STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215113	A. Building B. Wing	08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50573 Based on observation and interview, it was determined that the facility failed to maintain the residents' dignity by staff hovering over residents while assisting them to eat. This was evident for 3 (Resident #127, #62 and #14) of 3 residents observed being fed by staff. The findings include: On 07/29/24 at 8:09 AM, the surveyor observed GNA (Staff #43) standing over Resident #127 while feeding him/her in bed. On 07/30/24 at 12:37 PM, the surveyor observed GNA (Staff #44) standing over Resident #62 while feeding him/her in the smaller dining room. On 07/30/24 at 12:59 PM, the surveyor observed GNA (Staff #21) standing over Resident #14 while feeding him/her in the smaller dining room. On 07/30/24 at 01:04 PM, an interview with Staff #21 revealed that she was not aware of a feeding policy but knew to be in direct eye contact with the resident while feeding them. On 07/30/24 at 01:29 PM, an interview with the Director of Nursing (DON) revealed she would have to check if they have a feeding policy and that the expectation is to have eye contact with the resident and not be hovering over them while thet are being fed. The surveyor reviewed the findings of the three occasions when the surveyor observed a staff member standing over a resident while feeding them. On 7/30/24 at 3:05 PM, the surveyor reviewed the provided policy Assistance with Meals which revealed that staff should not be standing over residents when assisting them with meals. On 08/02/24 at 12:03 PM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the staff's failure to be seated when assisting residents with meals.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observation and staff interviews, it was determined that the facility failed to accommodate resident needs by 1) failing to ensure that a resident's call bell was within reach and 2) failing to respond to call bells in a timely manner. This was evident for 1(#64) of 24 residents reviewed in the initial pool and 4 (room [ROOM NUMBER], #501, #512, #503) of 4 rooms observed with activated call bells on 2 of 3 nursing units observed during the survey. The findings include: A call bell system is a method to ensure that residents in a long-term care facility have timely access to assistance by using the call bell system. 1) A medical record review on 7/23/24 at 2:45 PM found that Resident #64 was admitted to the facility in April 2024 with diagnoses that included Dementia. Continued review revealed an admission MDS assessment, dated 4/14/24, for Resident #64. The MDS had documentation that Resident #64's dignosis included moderate cognitive impairment and was dependent on staff for all his/her self-care needs. The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. An observation on 7/25/24 at 1:50 PM showed Resident #64 sitting in a wheelchair by his/her bedside, with a call bell device clipped to the middle of the bed and not within his/her reach. When asked how he/she called for help, the Resident stated, I will call the police. In a subsequent observation on 7/26/24 at 8:56 AM, Resident #64 was lying on his/her right side of the bed, and the call bell device was attached to the head of his/her bed. In an interview, Resident #64 stated he/she could not reach the call bell device. In an interview on 7/26/24 at 9:16 AM, staff #50, a geriatric nurse aide, confirmed that Resident #64's call bell device was not within his/her reach. An interview with the director of nursing (DON) on 7/30/24 at 8:24 AM showed that a call bell device should be within a Resident's reach to help them call for help when needed. In a subsequent interview on 7/30/24 at 12:18 PM, the DON had just come from Resident #64's room and reported that the call bell device was clipped to the bed again and unreachable, so she moved it closer to the Resident. 37276 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a) On 7/30/24 at 11:12 AM, while touring the 200 hall, the 400 hall, and the 500 hall, the surveyor heard a call bell alarming and observed that the call bell indicator light was on above room [ROOM NUMBER]'s door. At 11:17 AM, the call bell indicator above the room [ROOM NUMBER]'s door continued to be activated. At that time, a nurse was observed coming out of a resident's room near room [ROOM NUMBER], walking to the medication cart, and then walking to the nurse's station. At 11:21 AM, the nurse and transport personnel were observed walking into room [ROOM NUMBER]. After being observed to be activated for 10 minutes, the call bell indicator was noted to be off at 11:22 AM 2b) On 7/31/24 at 3:14 PM, while standing at the nurses' station, two surveyors heard a call bell alarming and observed the call bell indicator light was above room [ROOM NUMBER]'s door. The call bell indicator light and the call bell notification continued to alarm at the nurse's station. The call bell indicator light was noted to be off at 3:23 PM, after being activated for 9 minutes. 2c) On 7/31/24 at 3:15 PM, while standing at the nurses' station and observing the 200, 400, and 500 halls, 2 surveyors heard a call bell alarming and observed that the call bell indicator light above room [ROOM NUMBER] was activated. At the time of the observation, 5 facility staff were noted at the nurses' station. The call bell indicator light was noted to be off at 3:22 PM, after being activated for 7 minutes. 2d) On 8/2/24 at 7:11 AM, an observation was made of the call bell indicator light above room [ROOM NUMBER]. At that time, 2 nurses were noted to be at the nurses station and one nurse was walking down the 500 hall. At 7:19 AM, a geriatric nursing assistant (GNA) was observed walking into room [ROOM NUMBER], and the call bell indicator light was observed to be off at 7:19 AM, after being activated for 8 minutes. On 8/2/24 at 10:00 AM, a review of the facility's Call Bell Policy for Long-Term Care Facility, revealed that the call bell policy did not include the name of the facility, and was undated. The policy procedures included staff responsibilities. The policy for nursing staff was respond to call bells immediately, prioritizing those that may indicate urgent needs, and the policy for all staff was, all staff must aim to respond to call bells within 5 minutes. If unable to respond immediately, staff should inform the resident and provide an estimated time of response. On 8/2/24 at 12:27 PM, the Director of Nurses (DON) was made aware of the concern that resident call bells were not answered timely. The DON stated the facility did not have an electronic call bell auditing system to determine the length of time call bells were activated, but indicated that the facility had done observational audits.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 48259 Based on record review and interviews, it was determined that the facility failed to resolve repeated concerns that were reported during Resident council meetings. This was evident in resident council meetings between January 2024 and June 2024. The findings include: A review of resident council meeting minutes for 2024 was completed on 7/25/24 at 10:09 AM. The review revealed that the following concerns were voiced during the monthly Resident Council Meetings: January- Call lights were not answered promptly, and staff used their phones while providing care to the residents. February -Call lights were not answered promptly, and the staff used their cell phones while caring for residents. March- Call lights were not answered promptly and some not answered at all. April- Call lights were unanswered, and ice water was not passed on days and afternoons. May- Call lights were not answered, Ice water was not passed on days and afternoons, and staff used their phones while providing care to the residents. June- Ice water was not passed on days and afternoons, staff were using their phones while providing care to the residents, and call lights were not answered. A continued review of the facility's Resident Grievance/Complaints Procedures contained a statement that within 5 working days of the date you filed the grievance, you will receive a written summary of the results of the investigation. However, the review failed to show that the facility promptly addressed concerns or grievances voiced at the council meetings from January to June 2024. On 7/26/24 at 2:15 PM, the surveyor held a resident council meeting with six residents, including the resident council president. During the meeting, the residents stated that they had repeatedly voiced concerns about call bell response, ice water, staff talking on their phones while providing care to residents, and their televisions being blurry and fuzzy, and they received no feedback. An interview on 7/29/24 at 4:50 PM with staff #51, the activity director, failed to show that staff followed up with the council with responses and actions regarding their concerns. A subsequent interview on 7/30/24 at 6:57 AM with the nursing home administrator (NHA) failed to show that residents received feedback after the facility's investigation or resolution of concerns voiced at the council meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview was 8/5/24 at 9:37 AM, the NHA stated that concerns with the residents' TV cable were resolved after the surveyor's intervention.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. 48259 Based on observation, record review, and interviews, it was determined that the facility failed to ensure that residents were verbally provided with a notice of their rights and services during their stay. This was evident during a resident council meeting conducted during the annual survey. The findings include: On 7/26/24 at 2:15 PM, the surveyor held a resident council meeting with six residents, including the resident council president. During the meeting, it was reported that no one reviewed residents' rights at the monthly council meetings. On the same day, a review of the meeting minutes from January to June 2024 showed a statement that Residents Rights reviewed for every month. In an interview on 7/29/24 at 4:50 PM with staff #51, activities director, she stated she did not review residents' rights at the monthly meetings as documented on the meeting minutes. Staff #51 said she would begin reviewing the rights at monthly council meetings. On 7/30/24 at 6:57 AM, the nursing home administrator was informed of the concern that residents were not verbally informed of their rights during their stay in the facility. The NHA indicated that she was unaware this was not being done at the resident council meetings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573 Based on record review and staff interviews, it was determined that the facility failed to have a system in place to ensure that an advanced directive was obtained for each resident and that there is only one active MOLST for each resident. This was evident for 2 (Resident # 59 and #127) of 4 residents reviewed for advanced directives. The findings include: 1) On [DATE], review of Resident #59's medical record revealed that the resident was admitted to the facility in [DATE] and was deemed incapable by two physicians to make health care decisions in [DATE]. An initial review of the Maryland Orders for Life Sustaining Treatment (MOLST) on [DATE], revealed that these orders were discussed with the Health Care Agent as named in the resident's advance directives. Further review of the medical record failed to reveal documentation of the resident's advance directives. On [DATE] at 9:52 AM, the surveyor reviewed the concern with the Social Worker (SW Staff #19) that the MOLST was completed per the Advanced Directive, but the surveyor was unable to find an Advance Directive in the resident's chart. On [DATE] at 8:50 AM, further review of the medical record continued to fail to reveal an Advance Directive for the resident, and the surveyor asked the Directive of Nursing (DON) if they were able to locate one for the resident. On [DATE] at 9:05 AM, the DON indicated that she checked the Electronic Health Record (EHR), paper chart, and business office but no Advance Directives were found for the resident. On [DATE], the Social Worker reported the Resident #59's spouse had the Advance Directive and was bringing them a copy to upload to the medical record. Further review of the resident's medical record on [DATE] revealed an uploaded Advanced Directive for Resident #59. On [DATE] at 12:03 PM, the surveyor reviewed the concern with the DON regarding the failure to ensure that residents' Advanced Directives were kept on file. 2) On [DATE], review of Resident #127's medical record revealed that the resident was admitted to the facility in [DATE]. A review of the MOLST found in the paper chart revealed a Do Not Resuscitate (DNR) order and that it was completed per instructions on the resident's advanced directives. Further review of both the paper and Electronic Health Record (EHR) failed to reveal documentation of the resident's Advance Directives. Additionally, a review of the EHR revealed another active MOLST for Resident #127 that included an order for the resident to be full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 09:52 AM, the surveyor reviewed the concern with the Social Worker (Staff #19) that Resident #127's MOLST was completed per advanced directive but no Advance Directive was found in the medical record. Surveyor also reviewed the concern that there were two active MOLSTs with conflicting orders regarding the administration of CPR. On [DATE] at 12:33 PM, Staff #19 provided an advanced directive for the resident. On [DATE] at 8:00 AM, the DON provided a copy of the MOLST that revealed documentation of the full code order being voided. On [DATE] at 12:03 PM, the surveyor reviewed the concern with the DON on the facility's failure to ensure that Resident #127's Advanced Directives are kept on file and that there was only one active MOLST for the resident.