN #61 informed the staff that they would be providing Tuesday wound dressing changes for residents of the unit, and therefore, they, as the assigned nurse, did not change the wound dressing on 6/25/24. Additionally, LPN #60 confirmed having observed the heel protector boots at the bedside of the resident. On 6/27/24 at 1:23PM the surveyor conducted an interview with Assistant Unit Manager, LPN #46 who confirmed that the wound nurse was performing dressing changes on the unit instead of the assigned nurses on Tuesdays, as of 1-2 weeks ago, but was not aware of a process in place as to whether the wound nurse or the assigned nurse was responsible for the documentation of the dressing changes, or a process to ensure all residents were seen. On 7/12/24 at 9:08AM the surveyor conducted an interview with the Assistant Director of Nursing, Registered Nurse #57, who reported they were the assistant to the infection control nurse. During the interview, they reported that precautions were implemented by whoever put the orders in first, between the Infection Control Nurse and the Unit Managers.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42886 Based on medical record review and interview, the facility failed to provide adequate pressure ulcer management for a resident (resident #553). This was evident in 1 of 14 residents reviewed when investigating facility reported incidents and complaints during the facility's recertification survey. The findings include: Review of resident #553's medical record on 7/9/24 at 11:45am revealed the resident was admitted to the facility with a stage two sacral pressure wound. Continued review of the resident's medical record revealed that the resident's sacral pressure wound continued to worsen until the resident was assessed with a stage 4 sacral pressure wound approximately eight weeks later. Further review of the resident's medical record revealed that the facility failed to provide adequate pressure wound management treatments to attempt to prevent the worsening of the resident's sacral wound for approximately 8 weeks. The resident's attending provider ordered specialized wound care treatment after the resident was assessed with a stage 4 sacral pressure wound. Interview with the Director of Nursing on 7/9/24 at 1:00pm revealed that the facility admitted to failing to provide preventative wound care treatment to prevent the worsening of resident #553's sacral pressure wound from a stage two pressure wound at admission to a stage 4 pressure wound approximately 8 weeks later. The surveyor expressed concern for the facility's failure to provide adequate pressure wound management. The DON understood and provided no additional information on the deficient practice.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 15701 Based on observation, medical record review, and interview it was determined the facility failed to 1) follow physician's orders and the resident's care plan for the administration of oxygen, 2) follow medical orders for respiratory care of a resident and ensure labeling and changing of respiratory equipment, and 3) ensure a medical order was present for respiratory care delivered, ensure a medical order was followed, and ensure labeling and changing of respiratory equipment. This was evident for 3 (Residents #49, #81, and #163) out of 4 residents reviewed for respiratory care during the recertification/complaint survey. The findings include. 1) Resident #49 was observed in bed on 6/21/24 at 8:44 AM receiving oxygen via nasal cannula (a tube worn in the nostrils to administer oxygen) that was attached to a water bottle connected to an oxygen concentrator (a machine that concentrates oxygen from room air). The flow meter scale with a metal ball was observed between the 4 line to show an oxygen flow rate of 4.0 liters per minute (LPM). Review of resident #49's medical record at 12:58 PM on 6/21/24 revealed an oxygen administration order to provide continuous oxygen at 2 LPM. On 6/24/24 at 2 PM resident #49 was observed receiving oxygen at 4 litters per minute via the nasal canula. At 2:10 PM The residents nurse for the day (staff #3) was asked to check resident #49's oxygen converter. The nurse acknowledged that the oxygen was being administered at 4 L/min. She was asked what oxygen rate the resident is prescribed for the administration of oxygen. She indicated that she did not know, and she would have to look it up. She was asked if the tubing was dated to indicate the last time the tubing was change. She indicated that she did not see identification on the oxygen tubing to indicate when the tubing was last changed. Staff #3 reviewed the resident's medical record and confirmed the oxygen order for the administration of oxygen was continuous at 2 Litters per minute. She also acknowledged that the oxygen order was not transcribed to the treatment administration record (TAR) and therefor the staff were not signing off to indicate the resident was receiving the prescribed administration of oxygen. She indicated that she was going to change and date the resident's oxygen tubing. The unit manager (staff #4) joined the conversation and was informed of the findings and concerns. She was asked if the facility has a policy for changing oxygen tubing. She indicated that the policy may state that oxygen tubing is changed weekly on Wednesdays. The Director of nursing was informed of the wrong administration of oxygen, the lack of documenting the prescribed oxygen administration, and the oxygen tubing not labeled when changed on 6/26/24 @ 11:25 AM. 47200 (continued on next page)

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Lorien Health Systems - Columbia	6334 Cedar Lane Columbia, MD 21044

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 06/20/24 at 12:29PM the surveyor observed Resident #81 wearing unlabeled oxygen tubing which was hooked to their oxygen concentrator. Upon further observation of the oxygen setup, the surveyor noted that the humidification bottle was not labeled with a date or time. On 7/8/24 at 9:18AM the surveyor reviewed the medical record of Resident #81 which revealed the following active medical orders: oxygen equipment 11-7 shift weekly O2/neb equipment change O2 tubing nasal cannula/mask weekly if in use every night shift every Wed for infection control, and Oxygen: Every shift O2 at 2 liters/min continuous via n/c (nasal cannula) with humidified H20 every shift for acute on chronic respiratory failure with hypercapnea. On 7/08/24 at 10:50 AM the surveyor observed a tape label on Resident #81's oxygen tubing, and no humidification was in place on the oxygen concentrator setup. On 7/08/24 at 10:52 AM the surveyor requested a dual observation with Registered Nurse, (RN) Unit Manager #32 who confirmed with the surveyor that the tape label on the oxygen tubing was dated 6/26/24, approximately 12 days prior. At this time, the surveyor conducted an interview with RN Unit Manager #32 who reported to the surveyor that usually oxygen tubing is changed every 7 days, and further reported: It's overdue. When the surveyor inquired as to why there was no humidification in place on the oxygen concentrator, they proceeded to pick up a humidification bottle enclosed in packaging sitting on the Resident's nightstand, remove the packaging, and hook it up to the concentrator, and date and time the bottle. At this time, the surveyor shared their concerns with RN Unit Manager #32 who acknowledged the concerns and confirmed in the electronic medical record with the surveyor that humidification should have been in place for the resident. When the surveyor inquired as to the process in place for the care of respiratory equipment, they responded: every seven days it is expected for the tubing and the whole set up to be thrown away and replaced and dated and timed, night shift is responsible for this, and the nurse assigned as part of their overall assessment should be watching for needed replacement of the humidification bottles- they usually last 24-48 hrs. On 7/08/24 at 11:31AM the surveyor shared concerns with the facility Administrator, who confirmed understanding of the concerns. 