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 48259 Based on record review and staff interviews, it was determined that the facility failed to monitor and prevent the misappropriation of resident property. This was evident for 1 (#21) out of 2 residents reviewed for neglect. The findings include: A medical record review on 7/24/24 at 10:07 AM showed that Resident #21 had been residing at the facility since December 2022. A continued review contained an attending provider's order, dated 12/9/22, for Resident #21 for oxycodone 10mg, one tablet every 8 hours as needed for pain. A review of a facility-reported incident related to Resident #21 with MD #00193982 showed that, on 6/15/23, staff #52, a nursing supervisor, received 90 tablets of oxycodone 10 mg from the pharmacy for Resident #21. Continued review revealed that Resident #21 requested pain medicine on 6/29/23; however, it was discovered that all 90 tablets of oxycodone were missing from the narcotic box where they were stored. A review of the packing slip for 90 pills of 10mg oxycodone from the pharmacy was signed on 6/15/23 by staff #52. Further review of the Narcotic drug shift count sheet for June 2023 handed to the surveyor by the director of nursing (DON) showed no documentation for the 90 pills that were delivered on 6/15/23 for Resident #21. In an interview on 8/1/24 at 9:45 AM, the nursing home administrator stated that she could not show documentation that a complete investigation was conducted regarding Resident #21's missing medications when it was discovered on 6/29/23. In a subsequent interview on 8/2/24 at 8:30 AM, staff #53, the previous DON, reported that it was substantiated that 90 tablets of 10mg oxycodone were missing for Resident #21. In an interview on 8/2/24 at 1:44 PM, the DON said that usually, the off-going and oncoming nurses would sign the narcotic drug sheet count to indicate that the medications were counted and accounted for. However, she could not find any documentation showing that Resident #21's medication was being counted and accounted for from 6/15/23, when it was delivered, until 6/29/23, when it was discovered missing.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40927 Based on record review and staff interview, it was determined that the facility failed to develop a process to ensure that injuries of unknow origin and allegations of abuse were reported to the state agency. This was evident for 1 (#9) of 5 residents reviewed for injuries of unknown origin and 2 (#376 and #59) of 13 residents reviewed for abuse. The finding include: On 7/23/24 at 9:00 AM, a review of complaint #MD00206718 revealed that Resident #9 had been transported to the local hospital for treatment of a 15 cm laceration of their right lower leg. The complainant was concerned because facility staff were unable to explain how this injury occurred. Secondly the resident reported that two staff were transferring him/her from the wheelchair to the bed and s/he caught it on something cutting it open. An interview was conducted with the Director of Nursing (DON) on 7/23/24 at 12:45 PM, with the Regional Director of Clinical Operations present. The DON reported that geriatric nursing assistant (GNA) #22 and GNA #23 were unable to tell her how the injury occurred. They reported transferring the resident from the wheelchair to the bed and when the resident was on the bed they found the laceration. The DON reported that she investigated the incident and was unable to determine the exact cause of the injury. However, she failed to report the incident to the State Agency. The Administrator was interviewed on 7/25/24 at 11:57 AM regarding the incident. She reported she was aware of the incident. However, she failed to recognize it as an injury of unknown origin and report it to the State Agency as required. 48259 A review of the facility's grievances/concern binder on 7/30/24 at 7:52 AM revealed a grievance/concern form, dated 1/19/24. The form stated that, on 1/18/24, Resident #376's roommate witnessed a rough behavior from aide while giving care to Resident #376. The report indicated that the nurse aid did not use a Hoyer lift in transferring and tossed [Resident #376] in bed. Roommate very upset and wants to file police report. Continued review showed that the nursing supervisor and the nursing home administrator (NHA) were notified, and immediate action was taken not to allow the aide into the facility again. However, the review failed to show that the facility immediately reported the allegation of abuse to the state agency. During an interview with the NHA on 7/30/24 at 8:52 AM, she stated that an allegation of abuse must be reported to the state office within 2 hours, and a facility investigation should have been completed. The NHA confirmed that the allegation of abuse regarding Resident #376 was not reported to the state office. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/30/24 at 9:27 AM, the assistant director of nursing reported that she did not have any documentation to show that an investigation was completed for the allegation of abuse for Resident #376; however, the wound team assessed the resident's skin during rounds on 1/22/24. 50573 On 07/23/24 at 12:29 PM, Resident 59's responsible representative reported to the surveyor that the resident had been attacked by the roommate the night before and that the roommate had been moved to another room. On 07/23/24 at 02:35 PM, a review of the medical record failed to reveal documentation to indicate that a resident to resident altercation had occurred. On 07/23/24 at 02:36 PM, an interview with the Nursing Home Administrator (NHA) revealed she was unaware of any facility self-report from the previous day. On 07/23/24 at 02:40 PM, the NHA reported that the incident was a verbal altercation. The surveyor then informed the NHA that the responsible representative reported the resident was attacked. On 07/25/24 at 11:49 AM, an interview with a Licensed Practical Nurse (Staff #2) revealed that Resident #59 reported that Resident #13 pushed him/her but no one witnessed it. Further interview with Staff #2 revealed that she thinks she reported the physical push to the Director of Nursing (DON). On 07/25/24 at 06:00 PM, the surveyor expressed concern to the DON that Staff #2 reported the incident between Resident #59 and #13 as verbal and physical. The DON indicated she had obtained witness statements regarding the incident. The facility submitted a report regarding this incident to the Office of Health Care Quality on 7/23/24 at 8:56 PM. On 8/02/24 at 12:56 PM, a review of the initial report revealed that the incident occurred on 7/22/24. Further review of investigation documentation revealed an email dated 7/22/24 at 7:34 PM from the DON indicating that Resident #13 would be moved to a different room. An interview conducted by the DON with GNA (Staff #21) on 7/23/24 revealed that Resident #59 had reported that Resident #13 attacked him/her. A review of the final report revealed that the facility was unable to verify or refute the allegation of abuse due to insufficient information. On 8/02/24 at 01:05 PM, the surveyor reviewed the concern with the DON that staff failed to initially identify the incident as an abuse allegation.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on record review and interview with staff, it was determined the facility staff failed to notify the resident and his/her representative in writing when the resident was transferred to the hospital. This was evident for 3 (#924, #45, and #33) of 4 residents reviewed for hospitalization during the survey. The findings include: Review of Resident #924's medical record on 7/24/24 at 12:17 PM revealed that the resident was transferred to the hospital emergency roiagnom on [DATE] for evaluation of lethargy, low blood pressure and low sodium level. A Nursing progress note, dated 7/20/22 at 10:36 AM, by the former Director of Nursing (DON) (Staff #20), included Call placed to POA (Power of Attorney) for notification. However, the note did not indicate that the resident and his/her representative were notified in writing of the hospital transfer. In an interview on 7/29/24 at 8:55 AM, the Director of Nursing (DON) was made aware that the surveyor was unable to find evidence that the resident and representative were notified in writing of his/her transfer to the hospital on 7/20/22. No further information was provided. The facility's Policy Statement titled Transfer or Discharge, Emergency was provided to the surveyor on 7/29/24 at approximately 12:30 PM. Review at that time revealed (C) copywrite 2001 MED-PASS, Inc. (Revised December 2016). The policy included: e. Notify the representative (sponsor) or other family member. The policy did not include that notification was to be made in writing to the resident and representative. 48259 A medical record review on 7/24/24 at 12:41 PM showed that Resident #45 had been residing in the facility since May 2023. Continued review found a nurse's note, dated 6/22/24, which recorded that Resident # 45 had been transferred out to the hospital due to difficulty breathing and being lethargic. Further review of the nurse's note showed that an attempt was made to notify Resident #45's representative of the transfer. However, there was no evidence in the resident's medical record that a written notice of the transfer was given to the resident or resident representative. In an interview on 7/31/24 at 4:36 PM, the assistant director of nursing reported that the staff notified a resident's representative of a hospital transfer via phone and not in writing. 50573 (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/24/24, review of Resident #33's medical record revealed that he/she was admitted to the facility in March of 2024 and was transferred to the hospital in May of 2024. Further review of the medical record failed to produce written evidence that the resident and /or the resident representative were given written notice of the reason for transfer to the hospital. On 07/31/24 at 01:45 PM, an interview with the Assistant Director of Nursing (ADON) revealed that when a resident is sent out to the hospital, it is documented in the progress notes and that the resident's representative would be notified. Further interview with the ADON revealed that she was unaware that a written reason for transfer to the hospital needed to be provided to the resident and resident representative/family. On 08/02/24 at 12:03 PM, the surveyor reviewed the concern with the Director of Nursing regarding the facility's failure to ensure that a written reason for transfer is provided to the resident /resident representative when a resident transfer occurs.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 50573 Based on medical record review and interviews, it was determined that the facility failed to notify residents and/or their representatives in writing of the facility's bed hold policy upon transfer to an acute care facility. This was evident for 3 (#33, #45, #68) of 3 residents reviewed for hospitalization . The findings include: 1) A review of the medical record for Resident #33 revealed that, on 5/26/24, the resident was sent to the hospital for a change in his/her medical condition. Further review of the medical record failed to produce written evidence that the resident and /or the resident representative were given written notice of the bed hold policy. An interview with the Assistant Director of Nursing (ADON), on 07/31/24 at 01:45 PM, revealed that sometimes the facility keeps a paper copy of the bed hold policy for a resident if they are able to complete it, but occasionally, it is a verbal notice to the admissions director. Further interview with the ADON revealed that the bed hold policy was not provided in writing to the resident /resident representative when a resident transfer occurs and that she was not aware that the facility was required to provide one. On 08/02/24 at 12:03 PM, the surveyor reviewed the concern with the Director of Nursing regarding the failure to ensure that a written notice of the bed hold policy is provided to the resident /resident representative when a resident transfer occurs. 48259 2) A medical record review on 7/24/24 at 12:41 showed that Resident #45 had lived in the facility since May 2023. Continued review revealed that the Resident was lethargic and having difficulty breathing on 6/22/24. The attending provider was notified and ordered Resident #45 to be transferred to the emergency room for evaluation. Further review failed to show that a copy of the facility's bed hold policy was mailed to the Resident's representative. On 7/31/24 at 2:57 PM, an interview with the ADON revealed that the nurses handed the emergency medical team a packet that included a copy of the Resident's face sheet, MOLST (Maryland Order for Life Sustaining Treatment), and a list of medications and treatments. 3) In an interview on 7/24/24 at 9:00 AM, Resident #68 reported that he/she had been hospitalized in July 2024; however, the facility failed to notify him/her in writing of the bed hold policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medical record review completed on 7/25/24 at 10:10 AM found a nurse's note, dated 7/1/24, documenting a change in condition for Resident #68. The attending provider was notified and ordered to send the Resident to the emergency room for evaluation. The review showed that Resident #68's representative was aware of the acute transfer. However, it failed to show that the Resident and/or representative were notified in writing of the facility's bed hold policy. In an interview on 7/31/24 at 1:46 PM, the assistant director of nursing (ADON) reported that the bed hold policy was typically discussed with residents upon acute transfer to the hospital and not mailed. In a continued interview, the ADON stated that she was unaware that a written copy of the bed hold policy would be given to the Resident or mailed to the representative.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 48259 Based on record review and staff interviews, it was determined that the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days for a resident who was admitted to hospice care. This was evident for 1 (#45) of 3 residents reviewed for hospitalization . The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. The nursing home should complete a Significant Change in Status MDS assessment within 14 days when there's a major decline or improvement in a resident's status. A medical record review on 7/24/24 at 12:41 PM showed that Resident #45 had lived in the facility since May 2023. A continued review found that Resident #45's order summary report for July contained an attending provider's order, dated 7/2/24, that stated the Resident was admitted to hospice care on 7/2/24. Further review also found a Significant Change in Status MDS assessment, dated 7/15/24, for Resident #45. The MDS assessment was completed and signed in sections Z0500B & V0200B2 on 7/29/24, 27 days after admission to hospice care and 14 days late. An interview with staff #26, MDS coordinator, on 8/5/24 at 8:09 AM failed to show that staff were aware of the time frame for completing a Significant Change in Status MDS assessment after a resident was admitted to hospice care. During a subsequent interview, on 8/5/24 at 8:43 AM, staff #26 confirmed that Resident #45's Significant Change in Status MDS assessment, dated 7/15/24, was completed late and then stated that it should have been completed by 7/15/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 50573 Based on record review, interviews, and observations, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADL) were provided with showers. This was evident for 2 (#59 and #64) of 4 residents reviewed for ADL. The findings include: 1) A review of MD00196837 from September 2023 revealed an allegation that Resident #59 only had two showers in two months since their admission in July 2023. A review of the MDS, with an assessment reference date of 10/12/23, revealed that Resident #59 needed partial to moderate assistance with showers. Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. On 08/02/24 at 8:32 AM, the surveyor requested the shower task sheet for July 2023 to October 2023 for Resident #59. On 08/02/24 at 10:06 AM, an interview with the Director of Nursing (DON) revealed she was not able to provide documentation of showers for Resident #59 from July 2023 to October 2023. On 08/02/24 at 12:03 PM, the surveyor reviewed the concern regarding the facility's failure to ensure that a resident needing assistance with ADLs was receiving regularly scheduled showers. 48259 2) In an interview on 7/24/24 at 10:37 AM, Resident #64's representative reported that the resident was supposed to receive showers twice a week in the mornings; however, the staff was not providing them. A medical record review found that Resident #64 was admitted to the facility in April 2024 with diagnoses that included Dementia. Continued review revealed an admission MDS assessment, dated 4/14/24, for Resident #64. The MDS had recorded that Resident #64 had moderate cognitive impairment and was dependent on staff for all his/her self-care needs. A review of the shower book and Geriatric Nursing Assistant ADL documentation for Resident #64 from May 1 to June 30, 2024, was completed on 7/25/24 at 9:16 AM. The review showed a record of showers on 5/4/24, 5/18/24, 5/20/24, 6/3/24, 6/11/24, 6/13/24, and 6/20/24. Bed baths on 5/2/24, 5/7/24, 5/8/24, 5/9/24, 5/12/24, 5/15/24, 5/16/24, 5/22/24, 5/23/24, 5/25/24, 5/28/24, 5/29/24, 5/30/24, 6/2/24, 6/12/24, 6/16/24, 6/18/24, 6/21/24, 6/23/24, 6/25/24, 6/29/24. Staff had documented N/A (not applicable) on 5/11/24, 5/13/24, 5/17/24, 5/24/24, and 5/27/24; the remaining days were left blank. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation was made on 7/26/24 at 10:57 AM of Resident #64 lying in bed and staff #50, a geriatric nurse aid providing care to the Resident. Staff stated, I'm here trying to wash [him/her] up. In an interview on 7/26/24 at 2:51 PM, staff #50 stated, Let me be honest with you, sometimes you only have time to complete the basics, which doesn't include showers. With the number of residents, we are responsible for, sometimes it's impossible to give showers. Staff continued to confirm that Resident #64 did not receive his/her scheduled shower. During an interview on 7/30/24 at 7:57 AM, the director of nursing confirmed that Resident #64 did not receive his/her shower as scheduled on 7/26/24. The DON continued to state that Resident #64 was expected to have showers twice a week on Tuesday and Friday mornings, meaning that he/she would receive 8 showers monthly and bed baths on the non-shower days. However, the record review earlier showed that the Resident only received 3 showers and 13 bed-baths in May, 4 showers and 8 bed-baths in June.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 40927 Based on observation, record review, and interview, it was determined that the facility failed to recognize and address changes in the condition of residents. This was evident for 2 of 14 residents reviewed for hospitalization s and quality of care. (#127 and #921) This failure resulted in an immediate jeopardy. The findings include: 1.On 7/23/24, upon entry to the facility, Resident #127 was observed sitting in a wheelchair in a common area near the nurses' station. A medical record review on 7/25/24 at 9:08 AM revealed that the resident had returned from the hospital 7/19/2024. Review of the orders revealed that, on 7/19/24, the resident was ordered a Hospice evaluation (end-of-life care) and Morphine 0.25 mg by mouth every 3 hours for pain. Review of the progress notes revealed that, on 7/19/24 at 5:13 PM, a pharmacy alert was sent stating, This order is outside of the recommended dose or frequency. Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulfate) *Controlled Drug* Give 0.25 MG/5 ML by mouth every 3 hours for Pain. However, there was no documentation that staff called the physician to review this alert and clarify the order. Review of the medication administration record for July 2024 revealed the following order: Morphine Sulfate Oral Solution 20MG/5ML Give 0.25ml by mouth every 3 hours for Pain. The morphine was administered to Resident #127 on the following dates and times: 7/21/24- 12am, 6am, 9am, 12pm, 3pm 7/22/24- 9am, 12pm, 3pm, 7/23/24- 12am, 3am, 6am, 12pm, 3pm, 6pm, 9pm 7/24/24- 12am, 3am, 6am, 9am, 12pm, 3pm, 6pm 7/25/24- 12am, 3am, 6am, 9am Further review revealed that Licensed Practical Nurse (LPN) #2 wrote on 7/25/24, that the resident had been started on intravenous fluids (IV), that the patient was nonverbal but responded to touch. There was no other documentation about the resident's decline. There was no documentation that the doctor, family, or Hospice Care was notified of the change. Review of assessments revealed that no change in condition had been documented. Review of meal percentages for intake revealed that the resident had been eating 76% - 100% between 7/19/24 - 7/22/24 to eating 0% - 50% on 7/23/24. Then on 7/24/24 and 7/25/24, the resident was eating 0% - 25%. However, staff failed to notify hospice or the physician about this change and or investigate a possible cause of the change. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LPN #2 revealed the resident was bed bound, and not eating and drinking. For this reason, she had called the resident's family who requested IV fluids, so she called the attending physician to get the order. An interview with the DON on 7/25/24 revealed that she was not aware that the resident was on morphine routinely. The DON was asked where the resident care policies and procedures were located, she reported that she does not have access to the resident care policies and procedures. She stated she knew they were electronic, but had to ask the Administrator to print them for her. An interview with the Administrator and [NAME] President of Clinical Operations (VPCO) on 7/25/24 revealed that staff had an icon on their computer desktop to access the resident care policies and procedures. The VPCO stated she was going to check to make sure they had the icon and provide education. The DON reported that when the employee's desktops were reviewed for the resident care policy icon, it was not present. A follow-up interview with the DON on 7/26/24 revealed that she had reviewed the resident's discharge summary and found that the attending physician [who was the physician who cared for the resident in the hospital] had ordered the morphine as it was entered in the orders. She reported that those orders were verified with the attending physician on the day of admission by the admitting nurse. She stated that, with these findings, she talked to the attending physician, and he stated that the morphine order was supposed to be as needed and not routinely. The DON reported that the morphine order had been changed to as needed versus routinely. An interview with the attending physician on 7/29/24 at 9:54 AM revealed that he had mistakenly put in the Morphine as a routine medication versus as needed. Furthermore, when the admitting nurse confirmed the orders with him, he failed to catch the error. He stated that the pharmacist and nurses should review the orders to check for errors. He reported that an RN or unit manager was supposed to review all new admissions to check orders and clarify them if there was a concern. When informed that a pharmacy alert had been in the progress notes, he stated nursing had not notified him regarding the alert. He stated that when Resident #127 was admitted to the facility, he observed the resident in the dining room with family eating a meal. When staff notified him that the resident was not eating and drinking and the family requested IV fluids, he stated he thought about the resident's medications, but was unsure of the cause of drowsiness. However, he did not further look into this concern, He reported that, if he had been aware of the error in the Morphine order, he would have realized that was causing the resident's drowsiness. When asked how the resident was doing now that the medication was corrected, he stated the resident was sitting up and visiting with family. After surveyor intervention, a subsequent observation on 7/29/24 at 11:35 AM revealed the resident was in a wheelchair, self-propelling in the hallway. The resident was observed interacting with staff. A medical record review revealed on 7/29/24 the morphine order was changed to as needed. On 7/26/24 the resident intake was back to the normal of 76% - 100%. A review of the medical record on 8/1/24 at 11:30 AM revealed a progress note written on 7/31/24 at 3:51 PM that read the resident was being discharged to assisted living. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	30428 2. Record review on 7/23/24 at 12:25 PM for Resident #921 revealed that, around 12/8/2022, Resident #921 began complaining of abdominal concerns. Mylanta was ordered at that time. Further review revealed around 1/7/2023 that Resident #921, according to the progress notes, presented as tearful and had complaints of pain in their right lower abdomen. There was noted dimpling and with some hardened areas with pain that had been going on for approximately 2 weeks duration. S/he was also having some loose stools and was given loperamide. On 3/3/23, Resident #921 was having more nausea, vomiting and dizziness and was refusing meals for over 3 days. S/he was noted as pale with cool skin. S/he was ordered Reglan and omeprazole for the nausea and vomiting but unable to always take medications. There was an order at that time to send him/her to the emergency room for evaluation. The resident went and returned that day. Resident #921 was seen on 3/4/22 by the attending for follow up to the hospitalization and nausea and vomiting. There were no new interventions or plans for the resident according to the attending physician's note. He noted that s/he may need a gastrointestinal evaluation if not improved and if symptoms worsened. He was asked on 7/29/24 about the following up of consultations and he acknowledged that this was not completed. On 3/9/23, Resident #921 was seen by the nurse practitioner (NP). Staff were reporting s/he was refusing meals, had weight loss (approximately 30 lbs. at this point over the past few months) was on Reglan, but still had nausea and vomiting and was refusing medications. The intervention order was for a GI consult, however, that was not put into the resident's order set until 3/22/23. Interview with the DON on 7/25/24 at 2:08 PM revealed that the consult was never completed. According to a change in condition completed on 3/21/23, the nurse documented that she reported to the NP that Resident #921 was still complaining over the past few weeks regarding nausea, vomiting, abdominal pain, heartburn, sleeping more often, not wanting to get OOB, refusing medications and refusing meals. The NP ordered a nutritional consult. This was completed on 3/31/23, however, the dietitian still noted that s/he continued with weight loss and more nausea and vomiting. On 4/2/23, Resident #921 was sent to the emergency room for a change in mental status. S/he was placed on a non-rebreather. Within 2 hours of the emergency room admission, the hospitalist notified the family that they needed to admit him/her to hospice as there was nothing further that could be done. The general diagnosis was sepsis, shock and circulatory failure. The resident passed away within 48 hours. The facility medical director was interviewed on 7/29/24 at 10:42 AM regarding this resident. He stated that this was an unfortunate incident. He further stated that if there is an ongoing medical issue he does follow up with the ordered consults. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of these findings, a state of immediate jeopardy (IJ) was declared on 7/29/24 at 2:07 PM and an IJ summary tool was provided to the facility at that time. The facility submitted a plan to remove the immediacy on 7/29/24 at 6:57 PM and the facility's written plan to remove the immediacy was accepted on 7/29/24 at 7:10 PM with an alleged date of compliance of 7/30/24. The immediate jeopardy was abated the following day on July 30, 2024 at 9:30 AM. The provisions of the plan to remove the immediacy included the following: Resident #921 no longer resided in the facility. Resident #127 was assessed on 7/29/24 for any changes in condition with updates to the physician if indicated, a medication review was completed and any discrepancies identified were corrected immediately. Current facility residents were assessed starting on 7/29/24 and will be completed on 7/30/24 to identify if there has been a change in condition and that the physician has been notified in a timely manner with appropriate interventions initiated if indicated and that documentation of the change in condition is present in the medical record. Current facility residents with new onset of complaints of pain or injuries of unknown source over the last 30 days were reviewed on 7/29/24 to ensure that results were reviewed timely by the physician and that if indicated, an investigation was started if the facility could not identify the source of the injury present. Current facility residents' medication orders were reviewed with the pharmacy consultant and attending physician to ensure that orders were correct and appropriate for the resident and that any pharmacy alerts had been addressed. Current facility residents' orders for consults over the past 30 days were reviewed to ensure they have been carried out or scheduled as ordered. Facility licensed nurses received education starting on 7/29/24 (to be completed by 7/30/24) from the Director of Nursing on ensuring that residents are promptly assessed for any change in condition and ensuring that the physician was notified with documentation in the medical record along with implementing interventions in a timely manner, ensuring that physician orders with pharmacy alerts were addressed and the physician notified for changes to orders, if applicable. Staff members who did not receive the required education by 7/30/24 were to be educated prior to beginning their next shift. The facility Medical Director was re-educated on 7/29/24 by the Corporate Medical Director on the roles and responsibility of ensuring that residents are appropriately assessed for a change in condition with appropriate interventions and received follow up as indicated if the condition persists or worsens, that diagnostic tests are reviewed in a timely manner, that residents receive medication reviews according to physician and pharmacy standards and that ordered medications are reviewed with changes made if indicated by the pharmacy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The QAPI committee will continue to meet to identify the root causes, and to initiate improvements to the facility's processes and procedures ensuring that all residents are promptly assess for any changes in condition and ensuring that the physician is notified with appropriate documentation in the medical record along with implementing interventions in a timely manner, ensuring physician orders (especially related to narcotic orders) with pharmacy are addressed and physician notified for changes to the orders if applicable. Ensuring that diagnostic tests are completed and reviewed in a timely manner by the physician. If the diagnostic test reveals an injury of unknown origin the facility must investigate per regulation. Audits will occur weekly x [times] 4 weeks, biweekly x2 months, then monthly x2 months to ensure the facility remains in compliance. On 7/31/24 at 8:00 AM, after validation of the implementation of the facility's plan of removal, which included staff interviews, record reviews and direct observation, it was determined the facility met the minimum standards of compliance to remove the findings of an Immediate Jeopardy on 7/31/24 at 9:30 AM.