3) On 6/20/24 at 9:39AM the surveyor observed no labeling was present on Resident #163's oxygen tubing or humidification bottle. On 06/25/24 at 11:36AM the surveyor observed no labeling was present on Resident #163's oxygen tubing or humidification bottle. On 7/8/24 at 9:24AM the surveyor reviewed the medical record of Resident #163 which revealed there was no active medical order present for the humidification of their oxygen, and the following active medical order was found to be in place: Oxygen one to two liters of oxygen via nasal cannula, by MD order. On 7/08/24 at 9:40AM the surveyor observed no labeling was present on the oxygen tubing for Resident #163, and no labeling was present on the humidification bottle in use, and the oxygen liter setting was observed to be at zero. At this time family present at the resident's beside shared concern for the respiratory equipment needing to be changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/08/24 at 9:42 AM the surveyor requested a dual observation with unit management, however, they were not available at that time. The surveyor conducted a dual observation of the respiratory equipment set up for Resident #163 with Licensed Practical Nurse (LPN) #60, who communicated during the interview that the Resident's assigned nurse for this shift was Registered Nurse (RN) #69, who could not be found at that time. LPN #60 observed and confirmed the oxygen liter setting was at zero, and additionally confirmed there was no labeling on the oxygen tubing or humidification bottle, and that the humidification was currently in use. On 7/8/24 at 9:47AM the surveyor conducted a dual observation of Resident #163's respiratory equipment with RN #69. During the interview, when the surveyor inquired to RN #69 as to how long it had been since the oxygen tubing had been changed last, they reported the following information: I don't know how long the tubing has been there because there is no date, I will go get a new one. At this time the surveyor shared their concern for no medical order present for the humidification that was in place, no labeling on the humidification bottle, and for the oxygen level observed to be at zero. At this time, the surveyor observed RN #69 turn the oxygen delivery dial up to above one liter per minute. When the surveyor inquired as to how much oxygen the resident was ordered to receive, RN #69 replied: I am going to check the orders. At this time the surveyor shared concerns with RN #69 who acknowledged understanding of the concerns, and further reported to the surveyor: the oxygen was not turned down. On 7/8/24 at 9:56AM the surveyor shared concerns with Unit Manager #46 who confirmed understanding of the concerns. On 7/08/24 at 11:31AM the surveyor shared concerns with the facility Administrator, who acknowledged understanding of the concerns.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 42886 Based on record review and staff interview, a facility agency provider failed to place visit notes into a resident's medical record (resident #545) timely. This was evident for 1 of 14 residents reviewed when investigating facility reported incidents and complaints during the recertification survey. The findings includes: During the investigation of MD00181057, a review of resident #545's medical record on 7/8/24 at 9:29am revealed that the pharmacist consultant recommended a gradual dose reduction (GDR) for Seroquel (Quetiapine Fumarate). Continued review of resident #545's medical record revealed the facility contracted an agency psychiatric nurse practitioner (agency psychiatric NP) to assess the resident to ensure that the gradual dose reduction was safe for the resident. On 7/21/22, the agency psychiatric NP failed to assess the resident for a GDR due to his/her failure to locate Seroquel in the resident's medical orders. Further review of resident #545's medical record revealed the agency psychiatric NP put his/her visit notes into the resident's chart on 7/28/22. During a interview with the Director of Nursing (DON) on 7/8/24 at 12:40pm, the surveyor pointed out that the agency psychiatric NP failed to post his/her visit notes to resident #545's medical record until 7/28/22 when the visit was on 7/21/22. The DON admitted that posting visit notes eight days after the visit was not considered timely. The surveyor expressed concern that a provider failed to post visit notes on resident #545's medical record timely. The DON understood and provided no other information.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 50458 Based on record review and interview with the facility staff, it was determined that the facility failed to complete a performance review of every nurse aide at least once every 12 months. This was evident for 5 Geriatric Nursing Assistant, (GNA #26, GNA #27, GNA #28, GNA #29 and GNA #30) of the 5 GNAs reviewed for performance evaluations. The findings include: On 7/03/24 at 12:52 PM, review of staff personnel records revealed that GNA #26, GNA #27, GNA #28, GNA #29, GNA #30 had no performance evaluations. On 7/03/24 at 1:09 PM an interview with the Nursing Home Administrator (NHA) was conducted. She was asked to provide performance evaluations for GNA #26, GNA #27, GNA #28, GNA #29 and GNA #30. On 7/03/24 at 1:50 PM an interview with HR Director (Staff #31) and the NHA regarding employee performance evaluations was conducted. They both confirmed that they do not have performance evaluations for GNA #26, GNA #27, GNA #28, GNA #29 and GNA #30. They both stated the understanding that this was a deficiency.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47200 Based on observation, interview and record review it was determined the facility failed to ensure residents remained free from unnecessary medications. This was evident for 2 (#138, #163) out of 9 residents reviewed for unneccessary medications during the facility's recertification survey, and 1 (resident #545) out of 14 reviewed during facility reported incident and complaint investigations during the recertification survey. The findings include: 1.) On 7/2/24 at 11:47AM the surveyor observed Resident #138 with the upper half of their body laying down horizontally across the shorter width of their bed and they verbally acknowledged the nurse's presence, however, their body position remained the same. Review of the medical record on 7/2/24 at 12:38PM by the surveyor revealed multiple mental health diagnoses documented for Resident #138. On 7/2/24 at 12:54PM the surveyor observed the following active medical orders for the resident: Seroquel Tablet 25 MG (Quetiapine Fumarate): Give 1 tablet by mouth two times a day for delusional disorder and Sertraline HCl Oral Tablet 50 MG (Sertraline HCl): Give 3 tablets by mouth in the morning for Depression. On 7/2/24 at 1:19PM the surveyor conducted an interview with Director of Nursing (DON) regarding the location of medication regimen reviews and responses. The DON provided the following information in response to the surveyor's inquiry: All medication regimen reviews are on paper (documentation), if you need more information regarding a flagged item, you can request it. On 7/3/24 at 12:25PM the surveyor requested complete documentation of the previous three months medication regimen reviews for the resident from the DON. On 7/3/24 at 1:13PM the surveyor received and reviewed the pharmacy medication regimen reviews for Resident #138 which revealed one recommendation made on 4/25/24 for a dosage decrease for trazodone, a psychotropic medication the resident had previously been prescribed. At this time, the surveyor reviewed the discontinued medical orders and observed the April 2024 Medication Administration Record which revealed the psychotropic medication, trazodone, was prescribed by two separate orders documented as needed, in both orders, and was ongoing for the resident from 10/30/2023 until 5/1/24, and from 10/30/23 until 5/7/24. On 7/5/24 at 8:57AM the surveyor conducted an interview and shared their concern for the as needed use of trazodone via medical order not limited to 14 days with the facility Administrator, who confirmed there was no other documentation to provide regarding the concern and acknowledged understanding of the concern. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/05/24 at 9:33AM the surveyor conducted an interview with the DON, who reported the following to the surveyor: Trazodone is not an antispychotic so it is not limited to 14 days, it is an anti depressant so yes, it can be an ongoing order. On 7/5/24 at 10:40AM the surveyor reviewed the July 2024 medication administration record and treatment administration record for Resident #138 which revealed no comprehensive monitoring for side effects of psychotropic medication use or comprehensive monitoring for behavior. On 7/5/24 at 11:03AM the surveyor conducted an interview and shared their concerns with the Assistant Unit Manager, Licensed Practical Nurse (LPN) #46. LPN #46 reviewed the medical record with the surveyor present and reported the following information: They (staff) did not put it back in, at one point s/he was on monitoring, it just didn't get re-ordered when s/he got readmitted . LPN #46 further communicated to the surveyor that the side effect and behavior monitoring was last in effect for the resident during 2023. LPN #46 shared with the surveyor the following monitoring that should be in place for behavior and side effects of psychotropic medications: Any kind of adverse behaviors, biting, hitting, kicking, any changes with aggression, depression worse or better, any changes not his/her normal, side effect monitoring for movement and non-movement monitoring, we usually put both orders in, and behavior monitoring we have a standard order. After surveyor intervention, LPN #46 reported they were now instituting side effect monitoring and behavior monitoring orders for the resident. At this time, the surveyor requested a copy of the orders being instituted. On 7/05/24 at 11:32AM the surveyor reviewed documentation of the monitoring instituted on 7/5/24 by LPN #46. On 7/9/24 at 10:37AM the surveyor shared their concerns with the facility Administrator, who acknowledged and confirmed understanding of the concerns. On 7/12/24 at 10:29AM the surveyor conducted an interview with the DON as to the facility's process for ensuring the monitoring surrounding psychotropic medication use. The DON stated the following regarding the facility's current process: The expectation is that the admitting nurse enters the monitoring order and the unit manager should be reviewing records, daily orders, to catch any that didn't get ordered and then bring that issue to the daily meeting. At this time, the surveyor requested the last six pharmacy medication regimen review recommendations made for the resident from the DON. On 7/12/24 at 10:55AM, during an additional documentation request form the surveyor to the DON, the surveyor was handed one pharmacy recommendation made for the resident, however, the surveyor observed additional pharmacy recommendation documents on their desk with Resident #138's name on them. When the surveyor inquired as to the additional recommendations present, the DON gave the surveyor a second pharmacy recommendation for Resident #138. The surveyor then inquired again, as to the additional remaining pharmacy recommendation on their desk. At this time, the third pharmacy recommendation was handed to the surveyor. The DON stated the following to the surveyor: Oh you need this? Upon surveyor review of the third pharmacy recommendation received, the surveyor noted that the recommendation dated 4/25/24 included the following information regarding the trazodone orders: Psychotropic drugs PRN (as needed), orders for psychotropic drugs are limited to 14 days and included an area for the physician's response to the recommendation. At this time, the surveyor noted the recommendation had no physician response documented on it, and the two orders for trazodone were documented as continuing until one was discontinued on 5/1/24 (6 days after the recommendation was made) and one was discontinued on 5/7/24 (12 days after the recommendation was made). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 7/5/24 at 1:11PM the surveyor conducted a review of the medical record for Resident #163 which revealed active medical orders for several psychotropic medications including Lorazepam and Seroquel, however, no medical orders for monitoring of medication side effects, or behavioral monitoring of the resident could be found. On 7/9/24 at 10:24AM the surveyor conducted an interview with the Resident's assigned nurse, Licensed Practical Nurse (LPN) #51. When the surveyor inquired as to the monitoring for side effects and behavior monitoring for psychotropic medication use for Resident #163, they reviewed the medical record with the surveyor present, and they responded: It should be ordered. On 7/9/24 at 10:37AM the surveyor conducted an interview with the facility Administrator. During the interview, the Administrator reviewed the resident's medical record and confirmed that side effect and behavior monitoring should be in place via a medical order and was not currently ordered for the resident. At this time, the surveyor shared their concerns and the Administrator acknowledged and confirmed understanding of the concerns. On 7/12/24 at 10:29AM the surveyor conducted an interview with the DON as to the facility's process for ensuring the monitoring surrounding psychotropic medication use. The DON stated the following regarding the facility's current process: The expectation is that the admitting nurse enters the monitoring order and the unit manager should be reviewing records, daily orders, to catch any that didn't get ordered and then bring that issue to the daily meeting. 42886 3) During the investigation for MD 00181057, a review of resident #545's medical record on 7/8/24 at 9:29am revealed that the pharmacist consultant recommended a gradual dose reduction (GDR) for Seroquel (Quetiapine Fumarate). Continued review of resident #545's medical record revealed the facility contracted an agency psychiatric nurse practitioner (agency psychiatric NP) to assess the resident to ensure that the gradual dose reduction was safe for the resident. On 7/21/22, the agency psychiatric NP failed to assess the resident for a GDR due to his/her failure to locate Seroquel in the resident's medical orders. Further review of resident #545's medical record revealed the GDR was ordered by the attending provider on 8/11/22. The attending provider reduced the Seroquel order from 1 tablet twice a day to 0.5 tablet twice a day. During an interview with the Director of Nursing (DON) on 7/9/24 at 1:30pm, the DON admitted that resident #545 received an additional dose of 0.5 tablet twice a day from 7/21/22 to 8/11/22 because the agency psychiatric NP failed to assess the resident for the recommended GDR. The surveyor expressed concern about the facility's delay in starting the recommended GDR. The DON understood and provided no new information.