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 45139 Based on pertinent document review, observation, and interview, it was determined that the facility failed to implement preventative measures to prevent pressure injuries. This was evident for 4 residents (Resident #25, #47, #2, #75), out of 43 residents reviewed during a survey. The findings include: 1. On 7/26/24, the review of medical records for Resident #25, a long-term resident at the facility, revealed that the resident had a recently healed stage 3 pressure injury on the buttocks. A stage three pressure injury is when the full thickness of the skin is lost. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. On 7/26/24 at 10:10 AM, the Director of Nursing (DON) was interviewed regarding the facility's documentation for the turning and positioning of a resident to prevent pressure injuries. The Director of Nursing (DON) reported that the facility considers turning and repositioning part of the standard of care and that there was no order for turning and repositioning, nor documentation when turning and repositioning is done. The DON reported that she does not conduct any audits to ensure that turning and positioning of residents at risk for pressure injury was being done. Turning and repositioning patients is a strategy to prevent pressure injuries (PIs) by reducing pressure on areas at risk, maintaining circulation, and keeping skin healthy. This can help prevent bedsores, also known as pressure injuries. This allows offloading of a specific part of the body. Offloading is pivotal in facilitating healing and preventing injury reoccurrence by alleviating pressure from affected areas. On 7/29/24, multiple observations were made of Resident #25 in her/his room. Observation revealed the following: 7:35 AM Resident # 25 lying in bed on his/her back, the buttock area was not offloaded, and the resident's heels were lying on the sheets against the mattress. 7:59 AM Resident # 25 lying on his/her back with the Head of Bed (HOB), slightly inclined, the buttock area not offloaded. The resident's heels were lying on the sheets against the mattress. 9:01 AM Resident # 25 lying on his/her back with the HOB at a slight incline, buttock area not offloaded. The resident's heels were lying on the sheets, against the mattress. 9:45 AM Resident #25 lying on his/her back with the HOB at a slight incline, buttock area not offloaded. The resident's heels were lying on the sheets. A small wedge pillow was on the bedside table. 10:29 AM Resident # 25 lying on his/her back, flat in bed, buttock area not offloaded. The resident's heels were lying on the sheets against the mattress. A small wedge pillow was lying on the bedside table. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10: 53 AM Resident # 25 lying on his/her back, flat in bed, buttock area not offloaded. The resident's heels were lying on the sheets/mattress. A small wedge pillow was lying on the bedside table. 11:35 AM Resident # 25 lying on his/her back in bed with the HOB at a slight incline, buttock area not offloaded. The resident's heels were lying on the sheets/mattress. 12:30 PM Resident # 25 was sitting up in bed with their lower extremities (LE), on the mattress, eating lunch, with the buttock area not offloaded. The resident's heels were lying on the sheets/mattress. The small wedge pillow was under the resident's right arm. 1:07 PM Resident #25 was on his/her back with the HOB at a slight incline, a wedge pillow under their right arm, LEs on the bed and the buttock area not offloaded. The resident's heels were lying on the sheets/mattress. 1:30 PM Resident # 25 lying on his/her back in bed with the HOB and Foot of Bed (FOB) slightly inclined, buttock area not offloaded. The resident's heels were lying on the sheets/mattress. 2:30 PM Resident # 25 on his/her back, in bed with the HOB slightly inclined, buttock area not offloaded. The resident's heels were lying on the sheets. On 7/29/24 at 2:35 PM, GNA #21, who was assigned to provide care to Resident #25, was interviewed regarding how she turns and repositions a resident. She reported that a resident is turned and repositioned by turning the resident first to face the window, then turning to face the door, and then to lie on their back. In addition, the resident's heels are floated (kept from rubbing against the bed) The GNA reported that Resident #25 had been turned and repositioned during the day shift (7-3) on 7/29/24. On 7/29/24, the surveyor and GNA #21 observed Resident #25 in his/her room. The observation revealed Resident # 25 lying on his/her back in bed, the HOB slightly inclined, and the buttock area not offloaded. The resident's heels were lying on the sheets/mattress. GNA #21 reported that the one pillow provided was not thick enough to raise the resident's legs off the bed to prevent the resident's heels from rubbing against the sheets and mattress. In addition, she reported that the small wedge underneath the resident's arm is not enough to keep the resident on his/her side. GNA #21 reported that the resident was difficult to reposition. On 7/29/24 at 2:35 PM, the LPN (Staff #2) providing care to Resident #25 was interviewed. She reported that Resident #25 had been turned and repositioned on 7/29/24 during the day shift. Then she reported that the surveyors' observations of the resident remaining on her/his back were because the resident gets agitated and is difficult to keep in a certain position. On 8/1/24, a review of the resident's progress notes from 7/29/24 through 12:00 PM 8/1/24 failed to reveal documentation that the resident refused to be turned or repositioned, or that s/he was unable to be turned and repositioned. On 8/1/24, a review of Resident #25's current care plan failed to reveal that the resident was difficult to turn and reposition or refused to be turned and repositioned. Further review revealed the resident was to be encouraged to turn and reposition with rounds every 1-2 hours and PRN (as needed) as tolerated and the wound was to be offloaded. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 10:17 AM, the facility's wound care Physician (Staff #27) was interviewed. He reported that Resident #25 recently had a healed pressure injury on the buttocks. He reported that his recommendations were to turn and reposition the resident every 1-2 hours, if possible. He reported that the nurses had not reported any difficulty with pressure injury interventions for Resident #25. On 8/01/24 the Director of Nursing (DON) provided a facility policy titled Turning a Resident on His/her Side Away from You, dated 2010. A review of the policy section under documentation revealed the following should be documented in the resident's medical records: any problems or complaints made by the resident related to the procedure, If the resident refused the treatment, the reason(s) why and the interventions taken. On 8/01/24 at 3:35 PM, during an interview with the Corporate Clinical Director, (Staff #16) and the Director of Nursing (DON) regarding the above concerns, no further information was provided concerning pressure injury prevention and care. 2. On 7/26/24, a review of complaint #MD00181130 revealed a concern that some residents at the facility were being provided incontinence care by using 2 briefs instead of one. On 7/31/24 at 5:34 AM, GNA (Staff #28), reported that Resident #47 requested that 2 diapers be put on him/her. A brief interview with Resident #47 at 5:36 AM, confirmed that the resident did request to wear 2 briefs. The GNA confirmed that Resident #47 was wearing 2 briefs. 3. On 7/31/24 at 5:53 AM, GNA (Staff #28), was observed exiting Resident # 2's room with a trash bag. GNA #28 reported she had just completed incontinent care for Resident #2. Further observation of the trash bag revealed one brief and one pull-up. GNA #28 confirmed that Resident #2 was wearing one brief, and one pull-up before receiving incontinent care. On 7/31/24 at 5:54 AM, during a brief interview with GNA #28, GNA reported that residents pee a lot, maybe because they are on medications that make them pee a lot sometimes have a diaper and brief on. 4. On 7/31/24 at 6:19 AM, CMA/GNA (Staff #29) was interviewed. During the interview, she reported that around 3:00 AM, she provided incontinent care to Resident #75. CMA/GNA #29 reported that before providing incontinent care, Resident #75 had a brief under a pull-up and an additional brief on the bed lying under the resident. On 7/31/24 at 10:17 AM, the Director of Nursing (DON) was interviewed regarding incontinent care. She reported that the expectation is that GNAs check for the need for incontinent care every 2 hours. She reported that it is never appropriate to double brief, even if the residents asked for 2 briefs. The DON reported she was aware that this had happened in the past and had provided on-the-spot education to correct the issue. On 8/01/24, The Director of Nursing provided a copy of an On the Spot of Education dated 5/3/2024. A review of the education document revealed that 11 staff members attended the education. Further review revealed the following instructions: EFFECTIVE IMMEDIATELY: Toileting/Incontinence Care rounds are to be done every 2 hours. Please reposition the resident in bed also at this time this causes skin breakdown. NO DOUBLE BRIEFS ALLOWED! Thank you.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48259 Based on observation, record review, and interviews, it was determined that the facility failed to ensure that a resident with a limited range of motion received treatment and services as ordered by the attending provider to prevent further decline in the range of motion. This was evident for 1 (#24) of 4 residents reviewed for position and mobility. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. On 7/26/24 at 2:15 PM, during a resident council meeting, it was reported that Resident #24 was supposed to be wearing a splint on the left hand; however, staff was not providing it. On 7/29/24 at 4:03 PM, Resident #24 was observed sitting at the nurses' station with no splint on his/her left hand. A record review on 7/29/24 at 4:30 PM showed that Resident #24 had been residing in the facility since 2017, and their diagnoses included left-sided weakness due to stroke. Further review contained an attending provider's order, initiated on 8/31/23 for a left resting hand splint to be worn during the day as tolerated for contracture management. A continued review found an MDS assessment for Resident #24, dated 5/7/24. The MDS recorded that the resident required maximal to full assistance from staff for all his/her self-care needs. Further review of the MDS showed that Resident #24 had functional limitations of his/her upper and lower extremities. A review of an occupational therapy discharge summary for Resident #24, dated 6/18/24, noted that splint and brace program established/trained: Patient unable to donn splint, nursing staff educated on application and purpose of splint (donn-wear). A review of the July treatment administration record showed documentation by staff #24, a licensed practical nurse, that the splint was put on Resident #24's left hand on 7/29/24. In an interview on 7/29/24 at 5:03 PM, staff #55, a geriatric nurse aide, confirmed that Resident #24 was not wearing the splint and stated she did not know why it was not put on. During an interview on 7/29/24 at 5:07 PM, staff #24 confirmed that the splint was not put on the Resident's left hand and then stated she documented it in error that she put it on when she did not. In an interview on 7/30/24 at 8:01 AM, the director of nursing (DON) was made aware of the concern about not providing the splint to Resident #24's hand. The DON stated that it was an error for a nurse to document that she performed a task when she did not.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45139 Based on interviews, and record reviews, it was determined that the facility failed to accurately document a resident's dietary consumption to ensure the resident received adequate nutritional intake. This was evident for 1 Resident (Resident #12) out of 3 residents reviewed for nutrition during the survey. The findings include: On 8/2/24, intake #MD00208140 was reviewed. Review revealed a concern that Resident #12 did not receive adequate nutrition. Further review revealed that Resident #12 was admitted for rehabilitation. On 8/2/24 at 1:52 PM, review of the dietician progress note, dated 7/11/24, revealed that Resident #12 received nutrition by mouth (PO) and, through a feeding tube. Further review revealed the registered dietician was monitoring the resident's PO intake and prescribing tube feedings based on Resident #25's weight and his/her PO intake. On 8/2/24 at 11:15 AM, Registered Dietician (RD) Staff # 25, was interviewed via phone. Staff #25 reported that she had monitored the percentage of meals the resident had eaten at every meal. She continued that, if the resident's PO intake fell below 50 percent eaten at each meal, she would adjust the tube feeding to provide additional nutrition. Staff #25 reported she obtained the information regarding how much the resident had eaten from reviewing the Geriatric Nursing Assistant (GNA) task documentation. On 8/2/24, the GNA task documentation of Resident #12's PO intake for July 1st through July 22nd of 2024 was reviewed. The review revealed 66 opportunities (meals) to document the percentage eaten. Further review failed to reveal any documentation of what Resident #12 had eaten for 23 out of 66 opportunities (meals) during that time period. The following dates and times failed to have any documentation of Resident #12's PO intake: 7/1/24 at 12:00PM 7/2/24 at 8:00AM & 12:00PM 7/3/24 at 8:00AM & 5:00PM 7/4/24 at 5:00PM 7/5/24 at 8:00AM & 12:00 PM 7/6/24 at 8:00AM & 12:00 PM 7/7/24 at 8:00AM & 12:00 PM 7/8/24 at 5:00PM (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/10/24 at 5:00 PM 7/11/24 at 8:00AM & 12:00 PM 7/12/24 at 8:00AM & 12:00 PM 7/15/24 at 5:00 PM 7/18/24 at 8:00AM & 12:00 PM 7/20/24 at 8:00AM & 12:00 PM 0n 8/2/24 at 12:00 PM, the above concerns were discussed with the Director of Nursing (DON). The DON failed to provide any evidence that the GNAs documented Resident #12's food intake on the above dates and times.

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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. 45139 Based on observation, interview and record review, it was determined that the facility failed to 1) administer respiratory therapy (oxygen) according to professional standards and 2) maintain respiratory care equipment for residents who required continuous oxygen via nasal cannula. This was evident for 2 (#25 and #68) of 2 residents reveiwed for respiratory care. The findings include: 1) Resident #25 was a long-term resident of the facility with a history of chronic obstruction pulmonary disease (a chronic lung disease, that can make it difficult to breath). On 7/26/24 at 9:50 AM, review of the medical record revealed the following orders: An order with a start date of 4/10/24, Check O2 sat every shift, (oxygen saturation rate) and an order with a start date of 4/10/24, for 02 L/min via nasal cannula, as needed, for SOB [shortness of breath] related to Chronic obstructive pulmonary disease. Please indicate when 02 has been applied. See nurse notes for detail. On 7/29/24, multiple observations were made of Resident #25. Observations revealed that the resident was on O2 via nasal cannula at the following times: 7:35 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 7: 59 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 9:01 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 9: 45 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 10:30 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 10: 53 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 11:35 AM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 12:30 PM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 1:30 PM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. 2:30 PM observation, revealed Resident #25 on oxygen 2 Liters nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 9:55 AM, Resident #25's Treatment Administration Record (TAR), for the month of July 2024, was reviewed. The review revealed a space to document the time and date of the resident's O2 saturations, and if they received oxygen. Further review of the documentation, failed to demonstrate that Resident #25 received oxygen on 7/29/24. On 7/29/24 at 12:28 PM, LPN Staff #2 was interviewed regarding how the Resident #25 was administered oxygen. During the interview, she reported that she was currently providing care to Resident #25, and s/he was on continuous oxygen, except for short periods of time when the resident removes the nasal cannula. On 8/1/24 at 3:35 PM, the above concerns were discussed with the Director of Nursing (DON) and the Regional Director for Clinical Operations/services (Staff #16). The DON confirmed that the documentation in the TAR, failed to accurately reflect the resident's oxygen use. On 8/1/24 at 2:41 PM, the DON provided an updated oxygen order. Review of the oxygen orders revealed that the order for oxygen, as needed was discontinued. Further review revealed a new order for Resident #25 was to receive continuously oxygen, via nasal cannula. 48259 2) An observation on 7/23/24 at approximately 8:40 AM during the initial tour of the facility showed Resident #68 lying in bed and receiving 2 Liters (L) of continuous oxygen via nasal cannula. The observation found no humidifier water attached to Resident #68's oxygen concentrator. A prefilled humidifier with sterile water is used with oxygen concentrators to offer comfortable humidity and moisture to continuous flow oxygen therapy to prevent upper airway dryness. A subsequent observation on 7/24/24 at 9:03 AM showed that Resident #68 continued to receive 2L of continuous oxygen via nasal cannula with no humidification. Resident #68 was interviewed at that time. During the interview, he/she stated that he/she asked the nurses several times for the humidification water, but no one provided one. A medical record review showed an attending provider's order for Resident #68 for oxygen at 2L via nasal cannula continuously every shift for shortness of breath. In an interview on 7/24/24 at 9:34 AM, staff #24, a licensed practical nurse, reported that before admitting an oxygen-dependent resident, she was expected to have ready a concentrator, oxygen tubing, and sterile water for humidification and then obtain an attending provider's order for changing the tubing and water weekly. During an interview on 7/24/24 at 10:18 AM, staff #56, a registered nurse, stated that humidification water should be attached to Resident #68's oxygen. Staff #56 stated that she was unsure why the resident did not have it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/24/24 at 10:20 AM, staff #57, a nursing supervisor, reported that an admitting nurse was expected to obtain orders from an attending provider to change the oxygen humidification water weekly. However, an earlier review of Resident #68's medical record failed to show an attending provider's order for oxygen humidification. An observation made later the same day showed a humidifier bottle prefilled with sterile water attached to Resident #68's oxygen concentrator after the surveyor's intervention.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48259 Based on record review and staff interviews, it was determined that the facility failed to ensure that a resident received pain medication according to an attending provider's order and failed to document pain assessments to include the location of the pain and type of pain for a resident reporting pain. This was evident for 1 (#64) of 1 Resident reviewed for pain management. The findings include: A pain scale is 0-10; 0 means no pain, and 10 represents the worst pain. It is used to assess the level of pain a patient is experiencing for better treatment. Non-pharmacological pain management is an intervention without the use of medications. A review on 7/25/24 at 1:25 PM of complaint record #MD00208061 indicated that Resident #64 was usually in pain; however, staff failed to assess and manage his/her pain. A medical record review on 7/2524 at 2:30 PM showed that Resident #64 had been residing in the facility since April 2024 with diagnoses including cervical spine fracture. The review also noted that the resident had pressure sores on both buttocks and his/her sacral area. A subsequent review on 7/25/24 at 5:08 PM showed a provider's order, dated 4/9/24, that directed staff to assess Resident #64's pain every shift and offer non-pharmacological interventions including, but not limited to, hot/cold compresses, repositioning, and turning before administering medication. Then, document the non-pharmacological interventions attempted before giving PRN medications. Further review showed another provider's order, dated 5/13/24, for pain medication to be administered to Resident #64 every 4 hours PRN (as needed) for pain. A review of Resident #64's medication administration record (MAR)for July 2024 was completed. The MAR had recorded that the nurses administered oxycodone 5mg to Resident #64 on 7/14 for a pain level of 9, 7/17 for a pain level of 1, 7/24 for a pain level of 6, 7/27 for a pain level of 8 and 7/28 for a level of 10. However, the review failed to show a record of Resident #64's pain assessment, including the location, type of pain, and non-pharmacological intervention implemented before administering pain medicine. In an interview on 7/30/24 at 11:20 AM, staff #24, a licensed practical nurse, stated that before she administered any PRN medication to a resident, she would first offer a non-pharmacological intervention like massage or repositioning, then provide the medication if that didn't help resolve the pain. In an interview on 8/01/24 at 10:58 AM, the assistant director of nursing (ADON) checked Resident #64's progress notes and then stated that there was no documentation to accompany what happened on 7/14, 7/17, 7/24, 7/27, and 7/28. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON continued to say that the provider's order for a nonpharmacological intervention before administering a medication was not followed through. She also reported that her expectation of the nurses was to include their assessment of the resident's pain in their notes, including the location and type of pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 48259 Based on medical record review, observation, and interviews, it was determined that the facility staff failed to obtain pre- and post-dialysis treatment records for a resident. This was evident for 1 (#68) of 1 resident reviewed for dialysis. The findings include: A medical record review on 7/23/24 at 10:10 AM showed that Resident #68 was admitted to the facility in June 2024 with diagnoses including chronic kidney disease, with dependence on hemodialysis. Hemodialysis, also known as dialysis, is a treatment that filters and purifies the blood using a machine in people whose kidneys can no longer perform these functions naturally. Further review found an attending provider's order for Resident #68 to receive dialysis 3x a week on Tuesday, Thursday, and Saturday @ 10:30 AM. The order stated, On dialysis days please send a new dialysis form filled in patients' full vitals including weight for the morning. Additionally, there was an order for Post Dialysis Weight every Tuesday, Thursday, and Saturday. An observation on 8/1/24 at approximately 10:00 AM, showed Resident #68 going for dialysis treatment. The facility driver was questioned about the Resident's dialysis communication binder, and indicated that neither she nor the Resident had it. In an interview on 8/1/24 at approximately 10:30 AM, the assistant director of nursing stated that she called the dialysis center and was told that Resident #68's dialysis book had been left there after treatment in the past but could not tell when it was left there. On 8/2/24 at 10:30 AM, a review of Resident #68's dialysis binder contained dialysis communication forms. A review of the forms for July 9-August 1, 2024, was done. The form included areas to document the resident's name, the date, pre- and post-dialysis weights, vital signs, and lines for any additional documentation of complications and relevant observance. The review revealed dialysis communication forms for 7/9, 7/13, 7/20, 7/23 and 7/30. However, the review failed to show communication forms for 7/11, 7/16, 7/18, 7/25, 7/27. The form for 8/1 failed to show full pre-dialysis vitals, including weights. In an interview with the ADON on 8/2/24 at 11:55 PM, she reviewed the Resident's post-dialysis weights on the facility's electronic health record then she confirmed that the staff failed to obtain the Resident's post-dialysis weights on 7/16, 7/20, and 7/25. The ADON also confirmed the lack of dialysis communication forms for Resident #68 on 7/11, 7/16, 7/18, 7/25, 7/27. In an interview on 8/2/24 at 12:11 PM, the director of nursing said failure to complete Resident #68's dialysis communication form could prevent the facility staff, as well as the dialysis staff, from effectively assessing and managing the resident's care.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on record review and interview, it was determined that the facility failed to ensure that the resident's care was overseen by a physician. This was found to be evident for 3 (#905, #920, and #9) of 6 residents reviewed for quality of care during the investigation of a complaint conducted during a recertification survey and 1 (#57) of 4 residents reviewed for unnecessary medications. The findings include: 1) A review on 7/26/24 at 11:30 AM based on facility treatment of Resident #905 after multiple consecutive falls that occurred on the day of admission, revealed concerns related to the resident's admission including the physician's medication review. Resident #905 was admitted to the facility on an anticoagulant, Eliquis. On the day of admission, s/he had 2 unwitnessed falls, the second sustaining a bloody nose. Secondary to the bleeding, and due to additional concerns for a gastrointestinal bleed and unwitnessed falls, s/he was transferred to the hospital for further assessment. Upon readmission to the facility, although the Eliquis was discontinued due to the bleeding and risk of continued falls, the facility readmitted him/her on the Eliquis and administered the anticoagulant to him/her. A review of the medication administration record (MAR) on 7/26/24 revealed that the order for the Eliquis was never discontinued when Resident #905 went to the hospital. An interview with the facility Assistant Director of Nursing (ADON) on 7/29/24 at 5:58 PM revealed that when a resident goes to the hospital, their orders are discontinued, and all orders get discontinued so when residents come back it's all fresh. The DON was made aware of the concern that Resident #905 was readmitted to the facility after almost a month's stay in the hospital, the old orders were present and the old medications were administered. She stated that the physician must approve any medications that the resident receives and any previous medications that were ordered would have to be clarified. According to Resident #905's MAR and physician orders, on the day of readmission on 12/22/22, Resident #905 received medications that were previously ordered at their previous admission occurring in November of 2022. During the December 2022 hospitalization , Resident #905 had a pacemaker placed. His/her hydralazine (medication for high blood pressure) dose was adjusted in the hospital. This change made it to the physician's orders, however, the anticoagulant did not. This concern was reviewed with the ADON on 7/29/24 and again with the Director of Nursing (DON) during exit on 8/1/24. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the attending physician (who was the Medical Director) via a telephone call on 8/2/24 at 1:18 PM revealed the routine monitoring for a resident with high cholesterol was to order an annual complete metabolic panel and lipid panel. When asked about monitoring for a resident with diabetes type 2, he reported they should have a hemoglobin A1C completed every 6 months. When made aware that there was no order or lab results for these routine orders, he reported that it must have been an oversight on the part of himself and the nurse practitioner. However, the treatment plan was to be set by the physician prior to visits from the nurse practitioner. He was made aware of the concerns. The concerns were reviewed with the Administrator on 8/5/24 at 11:05 AM. Surveyor: [NAME], [NAME] 4) A medical record review on 8/1/24 at 10:39 AM showed that Resident #57 was admitted to the facility in April 2023 with diagnoses including diabetes. The review found an attending provider's note, dated 4/6/23, that stated the resident had an extended hospital stay, found to have elevated A1c (A1c- a blood test measuring a person's average blood sugar levels over the previous three months). Further review contained an attending provider's order, dated 9/26/23, for Resident #57 for an antidiabetic medication. However, the review failed to show that Resident #57's A1c had been tested since admission to the facility. In an interview on 8/2/24 at 11:30 AM, the Assistant director of nursing stated that Resident #57's medical record does not show a laboratory test of A1c since admission to the facility in April 2023. In an interview on 8/2/24 at 1:18 PM, Resident #57's attending provider reported that A1c is tested twice a year for residents who have a diagnosis of diabetes. The provider checked the resident's electronic medical record and confirmed that the resident's A1c had not been tested since admission to the facility. He stated that Resident #57 should have had an A1c laboratory test done six months after admission. The provider also said it was an oversight on his and his team's part and added that he would take care of it after the surveyor's intervention. 48259