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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. 47200 Based on observation and interviews it was determined that the facility failed to ensure 1) medications were securely stored, 2) all drugs and biologicals used in the facility are labeled in accordance with professional standards, including expiration dates and 3) failed to monitor and document daily, on the temperature log, the refrigerator temperature where residents' medications are stored to preserve their integrity. This was evident for 3 medication carts and on inspection of the medication rooms during the recertification survey. The findings include: 1) On 6/21/24 at 10:35AM the surveyor observed an unattended medication cart with the lock mechanism protruding outward on the 2 South Nursing Unit. Upon approaching the cart, the surveyor was able to open all drawers by use of the sliding mechanism and all medications stocked within the cart were observed to be accessible. On 6/21/24 at 10:37AM the surveyor conducted an interview of Licensed Practical Nurse (LPN) #58 upon their exit from a resident room, at which time the surveyor shared their concern. LPN #58 acknowledged understanding of the concern, confirmed the cart should be kept locked, and reported to the surveyor that they usually lock the cart when they step away from it. On 6/21/24 at approximately 11:19AM the surveyor shared their concern with the facility Administrator who acknowledged understanding of the concern. 44441 2) On 6/25/24 at 8:36 AM an inspection of the first-floor medication cart #3 was conducted with Staff #48 and revealed multidose medications opened with no opening dates on them. These mediations include: Fluticasone Propionate nasal spray (Flovent)- 50mcgs per spray, 0.54 Fl oz. Acetaminophen 160mg/5ml solution Carboxymethylcellulose sodium ophthalmic solution 5 % Ferrous Sulphate 220mg/5ml Elixir 16 fl. oz. Dorzolamide Hcl-timolol maleate eye drop 22.3-6.8 mg/ml -10 ml bottle Lactulose 10gm/15ml Soln.- 8 oz bottle Levetiracetam oral solution-100mg/ml solution bottle (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multi-Vite liquid 8 Fl oz bottle (236 ml) vitamin & mineral supplement Polyethylene glycol 3350 (Clear lax)- MiraLAX unflavored powder grit free 17.9 oz bottle, floor stock On 6/25/24 at 8: 47 AM staff # 48 confirmed that there were no opening dates on the medications found on cart #3 first floor. She stated that the medications should have been dated when opened to know when they expire. On 6/25/24 at 8:49 AM an inspection of medication cart #3 on 2W was conducted on the second floor with Staff #7. Several multidose medications were observed opened with no expiration dates on them. These medications include: Aspart insulin 100 unit/ml-injection x 2 bottles, the second bottle has no name on it. Novolog insulin 100 unit/ml injection Envarsus XR 1mg (Tacrolimus Extended-release tablet) Megestrol syrup susp 40mg/ml bottle On 6/25/24 at 9:17 AM staff # 7 confirmed that there were no opening dates on the medications found on cart #3 and that the medications should have been dated with an opening date. On 6/25/24 at 9:17 AM Staff #46 the assistant unit manager on the 2nd floor 2 [NAME] was made aware of the findings and concern. 3) On 6/26/24 at 9:33 AM the 1st floor refrigerator was inspected where the resident's medications were kept. The refrigerator logbook was reviewed and revealed that some days in April 2024 the refrigerator temperatures were not recorded. These dates were on April 5th, 9th, 10th, 13th, 14th,15th, 28th, & 29th. On 6/26/24 at 11:25 AM The findings and concerns were reviewed with Staff #7 the unit manager. She stated that the night shift nurses were responsible for completing the logbooks and will re-educate her staff on ensuring that the temperature logbooks were properly completed.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on interview and medical record review, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner, and 2) to assist a resident in scheduling a dental visit/appointment to obtain dental care outside the facility. This was evident for 2 (#49, #453) of 7 residents reviewed for dental services during a recertification/complaint survey. The findings include: 1) On 6/21/2024 during the initial pool screening, Resident #49 told a surveyor that s/he was seen by a dentist and indicated that s/he needed a new tooth but was told they were not sure if the resident's insurance will take care of it. On 6/27/2024 at 1:27 PM, a review of physician orders did not reveal any active orders for dental consult. However, further review revealed an order for dental consult dated 4/11/2023 that was discontinued on 2/3/2024: Dental Consult for loose tooth. No directions specified for order. Other Discontinued 2/3/2024 4/11/2023 On 6/27/2024 at 2:28 PM, a review of nurses' progress notes from April 2023 through June 2024 did not reveal that Resident #49 was having any dental issues, seen by a dentist, and/or went out for a dental appointment/consult. On 6/27/2024 at 3:02 PM, surveyor reviewed progress notes by external staff for the above time frame. There were no treatment notes by a dentist/dental group in the resident's electronic record. On 7/1/2024 at 11:45 AM, an interview was conducted with Resident #49. The resident stated that s/he was missing some teeth on both sides of the upper jaw and opened their mouth to show the missing teeth. The surveyor observed Resident #49's upper front middle tooth (central incisor) and back teeth (canines and molars) were missing. Resident #49 further stated that they say they are too expensive to put them back in and the dentist does not take my insurance. Resident #49 added that s/he would love to have his/her teeth back: I have been telling them, but they say they will give me a temporary one for the front tooth, but I can't chew because the back ones are not there. When asked when s/he last saw a dentist, Resident #49 could not recall. On 7/1/2024 at 11:51 AM, in an interview with Resident #49's nurse, Licensed Practical Nurse (LPN #3), she stated that she (LPN #3) was not aware that the resident had dental concerns, wanted to have missing teeth replaced and/or requested to see a dentist. Regarding dental consults, LPN #3 stated that dental appointments were scheduled by the unit secretary per doctor's orders and/or residents'/family request. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/2024 at 12:34 PM, in an interview with the 2 [NAME] Unit Manager (UM #4), she stated that dental appointments were made based on the type of insurance that the residents have: If a resident has PPHP (Medicare Advantage plan) insurance, they can see Mobile Dentist that comes to facility, otherwise, they will have to go out. However, UM #4 stated that she was not aware Resident #49 had any dental concerns. The surveyor requested from UM #4, documentation regarding the last time Resident #49 saw a dentist, if ordered dental consult for lose tooth dated 4/11/2023 was kept/notes of that appointment, and if there was a follow up dental visit, and why that order was d/c on 2/3/2024. On 7/2/2024 at 2:53 PM, in a follow up interview with UM #4, she stated that Resident #49 was not seen by a dentist as ordered on 4/11/2023. She stated that the reason why order was d/c on 2/3/2024 was because Resident #49 got readmitted from the hospital on 2/3/2024 (same day order was d/c) and the admitting nurse deleted it: The admitting nurse deleted the old orders to put in the new orders, and so the order for dental consult fell off. UM #4 confirmed that Resident #49 has not been seen by a dentist since the order was placed on 4/11/2023. However, UM #4 added that she was going to follow up with the resident and schedule an appointment for a dental consult. On 7/3/2024 at 12:44 PM, a follow up review of the nurses' progress notes revealed the following Nursing Narrative Note dated 7/2/2024 at 15:43 (3:43 PM): Patient's son - [name] has refused to pay for stretcher transportation for patient to go out to see the dentist, stated he is willing to pay for Mobile Dentist services for [parent] at the facility, awaiting next date the Mobile Dentist will be back for dental services, patient has no c/o tooth pain at this time, will continue to monitor. On 7/3/2024 at 1:02 PM, an interview was conducted with the Nursing Home Administrator (NHA). Regarding Resident #49's dental appointment not being made, NHA stated that UM #4 had informed her (NHA) about the missed order on 4/11/2023 for dental consult. NHA stated that she did not know how the order got missed at the time it was put in but that it fell off the resident's orders when Resident #49 went to the hospital and was readmitted to the facility on [DATE]. However, NHA stated that they spoke with Resident #49's son yesterday (7/2/2024) and were in the process of having the Mobile Dentist see the resident as soon as possible. On 7/3/2024 at 2:32 PM, in a follow up interview with NHA, she stated that Resident #49 has been scheduled to go for an outside dental appointment on 7/8/2024. NHA added that Son doesn't want to pay for it. I don't have a date for the Mobile Dentist to see the resident. Worst case scenario I will have to pay for it because no one wants to pay for transportation, and it has been over a year. On 7/12/2024 at 9:27 AM, in an interview with the Director of nursing (DON) and VP of clinical services (Staff #44), surveyor shared concerns regarding Resident #49's missed dental consult ordered on 4/11/2023. DON stated he did not think the resident had a loose tooth now and added that if Resident #49 was complaining, staff would have picked it up and scheduled an appointment for the resident. However, DON added that he will leave it to the Administrator to address since she (Administrator) was already on it. 44441 2) On 7/11/24 at 8:40AM, a review of a complaint incident #MD00207517 alleged that Resident #453 needed dental services secondary to a cracked tooth and obvious decay and that staff has been delinquent in arranging it despite frequent reminder by the resident's family member since March 2024. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's medical records on 7/11/24 at 9:56 AM revealed a Social Work's (SW) note dated 3/27/24 which documented a request by the resident's family member for a dental appointment for the resident for which the SW indicated she will follow up. Further review of the medical records did not reveal any further documentation about setting up a dental appointment for Resident #453. On 7/11/24 at 11:20 AM an interview was conducted with Staff #54 a social worker in charge of the Long-Term Care Unit (LTC). She was asked if resident was on her tracking list of residents waiting to be seen by a dentist. She said that resident was not on her list because nursing staff did not put in a request for resident to be seen per protocol. She was asked if she was notified by the previous SW that the family requested for resident to be seen. She indicated that she was not made aware of such a request by the family. The surveyor met with the complainant at the resident's bedside on 7/11/24 at 2:03 PM. S/he reiterated that they have spoken to multiple social workers including the administrator on different occasions. That he was told that the dental visit has to be arranged by a social worker, yet nothing has been done. On 7/11/24 at 2:22 PM, the unit manager on 2W, staff #4, came into the room and was made aware of the concern. She promised to follow up.

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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. 15701 Based on interview, observation and record review it was determined that the facility staff failed 1) to prevent bare hands contact of ready-to-eat food (toast). This was observed while conducting an in-room interview with resident #49, and 2) to ensure: kitchen staff use of hair coverings, clean and appropriate dating and storage of food items, maintenance of kitchen equipment, cold food storage free from ice accumulation, tray line accuracy, sanitary food prep surfaces free from personal items, and ensure monitoring of required dishwashing sanitization temperature levels. All residents have the potential to be affected by these practices. The findings include. 1) Resident #49 was interviewed on 6/21/24 at 8:49AM. At 8:49 AM GNA #2 knocked on the resident door and brought a covered plate into the room. She asked resident #49 if S/he wanted their toast buttered. Resident #49 agreed and GNA #2 picked up a half a slice of toast with her bare hand and proceeded to butter the bread with a knife. She placed the first half down and picked up the second half with her bare hand and buttered the second half of toast. GNA #2 was interviewed on 6/21/24 at 1:45 PM. She acknowledged that she had picked up the resident's toast with her hands and was unaware that she should not touch the food with her hands. The concern of the employee's bare hand touching of food was reviewed with the unit manager (staff #4) and the director of nursing on 6/26/24 at 11:25 AM. 47200 2) On 6/20/24 at approximately 7:45AM the surveyor observed one staff member in the kitchen with a surgical mask on which did not cover their beard hair that extended beyond the mask, and a second staff member at the service line putting on a hairnet. On 6/20/24 at 8:35AM the surveyor observed Dietary Aide #64 on the tray line with a surgical mask on which did not cover their beard hair that extended beyond the mask. At this time, the surveyor conducted an interview with Dietary Aide #64 who reported to the surveyor that the reason why they were wearing the mask was due to their concern for Covid, and confirmed with the surveyor that they were not wearing it for the purpose of covering their beard. On 6/20/24 at 8:37AM the surveyor conducted an interview with the Certified Dietary Manager (CDM) #63 and inquired as to their expectation for beard coverings within the kitchen. The CDM reported to the surveyor: That's a question that has never come up since I've been here. When the surveyor inquired as to the location of beard covers within the kitchen, the CDM inquired to Dietary Aide #62 to find out where they were located. The CDM further confirmed with the surveyor that Dietary Aide #64 should be wearing the beard cover. On 6/20/24 at 8:43AM the surveyor observed Dietary [NAME] #65 in the kitchen with no hair covering. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/20/24 at 8:50AM the surveyor observed a cart of ready to eat side items near the tray line which included lunch food side items during breakfast hours. The surveyor observed one container of noodle salad and one container of a pureed food item dated 6/19 with no other labeling. When the surveyor inquired as to how long the lunch items had been sitting without refrigeration during the breakfast hours, staff removed the items and discarded them. On 6/20/24 at 9:01AM the surveyor observed a tray of piled up various assorted food items located in the walk in refrigerator, including half a bag of grapes, spilled drink cups with clear liquid, container of dry cereal, paper type containers of hard boiled eggs with no date or time on them, an opened package with the remainder of a sandwich, clear container of baked goods with no labeling, magic cup, and spilled containers of nectar apple juice throughout the tray. Upon surveyor's interview of the CDM at this time, they reported: this tray is snacks for the cafe. At this time the surveyor shared their concerns and the CDM confirmed and acknowledged understanding of the concerns and the surveyor observed them remove the tray and discard the items. On 6/20/24 during surveyor's initial tour, a thermometer was observed within the reach in refrigerator located near the serving line which was observed to read 50F. The CDM reported to the surveyor that this thermometer was broken, and removed it from use. On 6/20/24 at 9:15AM the surveyor observed a circular wall thermometer located toward the back of the walk in freezer which appeared to be inoperable, and the temperature could not be deciphered due to being covered in frost internally. On 6/20/24 at 9:15AM the surveyor observed a metal pipe protruding from the ceiling of the walk in freezer which had approximately a one foot long section of frozen ice several inches wide extending from the pipe opening, down onto cardboard boxed food items. On 6/20/24 at 9:15AM the surveyor observed an icicle dripping clear liquid extending from the walk in freezer's light fixture. The floor below the light fixture was noted with slippery conditions and a two inch wide mound of ice accumulation. On 6/20/24 at 9:15AM the surveyor observed a thick icicle in the corner of the walk in freezer extending several feet in length and several inches wide. On 6/20/24 at 9:15AM the surveyor observed an icicle approximately one foot in length extending from a pipe wrapped with tape within the walk in freezer. The icicle extended from the pipe, onto, and attached to a container of frozen soup. On 6/20/24 at approximately 9:15AM the surveyor observed several temperature control knobs to be missing from the steam table. On 6/20/24 at 9:20AM the surveyor observed a one inch build up of ice accumulation on the inside perimeter of the ice cream freezer chest. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/20/24 at approximately 9:27AM the surveyor observed the milk refrigerator chest digital temperature to be 48F. Upon further observation the surveyor observed a bent metal hinge-type pin and an open gap between the black seal and the refrigerator box which allowed the surveyor to feel air exiting the box. At this time, the surveyor shared their concern, and observed the CDM adjust the lid to ensure the closing of the box. On 7/10/24 at 12:34PM the surveyor observed Dietary Aide #66 assembling trays of food on the tray line with no hair covering. On 7/10/24 at 12:37PM the surveyor conducted a random observation of a completed tray's ticket and observed that two of Resident #183's items selected on the ticket, including yogurt and carrot cake, were not present on the tray. Upon surveyor inquiry as to the missing items, carrot cake was placed on the tray, no yogurt was provided, and the tray was placed on the food cart. Dietary Aide #67 communicated a yogurt was needed to the porter staff member, who acknowledged them, and proceeded to leave with the food cart. Dietary Aide #67 was observed retrieving the yogurt and following after the porter and cart to place it on the resident's tray. On 7/10/24 at 12:42PM the surveyor conducted an interview with the CDM and inquired as to their expectation for hair coverings. At this time, the surveyor observed the CDM obtain a hairnet for Staff #66 to put on. On 7/10/24 at 12:55PM the surveyor observed the open lid to the milk refrigerator with approximately a two foot section toward the middle of the rubber seal to the lid which was sagging in a u-shape. The surveyor shared their concern with the CDM who confirmed this was not appropriately sealed and needed replacement. On 7/10/24 at 12:59PM the surveyor observed Assistant Dietary Manager (ADM) #68 removing drink bottles from the food prep table's shelf and placing them into a fast food bag that was present on the shelf. At this time, the surveyor observed a fast food drinking cup with a straw present on the food prep table surface. The surveyor shared the concern with ADM #68 who acknowledged the concern, and a kitchen staff member was observed removing the cup and throwing it away. On 7/10/24 at 1:11PM the surveyor conducted a second random observation of a meal tray and ticket for Resident #118. The plate cover was lifted revealing ham and mashed potatoes. When the surveyor observed the menu selection ticket, the selections made by the resident were for ham, sweet potatoes, and zucchini. At this time the surveyor inquired to kitchen staff as to the availability of the missing menu items. Food service staff confirmed the selections were available and the surveyor observed the selections present on the steam table. After surveyor intervention, the food tray items were corrected for accuracy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/10/24 at 1:45PM the surveyor observed the temperature logs for the dishwasher and noted the following: from 6/21/24 to 6/30/24 no evening monitoring of dishwasher temperatures was recorded, on 6/26/24 no monitoring of dishwasher temperatures was recorded, on 7/1/24 and 7/2/24 no evening monitoring of dishwasher temperatures was recorded, on 7/3/24 no morning or afternoon monitoring of dishwasher temperatures was recorded, on 7/4/24 and 7/5/24 no evening dishwashing monitoring of temperatures was recorded, on 7/7/24 no evening monitoring of dishwasher temperature was recorded, and on 7/8/24 no monitoring of dishwasher temperatures was recorded. At this time, surveyor concerns were shared with the CDM and ADM. Upon interview, both the CDM and ADM confirmed they were responsible for oversight of temperature logs and acknowledged understanding of the surveyor's concern.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on observation, medical record review, and interviews, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (Resident #131, #105) of 77 residents reviewed during a recertification /complaint survey. The findings include: Hemodialysis or simply dialysis is a process of filtering the blood of a person whose kidneys are not working normally. A hemodialysis (dialysis) catheter is used to access your blood for hemodialysis. It is a soft tube placed in a large vein in the neck, chest or groin. An arteriovenous (AV) fistula is a connection that's made between an artery and a vein for dialysis access. A surgical procedure, done in the operating room, is required to stitch together two vessels to create an AV fistula. 1) During a review of Resident #131's medical record conducted on 7/2/2024 at 10:27 AM, surveyor noted active physician orders for two different dialysis access: - ARM FISTULA: Left upper arm. MONITOR FOR BRUIT AND THRILL EVERY SHIFT every shift for MONITORING DOCUMENT PRESENCE OF BRUIT/THRILL dated 12/10/2023, And - Monitor Right jugular tunneled dialysis catheter and report any changes to MD every shift dated 12/9/2023. On 7/2/2024 at 10:53 AM, review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for June 2024 was completed: Staff documentation revealed Resident #131 had two different access sites for dialysis: Left upper arm fistula and right jugular tunneled dialysis catheter. Further review of the MAR and TAR revealed staff documentation on all three (3) shifts (day, evening, night) that Resident #131 was on a 1.5 L/day fluid restriction (ordered on 12/11/2023). However, there was no documentation of the actual amount of fluid intake per shift (amount resident drank/ actual shift total). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2024 at 1:06 PM, an interview was conducted with 2 [NAME] Unit Manager (UM #4) who confirmed that Resident #131 has a Left AV fistula for dialysis. She stated that the resident used to have a temporary right dialysis catheter when the left AV fistula was not functioning. She added that the right jugular tunneled dialysis catheter was discontinued once the left AV fistula started working. She confirmed that the resident no longer had the right jugular access despite staff documentation to the contrary. UM #4 reviewed the resident's TAR for June 2024 and confirmed that staff were documenting that they were monitoring Right jugular tunneled dialysis catheter that was no longer there. She stated she was going to follow up with the staff. Regarding documentation on 1.5 L/day fluid restriction, UM#4 reviewed the MAR for June 2024 and confirmed that they did not have a record of how much fluid resident was taking per shift. UM #4 stated that whenever Resident #131 returned to the facility from the hospital, they will start documenting the actual amount of fluid intake per shift to keep track of the 1.5 L/day fluid restriction. On 7/5/2024 at 8:59 AM, additional review of order summary report for resident #131 revealed an active order for: Audiology consult for hearing evaluation and possibly hearing aids every day shift dated 12/10/2023. On 7/5/2024 at 9:01 AM, a review of Resident #131's MAR and TAR for June 2024 revealed daily staff sign off on audiology consult for hearing evaluation and possible hearing aids. On 7/5/2024 at 9:13 AM, a follow up interview was conducted with UM #4: Regarding the active order for