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48470 Based on records review and interviews, it was determined that the facility failed to ensure the Director of Nursing (DON) was working in that capacity on a full-time basis due to currently being assigned the duties of the infection prevention nurse in addition to being the Director of Nursing. This practice has the potential to affect all residents in the facility. The findings include: During an interview with the Nursing Home Administrator (NHA) on 8/2/24 at 8:17 AM, she reported that the Infection Preventionist (IP) nurse had resigned without notice and left the faciity on the same day, on 7/22/24. Since then, the DON had been assigned to take over the role of the IP nurse on top her duties as the DON. On 8/2/24 at 9:40 AM, the DON was interviewed and reported that she has the certification for the IP but knew that she should not be the IP nurse as well. The DON indicated that this was because of her other responsibilities in the facility as the DON. The DON also reported that another staff in the facility was currently in training to be the IP nurse. A Review of the state regulations revealed that the infection preventionist position shall be staffed at a ratio of 1.0 Full Time Equivalent for every 200 beds. The facility was licensed for 80 beds. This meant the infection preventionist responsibilities should occupy 40% of the DONs time. On 8/2/24 at 9:53 AM, the NHA was again interviewed and discussed the concern that currently, the DON is not working in that capacity on a full-time basis. The NHA confirmed that they knew the DON could not act as the IP nurse as well and stated, It was an unexpected vacancy of the position and the Assistant DON is working through her modules as fast as she can to take over the role of the IP nurse.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 37276 Based on review of Geriatric Nursing Assistant (GNA) personnel files and staff interview, it was determined the facility failed to conduct yearly performance reviews at least every 12 months. This was evident for 5 of 5 (Staff #29, #31, #32, #33, #34) Geriatric Nursing Assistant (GNA) staff reviewed and has the potential to affect the care received by all residents. The findings include: On 7/30/24 at 1:35 PM, the surveyor reviewed the employee files of 5 (Staff #29, #31, #32, #33, #34) geriatric nursing assistants (GNAs) who were employed by the facility for more than 12 months and selected from a list of employees provided by the facility. a) of Staff #29's employee file revealed a hire date of 11/30/22. No documentation was found that an annual performance review had been conducted in the past year. b) Review of Staff #31's employee file revealed a hire date 5/9/17. No documentation was found that an annual performance review had been conducted in the past year. c) Review of Staff #32's employee file, revealed a hire date. No documentation was found that an annual performance review had been conducted in the past year. d) Review of Staff #33's employee file, revealed a hire date. No documentation was found that an annual performance review had been conducted in the past year. f) Review of Staff #34's employee file, revealed a hire date. No documentation was found that an annual performance review had been conducted in the past year. On 7/31/24 at 11:49 AM, the Director of Nurses (DON) was made aware of the above findings. The DON confirmed the findings, and indicated GNA performance reviews and competency evaluations were not being completed since she has been the role of DON.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 37276 Based on observation, pertinent document review and staff interview, it was determined that the facility staff failed to maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This was evident during a review for sufficient and competent nurse staffing and has the potential to affect all residents. The findings include: On 7/30/24 at 10:58 AM, a review of the nurse's station revealed a Daily Staffing Report that had the facility's name, with a space to document the date, the facility census, and the PPD (patient per day), which documented the shift census for day, evening and night shifts, and the number and projected hours worked by licensed and unlicensed staff directly responsible for resident care per shift. In the morning on 8/1/24, the surveyor requested the Daily Staffing Reports for February 2024. Review of February 2024's Daily Staffing Reports provided to the surveyor failed to reveal a Daily Staffing Report for 16 (2/3, 2/4, 2/7, 2/8, 2/9, 2/10, 2/11, 2/12, 2/14, 2/17, 2/18, 2/19, 2/24, 2/25, 2/27,2/28, 2/29, 2024) of 29 days in February. On 8/1/24 at 3:39 PM, the concerns with the missing Daily Staffing reports were discussed with the Director of Nurses (DON) and Staff #16, Regional Director for Clinical Operations. The DON and Staff #16 acknowledged the concerns at that time and no further comments were offered at that time. On 8/2/24 at 1:16 PM, the NHA provided the surveyor with a Daily Staffing Report dated 2/28/24, and no further Daily Staffing Reports for February 2024 were provided to the surveyor by the time of exit on 8/5/24 at 5:30 PM. Cross Reference S3130

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 50573 Based on medical record review, interview, and observation, it was determined that the facility failed to ensure a resident's behaviors were being monitored and documented consistently. This was found to be evident for one (#62) of one resident reviewed for behavioral health care. The findings include: On 7/23/24 at approximately 8:05 AM, Resident #62 was observed lying on the floor near the nursing station. Several residents and staff were in the area at the time of this observation. On 7/23/24 at 11:42 AM, Resident #62 was observed sitting on the floor next to his/her wheelchair in the hallway near the doorway of the resident's room. The resident then proceeded to lie down on the floor. No staff were present at the nursing station or within view of the resident at this time. On 7/23/24 at 11:46 AM, the Director of Nursing (DON) arrived at the unit and acknowledged the resident on the floor. The DON commented that the resident is care planned for this [behavior]. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. A review of the care plan revealed a care plan focus that Resident #62 liked to place herself/himself on the floor from the wheelchair and will crawl around. The care plan focus further indicated that she/he is comfortable like that. Further review of Resident #62's medical record revealed a care plan focus that the resident was dependent on staff for needs and will sit on the floor at times. On 7/31/24 at 11:50 AM, a review of Resident #62's medical record revealed a section of the Treatment Administration Record (TAR) that had an area for staff to document Yes or No to indicate if behaviors were being observed. Behaviors listed on the TAR consisted of specific behaviors such as verbal aggression, agitation, and yelling out and included an option of other, but failed to include lying on the floor as a documentation option. Further review of the TAR from 7/23/24 revealed behavior documentation was marked as no which indicated none of the behaviors were observed. Further review of the medical record failed to reveal documentation to indicate Resident #62 was found lying on the floor on two occasions on the morning of 7/23/24. On 7/31/24 at 1:56 PM, an interview with the Assistant Director of Nursing (ADON) revealed that there had been some confusion regarding nurses' documentation of behaviors of residents during shifts and that everyone had a different interpretation, especially with the influx of agency nurses. Further interview revealed that if a behavior was noted the expectation was for it to be documented under progress notes. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 8:41 AM, an interview with Geriatric Psychiatric Nurse Practitioner (Staff #54) revealed that she relied on the documentation from nursing staff of resident behaviors to manage the medications they were prescribed and that there was a lack of documentation of behaviors. On 08/01/24 at 11:51 AM, an interview with the Director of Nursing (DON) revealed that the expectation was for the nurses to document the behaviors noted during their shift on the TAR by marking yes or no. Further interview revealed that, if the nursing staff marked yes, a progress note would be prompted upon documentation and the expectation was that they would free type behaviors noted during their shift; if none of the behaviors listed on the documentation prompt sheet were observed during a shift, then the nursing staff would chart no and no further explanation was needed. The DON was unable to confirm if education was completed by nurses on behavior charting. On 08/02/24 at 12:03 PM, the surveyor reviewed the concern to the DON regarding the facility's failure to ensure the resident's behaviors were being monitored and documented consistently.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50573 Based on review of medical records and interview, it was determined that the facility failed to ensure that narcotic medications were consistently reconciled by two nurses at the change of shift. This was evident for three out of the three medication carts reviewed for medication storage during the survey. The findings include: On 7/30/24 at 12:50 PM, the surveyor obtained copies of the narcotic shift count sheet from the 400 hall medication cart. A review of this sheet failed to reveal two licensed nurses' signatures on 7/19/24 7 PM shift, 7/23/24 6 AM shift, 7/25/24 11 PM shift, and 7/26/24 from the 7 PM shift change. On 7/30/24 at 12:58 PM, the surveyor obtained copies of the narcotic shift count sheet from the 200 hall medication cart. A review of this sheet failed to reveal two licensed nurses' signatures on 7/27/24 from the 7 AM shift change. On 8/1/24 at 9:34 AM, the surveyor obtained copies of the narcotic shift count sheet from the 500 hall medication cart. A review of this sheet failed to reveal two licensed nurses' signatures on 7/24/24 7 AM, 3 PM, and 5 PM shifts, 7/29/24 11 PM shift, and 7/30/24 from the 7 AM shift change. A review of the facility's controlled substance policy on 08/01/24 revealed that the nursing staff must count controlled substances at the end of each shift and that it was the nurse coming on duty and the nurse going off of duty to make the count together. On 8/2/24 at 11:14 AM, an interview with the Director of Nursing (DON) revealed that the facility does not audit the narcotic shift count sheets, but that it would happen going forward. The surveyor reviewed the concern with the DON regarding the failure to ensure the narcotic medications were consistently reconciled by two nurses at the change of shift.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 30428 Based on medical record review and interview with facility staff, it was determined that the facility pharmacist failed to comprehensively review the medical record and identify medication errors and alert the staff; and and the facility failed to develop policies and procedures for the monthly Medication Regimen Review (MRR) that include time frames for different steps in the process. This was evident for 1 (Resident #911) of 13 residents reviewed for medication concerns. The findings include: 1) Review of the medical record for Resident #911 related to a complaint revealed that on their admission they were inadvertently ordered Lasix incorrectly (a diuretic). On 7/31/24 at 10:13 AM, the facility pharmacist (Staff #13) was interviewed. His process for reviewing medications and audits was reviewed at that time. He stated that he would review discharge summaries of new admits, medications administration records and physician orders. The concern and findings related to Resident #911 was reviewed. Resident #911 was admitted on 80 mg of Lasix 7 days a week. Right away, Staff #13 stated that that's a lot of Lasix and asked if any interventions were in place i.e. weight monitoring. This surveyor stated that s/he had lost 7 lbs. in a week, but they were only admission weights, and no additional orders were in place for further weights and monitoring. It was also reviewed at that time that the hospital discharge orders were for only 5 days of the 40 mg of Lasix and 2 days of the 80 mg a week. During this interview, the surveyor confirmed that Staff #13 had completed a pharmacy review on this resident on 9/30/23, 12 days after this resident's admission and there were 'no noted irregularities.' The concern that this order went through the admission nurse, the attending and the pharmacist was reviewed at this time with Staff #13. 48470 2) On 7/30/24 at 10:40 AM, a copy of the facility's policies and procedures for MRR was provided by the Regional Director for Clinical Operations (Staff #16). A review of the facility's MRR policies and procedures revealed the steps that the pharmacist and facility staff would do for the process, but failed to specify the time frame for each step. On 7/30/24 at 11:33 AM, the concern was discussed with Staff #16 that the facility's MRR policy and procedures did not specify time frames for the pharmacist to document his/her findings, timeframes for facility staff to report findings to the physician, time frames for the pharmacist to report an irregularity that required immediate action from the physician, and time frames for the physician to respond to urgent and non-urgent irregularities identified. Staff #16 acknowledged the concern and indicated that she would review the policy and verify that there was not another one on file. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Later that day at 12:23 PM, Staff #16 confirmed with the surveyor that there was no other policy on file regarding the MRR and stated, The policy is being revised currently after the concern was brought to the facility's attention.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 48259 Based on record review and staff interviews, it was determined that the facility failed to ensure residents received their medications according to the attending physician's orders. This was evident for 2 (#24, #72) out of 6 residents reviewed for unnecessary medications. The findings include: 1) A record review on 7/29/24 at 4:30 PM showed that Resident #24 had been residing in the facility since 2017, with diagnoses that included hypertension. Further review contained an attending provider's order, dated 1/13/2023, for an antihypertensive medication to be administered daily to Resident #24. The order had a parameter to hold (not to give) the medicine for SBP less than 130 mmHg (millimeters of mercury). Blood pressure (BP) is often written as an upper and lower number. Systolic blood pressure (SBP) is the upper number. It measures the pressure in the arteries during heart muscle contraction. A review of Resident #24's medication administration records (MAR)for June 1- July 29, 2024, was completed on 7/29/24 at 6:06 PM. The review showed that Resident #24's antihypertensive medication was administered on 6/8/24 for SBP of 110, 6/9/24 for SBP of 118, 6/19/24 for SBP of 129, 6/20/24 for SBP of 123, 6/21/24 for SBP of 127, 6/22/24 for SBP of 124, 6/27/24 for SBP of 128, 7/1/24 for SBP of 126, 7/2/24 for SBP of 117, 7/5/24 for SBP of 125, 7/7/24 for SBP of 125, 7/19/24 for SBP of 121, 7/20/24 for SBP of 124, 7/24/24 for SBP of 124, 7/27/24 for SBP of 126, and 7/28/24 for SBP of 128. In an interview on 8/5/24 at 7:40 AM, the Director of Nursing (DON) stated that the antihypertensive medication should have been held per the attending physician's order. 2) A medical record review done on 8/1/24 at 11:29 AM showed that Resident #72 was admitted to the facility in July 2024 with diagnoses including hypertension. Continued review contained an attending provider's order for Resident #72 for an antihypertensive medication to be given daily. The order had a parameter to hold the medication for SBP less than 120 mmHg (millimeters of mercury). A subsequent review of Resident #72's MAR for July 5 - July 28, 2024, was conducted on 8/5/24 at 7:16 AM. The review found that the resident received the antihypertensive medication on 7/5/24 for SBP of 114, on 7/6 for SBP of 118, and on 7/21 for SBP of 111. In an interview on 8/5/24 at 7:46 AM, the DON confirmed that, per the MARs, Resident #72's antihypertensive medication was given to him/her by the nurses on 7/5/24, 7/6/24, and 7/21/24. The DON continued to state that her expectation of the nurses was to hold the medicine because the SBPs were lower per the ordered parameter.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50573 Based on observation, interview, and medical record review, it was determined the facility failed to ensure a medication error rate of less than 5%. This was found to be evident based on errors identified during medication observations of 4 residents (Resident #5, #11, #54, and #476) out of 5 residents observed. The observations were made on each of the three hallways of the facility and involved three different staff members including an agency certified medication aide, one agency Licensed Practical Nurse (LPN), and one staff LPN. The findings include: 1) On 07/29/24 at 08:02 AM, the surveyor observed LPN (Staff #2) prepare medications for Resident #5. The nurse was observed to obtain the following medication from the medication cart: 1 Finasteride 5mg 1 Isosorb 30 mg 1 Extra strength probiotic support 1 Metoprolol 25mg 1 Bumetanide 1mg 1 Lovastatin 40 mg 1 Gabapentin 100mg and placed these 7 medications in a medicine cup. The nurse also obtained a cup of nutritional shake. The LPN administered the 7 medications listed above. On 07/29/24 at 09:42 AM, after the observation was completed, a review of the medical record revealed Finasteride was ordered to be given at bedtime. It was observed to be administered at the 8:00 AM medication pass. A review of the Medication Administration Record (MAR) revealed that LPN (Staff #2) failed to document that it was administered at 8:00 AM. Further review of documentation from the 8:00 AM medication documentation on the MAR revealed that potassium 10 meq was signed off as given for 0900, Tylenol 650 mg was signed off as given for 0800, and sodium chloride 1 gm was signed off as given for 0900, but the two surveyors observing the administration did not see Staff #2 administer any of these three medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This constituted 4 errors at the 8:00 AM medication administration with Resident #5 since one medication was given at the wrong time and three medications were documented as given but were not observed to be administered. On 07/29/24 at 11:25 AM, the surveyor reviewed the observed medication administration concerns with the Director of Nursing (DON). 