audiology consult dated 12/10/2023, UM #4 stated that she believed Resident #131 had that appointment and added that the order should have been taken off when the appointment was scheduled. UM #4 further stated that she was going to discontinue the order. The surveyor reviewed Resident #131's TAR for June with UM #4 who confirmed that staff documentation was inaccurate. On 7/12/2024 at 8:55 AM, in an interview with the Director of Nursing (DON) and VP of Clinical Services (Staff #44), surveyor reviewed staff documentation on Resident #131's MAR and TAR for June 2024. They both stated that the right jugular tunneled dialysis catheter was a temporary order that should have been discontinued. Staff #44 confirmed that Resident #131 no longer had the right jugular tunneled dialysis catheter. - Reviewed staff documentation of Fluid restriction monitoring (not giving the actual amounts per shift taken by the resident): DON confirmed that the breakdown was supposed to come from dietary and was missing in the records. - Reviewed staff documentation on Audiology consult dated 12/10/2023: DON stated, they can't be signing this. Both DON and Staff #44 reviewed Resident #131's records and confirmed that staff documentation was inaccurate. 2) On 7/10/2024 at 8:46 AM, a review of active orders for Resident #105 revealed orders for: ENTERAL: - Jevity 1.5 via PUMP 60ML/HOUR HOURS PER DAY 18 OR UNTIL TOTAL NUTRIENTS HAS BEEN DELIVERED. DOWNTIME 9AM, UP AT 3PM TOTAL NUTRIENT 1170ML TOTAL CALORIES 1755CAL every day and evening shift dated 7/7/2024, and WATER FLUSH ENTERAL TUBE WITH 200 ML OF H20 Q4HR FOR TOTAL VOLUME OF 1200ML FREE H20 FLUSHES / 24HRS every 4 hours dated 6/26/2024. However, the orders lacked the amount of water flushes during medication pass (before, in-between, and after). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/2024 at 9:10 AM, a review of Resident #105's MAR and TAR for June and July 2024 was completed. Staff documentation lacked the amount of water flushes required with medication pass. On 7/10/2024 at 10:42 AM, an interview was completed with Licensed Practical Nurse (LPN #43) who has worked in the facility for [AGE] years. Regarding Resident #131's tube feeding and medication pass, LPN #43 stated that the resident was getting free water flushes of 200 ml every 4 hrs. programmed in the feeding pump. Regarding medication administration, LPN #43 stated that the protocol was to flush with 5 ml of water in-between meds and 30 ml before and after med pass. On 7/10/2024 at 10:50 AM, an interview was completed with Licensed Practical Nurse (LPN #6). When asked how staff would know how much water and how often to flush the feeding tube, LPN #6 responded that they have an Enteral Protocol sheet in the resident's paper chart that indicates the amount and rate of tube feed including amount and frequency of water flushes. LPN #6 stated that the information was also found in the orders section in PCC (electronic record) and should be documented in the resident's MAR and TAR. Surveyor reviewed with LPN #6 Resident #105's active orders, MAR and TAR for June and July 2024. LPN #6 verified and confirmed that there were no orders for water flushes during and after medication pass. LPN # 6 brought out Resident #105's paper chart and showed surveyor an individualized Enteral Protocol sheet for Resident #105 dated 11/16/2022. Further review revealed . Tube feeding: Nutrient Jevity 1.5, Tube feeding Method/Frequency: PEG & Pump checked. However, the amount was 65 ml/hr. and different from the current order for 60ml/hr. - Flush tube with 200 ml of water q 4 hours, total volume of flush 1200 ml/qd (excluding medication flushes). - Flush tube with 25-30 ml of water before and after each medication pass. - Flush tube with 5 ml of water between each medication . LPN #6 verified and confirmed that the active orders, MAR and TAR did not address water flushes during medication pass as indicated in the individualized enteral protocol. LPN #6 confirmed that the Enteral Protocol form dated 11/16/2022 was outdated and resident's tube feeding rate was currently 60 ml/hr and not 65 ml/hr as indicated on the enteral protocol form. LPN #6 further looked through the resident's paper chart and could not find any current enteral protocol for Resident #105. On 7/10/2024 at 11:00 AM, an interview was conducted with the 2 [NAME] Unit Manager (UM #4). The surveyor reviewed Resident #105's active orders, MAR and TAR with UM #4 who verified and confirmed that there were no orders for water flushes during medication pass. UM #4 stated, I don't see the order and added that they should have specific orders for water flushes with medication pass, so nurses know what to do during med pass. Surveyor reviewed the individualized Enteral Protocol dated 11/16/2022 found in the resident's paper chart with UM #4. UM #4 verified and confirmed that the Enteral Protocol was not updated to reflect the resident's current tube feeding orders (the amount noted was 65 ml per hour which was different from the current ordered amount of 60 ml/hr.). UM #4 further stated that she was going to contact the dietician to have Resident #105's Enteral Protocol updated to reflect the current orders for tube feeding. On 7/10/2024 at 2:11 PM, in an interview with the DON, surveyor reviewed Resident #105's active orders and Enteral Protocol dated 11/16/2022. DON verified and confirmed that the orders should have reflected the water flushes with med pass. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regarding the Enteral protocol dated 11/16/2022, DON acknowledged that it was outdated and should have been updated to reflect the current orders. He added that the orders in PCC should be identical to those in the individualized Enteral Protocol for the resident, so staff do not need to look elsewhere (e.g. paper chart) for that information. On 7/12/2024 at 9:22 AM, a follow up interview was completed with the DON and VP of clinical services (Staff #44). Surveyor reviewed Resident #105's tube feeding orders lacking water flushes with medication pass and outdated enteral protocol dated 11/16/2022 in the resident's chart. DON stated that he followed up with the dietician who told him that she (dietician) had the updated form in their dietary folder but failed to put it in the resident's chart. On 7/12/2024 at 11:16 AM, an additional review of active orders revealed Resident #105's orders had been revised and new orders for tube feeding including water flushes during med pass put in after surveyor's intervention.

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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. 47200 Based on observation, interview, and medical record review it was determined the facility failed to: 1) ensure staff donned appropriate personal protective equipment for enhanced barrier precautions, and ensure the medical order for enhanced barrier precautions was timely implemented and followed, and 2) use appropriate infection control practice during urinary catheter maintenance. This was evident for 1 (Resident #393) out of 7 residents reviewed for pressure injuries and 1 (Resident #6) out of 4 residents reviewed for urinary catheter during the recertification survey. The findings include: During an interview with Resident #393 on 6/21/24 at 9:55AM they reported to the surveyor that their call bell was not in reach and they needed assistance with repositioning. At this time, the surveyor reported the concern to Licensed Practical Nurse (LPN) #51 who offered the following response: I have to go find their nurse because of the sign on the door, it's not my patient. At this time, the surveyor further noted the signage on the door to the room which indicated that enhanced barrier precautions were to be followed for this resident room. LPN #51 further reported to the surveyor that Resident #393 was on contact precautions because of the wound on their leg. On 6/21/24 at 9:57AM the surveyor observed LPN #51 put on a gown and assist the resident by retrieving their call bell. Resident #393 appeared concerned and asked LPN #51 why they had to put a gown on. LPN #51 replied to the resident: because of the wound on your leg if I have to do the wound. Resident #393 stated the following to LPN #51: You're the only one who has put that gown on. Both Resident #393 and their roommate, Resident #176, reported to the surveyor that the enhanced barrier precautions sign on the door had just gone up yesterday and they had not received communication as to why. Resident #393 and Resident #176 reported to LPN #51 that they were concerned about why the gown was just put on by them, and wanted to know if someone was sick. Resident #393 asked LPN #51 why the sign went on the door the day prior, but no one had utilized the gown and gloves prior to this time. On 6/26/24 at 9:17AM the surveyor conducted a review of the medical record for Resident #393 which revealed the resident was admitted to the facility with wounds on 6/14/24. The medical order for enhanced barrier precautions was observed as having been implemented on 6/23/24, approximately 9 days later, instead of upon admission. On 6/26/24 at 11:23AM the surveyor entered the room of Resident #393 and observed the enhanced barrier precaution signage posted on the door to the room, and LPN #59 was observed at the bedside performing the resident's wound dressing change on their right foot with a mask and gloves on, and no gown on. On 6/26/24 at 11:31AM the surveyor observed LPN #59 enter the room again, with no gown on. On 6/26/24 at 11:33AM the surveyor observed LPN #59 changing the resident's left foot dressing with no gown on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215112	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Health Systems - Columbia	6334 Cedar Lane Columbia, MD 21044

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:40AM the surveyor conducted an interview with LPN #59 regarding their understanding of what personal protective equipment needed to be worn for the resident on enhanced barrier precautions. LPN #59 reported to the surveyor that they have to wear gloves, a gown and a mask during dressing changes and acknowledged that they did not wear the gown to perform the dressing changes. At this time the surveyor shared their concerns with LPN #59 who confirmed understanding of the concerns. On 6/26/24 at 12:02PM the surveyor observed LPN #59 and GNA #24 standing at the bedside of Resident #393, moving the resident up in bed with their bed sheet, and no gowns were being worn. On 6/26/24 at 12:03PM the surveyor conducted an additional interview with LPN #59 who reported the following information to the surveyor regarding why they did not have gowns on: We have to wear a mask, gloves, and gown if we are doing invasive procedures, but right now we are just moving him/her up in bed. On 6/26/24 at 12:39PM the surveyor conducted an interview with the facility's Wound Nurse, LPN #61 who confirmed the following facility expectation for personal protective equipment to be utilized for enhanced barrier precautions: Staff need a gown and gloves on, no mask, when doing wound care, and yes, the same for repositioning someone in bed. On 7/12/24 at 9:08AM the surveyor conducted an interview with the Assistant Director of Nursing, Registered Nurse #57, who reported they were the assistant to the infection control nurse. During the interview, they reported that precautions were implemented by whoever put the orders in first, between the Infection Control Nurse and the Unit Managers. 50458 2) A urinary catheter is a flexible tube placed in the body to drain and collect urine from the bladder. On 06/21/24 at 2:48 PM, it was observed that the urine collection bag for Resident #6 was on the floor. On 07/02/24 11:38 AM an interview was conducted with the Director of Nursing (DON). He was informed that on 6/21/24, the urine collection bag for Resident #6 was on the floor. He stated that this was unacceptable.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on record review and staff interview, it was determined that the facility staff failed to document that residents and/or their Responsible Parties (RPs) were provided education on the Influenza vaccine before requesting consent. This was evident for 1 (Resident #109) of 5 residents reviewed for Immunizations during the survey. The findings include: Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people [AGE] years and older, pregnant people, and people with certain health conditions or a weakened immune system are at the greatest risk of flu complications. Influenza (Flu) vaccines can prevent influenza. (Centers for Disease Control and Prevention- vaccines and preventable disease) During an interview with the Infection Control Preventionist (Staff #15) on 07/02/24 at 9:09 AM, Staff #15 stated, I go over Flu and Pneumonia vaccine, get consents. I give the residents or family members flyers for education if they refuse. All these are documented PCC (electronic medical record) under the immunization tab. The surveyor reviewed five randomly selected residents' immunization records on 7/02/24 at 10:39 AM. The review revealed that Resident #109 resided at this facility since December 2023, and the resident refused the Flu vaccine. However, there was no documentation to support that resident (or Representative Party) received education regarding the flu vaccine. 07/03/24 at 11:13 AM, Staff #15 confirmed that Resident #109 declined the Flu vaccine, but no documentation was in place. Staff #15 stated that she spoke with the unit manager and confirmed that verbal education was provided to the family member but did not document it. On 7/12/24 at 2 PM, the surveyor shared concern about the Flu vaccine with the Nursing Home Administrator (NHA) and Director of Nursing (DON). They validated the concern.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 48168 Based on record review and interview it was determined that the facility failed to ensure all staff received training in effective communication. This was evident for all staff during the Extended Survey investigation portion of the recertification survey. The findings include: On 7/05/24 at 11:19 AM an interview with the Human Resources Director (Staff #31) was conducted. She brought the annual training plan that the facility's corporate office required to be completed by nurses and Geriatric Nursing Assistants (GNAs). It did not include any training about effective communication. Staff #31 also provided the training records for 4 GNAs (GNA #27, GNA #28, GNA #29, and GNA #30). On 7/05/24 at 12:20 PM in an interview with the Director of Nursing (DON) and the Chief Executive Officer (CEO), they provided training materials from the recent skills day. A review of the documents provided revealed that there was no training for effective communication. On 7/10/24 at 1:30 pm a record review of training records for GNA #27, GNA #28, GNA #29, and GNA #30 revealed that none of them had any training for effective communication. Another request was made to Staff #31 to check if there was any evidence of any effective communication training to employees. She said she would check. On 7/11/24 at 8:15 AM additional training records were provided by the [NAME] President of Clinical Services (Staff #44). However, the additional training documents did not include any evidence of effective communication training. On 7/11/24 at 8:22 AM in a follow up interview with Staff #44, she confirmed that the facility did not have evidence of effective communication training for any staff.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 48168 Based on record review and interviews it was determined that the facility failed to have a Behavioral Health Training Program. This was evident during the Extended Survey portion of the recertification survey. The findings include: On 7/05/24 at 11:19 AM an interview with the Human Resources Director (Staff #31) was conducted. She brought the annual training plan that the facility's corporate office required to be completed by nurses and Geriatric Nursing Assistants (GNAs). It did not include any information about a Behavioral Health Training Program. Staff #31 also provided the training records for 4 GNAs (GNA #27, GNA #28, GNA #29, and GNA #30). On 7/05/24 at 12:20 PM an interview with the Director of Nursing (DON) and the Chief Executive Officer (CEO), was conducted and they provided training materials from the recent skills day. There was no evidence of any Behavioral Health Training Program in the documents provided. On 7/10/24 at 1:30 pm a record review of training records for GNA #27, GNA #28, GNA #29, and GNA #30 revealed that none of them had any training for Behavioral Health. Another request was made to Staff #31 to check if there was any evidence that the facility had a Behavioral Health Training Program to provide to employees. She said she would check. On 7/11/24 at 8:15 AM additional training records were provided by the [NAME] President of Clinical Services (Staff #44). However, the additional training documents did not include any evidence of any Behavioral Health Training Program. On 7/11/24 at 8:22 AM in a follow up interview with Staff #44, she confirmed that the facility did not have a Behavioral Health Training Program at that time. She further stated that the facility previously worked with a contracted behavioral health company who provided behavioral health training, but they were no longer working together.