2) On 07/31/24 at 08:07 AM, the surveyor observed LPN (Staff #2) prepare medications for Resident #476. The nurse was then observed to obtain the following medication from the medication cart: 1 memantine hcl 10mg 1 arthritis pain tylenol tab 650 mg 1 iron 1 multivitamin 1 calcium 600mg 1 vit D3 and placed these 6 medications in a medicine cup. The nurse proceeded to take the vitals machine used on the previous resident, obtained the blood pressure for Resident #476, and then administered the previously prepared medications. On 7/29/24 at 9:42 AM, after the observation was completed, a review of Resident #476 's medical record revealed calcium 500 mg was ordered and the surveyor observed calcium 600 mg being given. A review of the Medication Administration Record (MAR) revealed LPN (Staff #2) failed to document the administration of the Tylenol arthritis pain 650 mg that was observed given. This constituted 2 errors of the 8:00 AM medication administration with Resident #476 since one medication was given at the wrong dose and one medication was observed administered, but was not documented as administered. On 7/29/24 at 11:25 AM, the surveyor reviewed the observed medication administration concerns with the DON. 3) On 7/30/24 at 8:07 AM, the surveyor observed a Certified Medication Aide (CMA Staff #29) prepare medications for Resident #11. Staff #29 was observed to obtain the following medication from the medication cart: 1 sevelamer 800 mg (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 lidocaine patch 4% 1 bisacodyl EC 5 mg And placed the 2 pills in a medication cup Staff #29 proceeded to cut open both lidocaine patches, label and place one on the resident's left inner thigh and one on the left knee. Staff #29 administered the rest of the previously prepared medications. On 07/30/24 at 9:30 AM, after the observation was completed, a review of the medical record revealed an order for a 4% lidocaine patch for the left inner thigh but failed to reveal an order for a 4% lidocaine patch for the left knee. This constituted 1 error of the 8:00 AM medication administration with Resident #11 since one medication was given but was not ordered. On 7/30/24 at 11:15 AM, the surveyor reviewed the observed medication administration concern to the DON. 4) On 7/30/24 at 8:40 AM, the surveyor observed LPN (Staff #24) prepare to administer medications to Resident #54. Staff #24 was observed to obtain the following medication from the medication cart: 1 tramadol 50 mg 1 buspirone 7.5 mg 1 calcium 250 mg 1 Plavix 75 mg 1 duloxetine 60 mg 1 hydrochlorothiazide 50 mg 1 isosorb mono 30 mg ER 1 metoprolol tart 25 mg 2 lidocaine 4% patches 1 bottle 4% lidocaine cream 1 eliquis 2.5mg and placed these 9 medications in a medicine cup. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #24 proceeded to administer the previously prepared oral medications and opened the lidocaine patches. Staff #24 placed one 4% lidocaine patch on Resident #54's R knee and the resident's right front lower leg while reporting I am not sure where this goes. Staff #24 applied 4% lidocaine cream to Resident #54's right leg and rubbed it around the two lidocaine patches placed on his/her right leg and knee. On 7/30/24 at 9:30 AM, after the observation was completed, a review of the medical record revealed Resident #54 had an order for a 5% lidocaine patch to be applied to the right knee and a 4% patch for the right leg. A review of the MAR documentation from the 0800 and 0900 administration record revealed that the 5% lidocaine to the right knee and 4% patch to the right leg were both signed off based on initials. Further review of the medical record from the observed medication administration for Resident #54 revealed diclofenac sodium external gel 1% was documented as administered however, it was not observed to be given. Further review of the medical record failed to reveal an order for 4% lidocaine cream. On 7/30/24 at 10:12 AM, the surveyor asked LPN (Staff #24) if the initials from the MAR documentation were hers and she reported they were not her initials This constituted 3 errors of the 0900 medication administration for Resident #54 from two medications being administered but not ordered and one medication documented as administered, but was not observed to be given. On 7/30/24 at 11:15 AM, the surveyor reviewed the concern from the observed medication administration with the DON. Further interview with the DON confirmed that the initials documented under Resident #54's record were not Staff #24's and that she would have to go and find Staff #24 to determine how it happened. On 7/30/24 at 11:22 AM, the DON confirmed that (LPN, Staff #24) was signed in by a staff member on the previous shift. On 8/2/24 at 12:03 PM, the surveyor reviewed the concern with the DON that the total medication error rate for the medication observations was over 5%.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on reviews of medical and administrative records, observations and interviews, it was determined the facility administration failed to develop and implement procedures based on the regulatory requirements to effectively attain and maintain the highest practicable wellbeing of each resident. This was evident for 6 (R#932, R#937, R#933, R#938, R#940 and R#931) of 43 residents reviewed during the revisit survey and has the potential to affect all residents in the facility. The findings include: 1) Resident (R) #932's medical record was reviewed on 10/21/24 at 10:40 AM. The record revealed a Notice of Transfer/Discharge indicating that R#932 was transferred to the hospital emergency room (ER) for evaluation and treatment on 10/14/24. R#937's medical record was reviewed on 10/22/24 at 9:55 AM. The record revealed a Notice of Transfer/Discharge indicating the resident was transferred to the hospitalER on [DATE] for evaluation and treatment. R#933's medical record was reviewed on 10/21/24 at 1:05 PM. The record revealed a Notice of Transfer/Discharge, dated 10/18(no year) indicating the R#933's health improved, and s/he was being discharged on to an Assisted Living Facility on that same date. R#938's medical record was reviewed on 10/22/24 at 10:26 AM. The record revealed a Notice of Transfer/Discharge indicating s/he was transferred to the hospitalER on [DATE] for evaluation and treatment. The same Notice of Transfer/Discharge form was used by the facility for each of the above residents. The notices failed to include an explanation of the right to appeal the transfer/discharge to the State; The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests; Information on how to obtain an appeal form; And information on obtaining assistance in completing and submitting the appeal hearing request as is required. Additionally, the notices provided to R#932, R#937, R#933 and R#938 included a proposed date, approximately 10 days after their transfer/discharge date , for a meeting between the resident, their representative and the facility to develop a post-discharge plan. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 10/22/24 at 4:30 PM, the Director of Nursing (DON) indicated that she completed the transfer/discharge notices. She was asked to explain the post-discharge plan and rationale for conducting a meeting 10 days after the resident was transferred or discharged from the facility. She indicated she did not know, and that the surveyor would have to ask corporate. She explained that she was told to fill it out, give it to the resident. She added that she would either mail it or leave it in an envelope at the resident's bedside and notify the representative of its location. She indicated that she knew the representatives received the notices because they've called to ask about the proposed post-discharge plan meeting thinking it meant the resident was being discharged . She was unable to explain the purpose of the facility's form. An interview was conducted with Staff #6 the Social Worker on 10/23/24 at 10:04 AM. She was shown the Notice of Transfer/Discharge and indicated that nursing was responsible for providing notices to family for residents being transferred to the hospital. She was asked about the proposed discharge planning meeting at the bottom of the form and indicated that she was told that it's a date for the facility to meet with the family if they have any questions. She explained that she was told by the DON and Administrator that they have so many days after discharge to call us if they have any questions. At 10:05 AM on 10/25/24, the above concerns were reviewed with Staff #7 the Regional Nurse; the DON was also present. Staff #7 indicated that the transfer notice information regarding the appeals notice was provided by the corporate office and obtained from a federal regulation as well as the state regulations listed at the bottom of the page. Cross reference F623. 2) During the above medical record reviews for R#932, R#937 and R#938's medical records also revealed that the facility staff failed to provide the residents and their representative a written notice which specified the duration of the facility bed-hold policy, at the time of the resident's transfer from the facility to the hospital. The same deficient practice was identified during the last survey and the facility developed a plan to correct the deficient practice by 10/7/24. However, the form developed and utilized by the facility included a provision for staff to provide notification via telephone. The facility administration failed to develop a process to ensure that a written bed hold policy notification was provided to the resident and their representative as required. Cross reference F625. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) The facility administration failed to develop and implement an effective discharge planning process to ensure that the discharge needs of each resident were identified and resulted in the development of a discharge plan. During review of the medical records for R#933 on 10/24/24 at 1:05 PM, R#940 on 10/23/24 at 11:03 AM, and R#931 on 10/23/24 at 12:12 PM, the surveyor identified that the facility staff failed to develop discharge plans of care, failed to assess and document the residents post discharge care needs, and the measures taken to facilitate safe and effective transition. Staff #6 the Social Worker was interviewed on 10/23/24 at 10:04 AM. She was asked if the facility had a written protocol for their discharge planning process. She indicated that, when she first came to the facility, there was no one in the department, and she had to develop a process herself. She indicated that her process did not have a written protocol. She described her process as - meet with resident who is admitted , find out their goal, it's usually written in their initial assessment, then follow up with them in the care plan meeting. When asked if a plan of care was developed, she indicated that his/her discharge plans were discussed in the Care Plan meeting. She was asked if the facility developed a plan of care for discharge. She confirmed that no discharge care plan was developed and stated, I typically don't do a care plan for discharge planning, I was not told to do that and I typically include it in my notes. Cross reference F660. 40927 4) A record review for Resident #9 on 10/29/24 at 12:10 PM revealed the resident had been seen by the attending physician on 8/16/24. Further review revealed that the physician had not visited the resident in over 60 days. On 10/29/24 at 1:54 PM a record review for Resident #947, revealed the resident's last visit with the attending physician was on 8/28/23. An interview with the Medical Records Staff #8 on 10/29/24 at 2:12 PM revealed she conducted an audit to ensure that residents had seen a provider in the last 30 days , but had not determined if the physician was seeing them every 60 days. She reported she was not aware that she was supposed to check which provider had seen the resident. Therefore, when auditing Resident #9's and Resident #947's medical record, she was not capturing that they had not been seen by the physician in the last 60 days. When asked what education she had received regarding the task of auditing and monitoring provider visits to ensure they were seen timely she stated she had not received the information that was reviewed with her by the surveyor. During an interview with the Director of Nursing (DON) on 10/29/24 at 3:34 PM it was reported that she had not been involved in the task of auditing and ensuring residents had been seen by the physician at least every 60 days. On 10/30/24 at 10:15 AM a subsequent interview with Medical Records Staff #8 revealed she had been entering a date of the last visit in point click care (their electronic medical record system) and then it generated a date that the resident was due for their next visit. According to Staff #8 the system did not differentiate between the attending physician and the nurse practitioner. Therefore, the facility had not developed a way to determine when the residents were due to see the attending physician verses the nurse practitioner in order to ensure ongoing compliance with the requirement. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with the Nursing Home Administrator on 10/30/24 at 10:58 AM revealed she thought that Medical Records Staff #8 had been educated by the Regional Director of Nursing. Reviewed the education sign in sheet for the education provided for this regulatory requirement based on their annual survey plan of correction and found Medical Records Staff #8 had not received any education regarding the timeliness of physician visits. The NHA reported that she gave Staff #8 the audit tool and reviewed with her to look for provider visits and no other education was provided. Cross reference F712. 5) According to the federal regulations all direct care staff were to receive communication training. On 10/22/24 at 8:59 AM a review of Licensed Practical Nurse (LPN) #10's training record, who had been hired on 10/9/24, failed to reveal he had received the required communication training. An interview with the Human Resources (HR) Director on 10/22/24 at 1:48 PM revealed that she was monitoring that all current staff had completed the communication education. When asked if the new hire orientation had included the communication training, she reported it had not been included. She stated that when she started at the facility there was no orientation process in place. After the survey in June 2024, she was trying to add the required trainings, as she learned about them, to the facility's orientation, however she had not fully implemented them. During an interview with the Nursing Home Administrator (NHA) on 10/22/24 at 3:12 PM she reported that the corporate office provided the trainings for staff. She confirmed they had failed to develop and implement an education plan for new hires. On 10/22/24 at 3:55 PM an interview with the [NAME] President of Clinical Services revealed she was creating an education plan for the facility after surveyor intervention. When asked why this had not been done by the compliance date, she reported she was unaware of the issue. Cross reference F941. 6) According to the federal regulation all staff in the facility were to receive behavioral health training. However, on 10/22/24 at 10:21 AM a review of Staff #10's employee file revealed he was hired on 10/9/24 and Staff #13 was hired on 8/14/23 and neither employee had the behavioral health training. An interview with the Human Resources Director on 10/22/24 at 1:48 PM revealed that she had been given the task to collect the employees posttest after each training and check off when it had been completed. She provided the checklist for the behavioral health training and review of this list revealed the training had been provided to nurses and nursing aides only. An interview with the Nursing Home Administrator on 10/22/24 at 3:12 PM revealed that she was not aware that all staff were required to have behavioral health training. Cross reference F947.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 37276 Based on review on record review of facility documentation and staff interview, it was determined that the facility staff failed to conduct and document a comprehensive facility-wide assessment as evidence by failing to address: 1) the facility's average number of residents, 2) staff competencies necessary to provide the level and types of care needed for the resident population, 3) an evaluation of the facility's training program to ensure that any training needs are met for all new and existing staff, and contractual individuals providing services and volunteers, consistent with their expected roles and 4) Failed to have a facility-based and community-based risk assessment, utilizing an all hazards approach. This was evidenced during a Sufficient and Competent Nurse Staffing review, and extended survey review. This deficient practice has the ability to affect all residents in the facility. The findings include: The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary care and services the residents require during both day-to-day operations and emergencies. The assessment is used to make decisions about the direct care staff needs as well as the facility's capabilities to provide services to the residents in the facility. The assessment must be reviewed as necessary and at least annually. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics in performing that an individual needs to perform work roles or occupational functions successfully. On 8/2/24 at 9:00 AM, a review of the facility assessment, a 25-page document labeled with the facility's name and Facility Assessment 2024 identified concerns. 1) In the resident profile section, Part 1, Section 1A, Facility Capacity and Physical Characteristics revealed documentation that the total number of beds licensed by the facility was 80 but failed to include the number of residents. The facility assessment had the description, Average Daily Census (past 3 months) with no response documented to indicate the facility's average daily census. 2) Section 1.E Acuity: Special Treatments and Resident Care Need, identified an average of 60 residents a month that had behavioral health care needs, and an average of 60 residents a month had a mental illness diagnosis, and an average of 15 residents a month had a dementia and/or Alzheimer's diagnosis. 3) Part 3: Facility Resources Need to Provide Competent Support and Care of our Resident Population Every Day and During Emergencies documented: Section 3.B Staffing Plan: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- the facility will have sufficient staff with competence and skills aligned to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident as determined by individual plans of care, census, acuity and diagnosis of facilities population, and - the facility has Psychogeriatric Services (Behavioral Health practitioners) that have competencies and skill sets to care for many behavioral diagnoses. These clinicians have appropriate training and supervision in caring for residents with mental and psychosocial disorders. Section 3.C Individual staff assignment: The facility considers areas such as, but not exclusively limited to the following: Resident care needs, acuity, census, being cared for by a specific gender, language and communication abilities. Section 3.D Staff training education and competencies Licensed nurses: Certification required: valid Nursing license; Competency requirements: See Licensed Nurse Competency Direct care Certification requirements: Valid GNA or CMA certification: Competency requirements: See GNA/CMA competency checklist Continued review of the facility assessment failed to reveal evidence that the facility identified and recommended staff training and competencies. During the recertification survey, review of employee files and staff training revealed that the facility had no system in place to provide staff the required training and competencies and record the hours and type of annual inservice training completed by each staff member to accurately evaluate and ensure competency of staff. In addition, the facility failed to include or address an evaluation of the facility's training program to ensure any training needs are met for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. Review of 5 randomly selected employees reviewed for continuing education and competencies revealed: 2 of 5 GNA staff members had not received abuse training. 5 of 5 GNA staff members had not received at least 12 hours of continuing education in the past year. 5 of 5 GNA staff members had not received an annual performance review. 5 of 5 GNA staff members had not received behavior management training. 5 of 5 GNA staff members had not received communications training. 4 of 5 GNA staff members had not received infection control and prevention training (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4) Review of the facility assessment failed to reveal a facility-based and community-based risk assessment , utilizing an all-hazards approach had been included in the facility assessment. On 8/1/24 at 4:00 PM, the above concerns were discussed with the Director of Nurses (DON) and Staff #16, Regional Director for Clinical Operations. The DON and Staff #16 acknowledged the concerns, and no further comments were offered at that time. On 4:10 PM, the DON reported to the surveyor the Nursing Home Administrator was made aware of the concerns with the facility assessment. Cross Reference: F941, F943, F945, F947, F949F

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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 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** 48470 Based on records review and interviews, it was determined that the facility failed to maintain complete and accurate medical records. This was evident in 1 (Resident #127) of 26 residents reviewed during the survey. The findings include: Resident #127 has been residing in the facility since July of 2022. The resident's record indicated that s/he was hospitalized on [DATE] for hyperglycemia. Hyperglycemia occurs when there's too much sugar (glucose) in your blood. It's also called high blood sugar or high blood glucose. This happens when your body has too little insulin (a hormone) or if your body can't use insulin properly (insulin resistance). On 7/25/24 at 9:32 AM, a review of Resident #127's progress notes revealed the resident's blood sugar (BS) was 600 mg/dl, and the doctor ordered to give 12 units of insulin and recheck the BS after an hour. This was documented by the Licensed Practical Nurse (LPN Staff #2) with an effective date of 7/2/24 at 4:52 PM. On 7/25/24 at 10:17 AM, Resident #127's electronic medication administration record (eMAR) was reviewed and revealed no evidence that the doctors order was transcribed and administered on 7/2/24. Further review of the eMAR revealed LPN Staff #3 had administered 12 units of insulin on 7/4/24 at 7:23 AM, and a BS check after 1 hour was documented by Staff #2. The term stat, which comes from the Latin statim, meaning immediately, is designed to give priority to orders that are needed most quickly. Generally speaking, a stat medication order should be administered within 30 minutes of the time it is ordered In an interview with the Assistant Director of Nursing (ADON) on 7/25/24 at 10:43 AM, the progress note documented by Staff #2 effective 7/2/24 at 4:52 PM was reviewed, and she confirmed that the physician gave a verbal stat order. A review of Resident #127's medical records was conducted with the ADON, and she confirmed that there was no evidence that the 12 units of insulin was administered on 7/2/24 and there was no order from the physician to support the 7/4/24 one-time administration of 12 units of insulin. The ADON indicated that the administration of the 12 units of insulin on 7/4/24 could have been an identical, but separate order from 7/2/24, however, the nurse who received the order failed to document it in the medical record. The ADON acknowledged that these were concerns that needed to be addressed. On 7/25/24 at 11:49 AM, Staff #2 was interviewed about her process with verbal orders. Staff #2 explained that after reading back an order to the physician for verification, she would document it in the resident's medical record and put the order in the computer system so she could document the administration of the order. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #2 was asked to review the progress note she wrote on 7/2/24 effective 4:52 PM, and she reported that the order was stat, administered the insulin as ordered, and then documented in the resident's medical record. Staff #2 was asked to show where in Resident #127's medical record did she document that she administered 12 units of insulin on 7/2/24. After reviewing the medical record, Staff #2 confirmed that she failed to document that she administered the insulin as ordered and failed to follow her process when she receives a verbal order. Later at 2:16 PM, Staff #2 was again interviewed and she reported that the one-time administration of the 12 units of insulin on 7/4/24 was an identical but separate verbal order from the doctor. Staff #2 reported that Staff #3 was the nurse who administered the medication and was in orientation with her at that time. On 7/31/24 at 9:59 AM, the concern was discussed with the Director of Nursing (DON) that after Resident #127's medical records were reviewed and staff interviews conducted, staff failed to keep a complete and accurate medical record by failing to document the administration of insulin on 7/2/24 and failing to document the doctors verbal order for the insulin administration on 7/4/24 at 7:32 AM. The DON acknowledged the concern and indicated that staff would be educated.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37276 Based on surveyor observation, interviews with staff and review of resident and facility records, it was determined that the facility failed to have an effective quality assessment and assurance program by failing to implement plans of action to correct quality deficiencies identified during the prior recertification survey. The findings include: On 8/5/24 at 3:06 PM, a review of the last recertification survey with a plan of correction date of 9/15/19, and a recertification survey concluded in 2/2018 revealed that effective processes were not put in place to prevent repeat deficiencies. The corrective actions implemented by the facility after the recertification surveys failed to effectively correct deficiencies related to reasonable accommodation of needs (F 558), Pharmacy services/procedures/pharmacist/records (F755), drug regimen is free from unnecessary drugs (F757), and free of medication errors rates 5 percent or more (F759). These failures resulted in a continuation of the deficient practices as identified during the current recertification and complaint survey. Cross reference F558, F755, F757 and F759. On 8/5/24 at 3:45 PM, the Quality Assessment and Improvement program was discussed with the Nursing Home Administrator (NHA). The NHA was made aware of the deficient practiced cited during the last recertification survey were again identified during the current survey, and the corrective actions the facility implemented after the previous surveys failed to effectively correct these deficient practices. The NHA acknowledged the concerns verbalized understanding of the concerns at that time.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 37276 Based on review of facility documentation, it was determined the facility staff failed to ensure thatthe Infection Preventionist (IP) attended and participated in the facility's quality assessment and assurance (QAA) committee at least quarterly. This was evident during a review of the Quality Assurance Program (QAPI) and has the potential to affect all residents in the facility, The findings include: On 8/5/24, at approximately 3:00 PM, a review of the sign-in sheets for the facility's Quality Assurance (QA) Committee meeting attendance sheets revealed that, from July 2023 through July 2024, there was a QA committee meeting held monthly on 7/20/23, 8/15/23, 9/22/23, 10/2/23, 11/16/23, 12/19/23, 1/18/24, 2/22/24, 3/21/24, 4/11/24, 5/9/24, 6/13/24, and 7/11/24. A review of the attendance sheets revealed that the IP only attended 1 meeting, on 10/2/23, out of the 13 monthly meetings held. There was no evidence to indicate the infection preventionist attended the QA meetings at least quarterly. On 8/5/24 at 3:45 PM, during an interview, the Nursing Home Administrator (NHA) verified the findings that the attendance sheets failed to reveal evidence the IP attended the monthly QA meetings at least quarterly. Cross reference S3070.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observation, records review, and interview, it was determined that the facility failed develop and implement infection prevention and control policies and prodedures as evidenced by 1) facility staff's failure to don appropriate personal protective equipment (PPE) before giving direct care to 1a) a resident with a central line (an IV access to a person's veins), and 1b) a resident with an open wound, 2) facility staff's failure ot follow infection prevention and control practices during medication administration, 3) the failure to process laundry in a manner that prevents the spread of infection, 4) the failure to have a system in place to identify and prevent the growth of legionella in the facility's water system, and 5) the failure to review infection prevention and control policies and procedure annually. This was evident for 1 resident (#68) reviewed for dialysis, and 1 (#64) of 2 residents reviewed for pressure ulcers, 1 out of 5 medication administrations observed and has the potential to affect all residents in the facility. The findings include: 1a) An observation on [DATE] at approximately 8:40 AM, during the initial tour of the facility noted a dialysis central line to Resident #68's upper chest. The observation failed to show an EBP (Enhanced Barrier Precautions) signage on the Resident's door and a supply of gowns in the Resident's room. Enhanced Barrier Precautions (EBP) are infection control interventions designed to reduce transmission of infection in nursing homes. It involves gown and glove use during high-contact Resident care activities like dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting for residents with central line, urinary catheter, feeding tube, tracheostomy, or any skin opening requiring dressing. Further observation on [DATE] at approximately 9:00 AM showed staff #58 assisting Resident #68 to transfer from the bed to the wheelchair and the bathroom. Staff #58 continued to help the Resident with hygiene and dressing. Staff #58 had put on gloves. However, the observation failed to show that staff #58 wore a gown. A medical record review on [DATE] at 10:10 AM showed an attending provider's order, dated [DATE], for Resident #68 to receive dialysis three times a week for chronic kidney disease. In an interview on [DATE] at 9:03 AM, Resident #68 reported that the staff wore gloves when providing care to him/her, but not gowns. In an interview on [DATE] at 1:37 PM, the director of nursing said that because of his/central line for dialysis, there should have been an EBP signage on the door for all staff to know what to wear when providing direct care to the Resident. 1b) In an interview on [DATE] at 10:38 AM, Resident #64's representative mentioned that the Resident was admitted to the facility with a wound. A review on [DATE] at 9:16 AM of Resident #64's treatment administration record contained an attending provider's orders for daily wound dressing changes to the Resident's wounds to the right buttock, left buttock, and sacrum. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on [DATE] at 9:50 AM noted that staff #29, a geriatric nurse aide, was providing direct care to Resident #64. Staff #29 had put on gloves and not a gown. An observation was made on [DATE] at 10:57 AM of Resident #64 lying in bed and staff #50, a geriatric nurse aid providing direct care to the Resident. Staff #50 had put on gloves; however, she did not wear a gown. Staff #50 was questioned, and she stated she only wore gloves when she provided direct care to Resident #64. In an interview on [DATE] at 11:31 AM, staff #29 stated she only wore a gown before providing direct care to a resident whose wound had a bloody drainage. Staff #29 said that Resident #64's wounds did not drain blood, so she did not need to gown up before providing direct care. 50573 2) On [DATE] at 8:20 AM, the surveyor observed Licensed Practical Nurse (Staff #35) prepare to administer insulin to Resident #475. Staff #35 obtained the insulin bottle and showed the surveyor that it matched the one ordered. Staff #35 obtained a syringe and needle and drew up 4 units of insulin then showed the surveyor the syringe. Staff #35 proceeded to take the syringe of insulin with the exposed needle into Resident #475's room and placed it on the edge of the tissue box while she performed hand hygiene and then administered the insulin to the resident. On [DATE] at 11:25 AM, the surveyor reviewed the observation of insulin administration with the Director of Nursing (DON) and she indicated that it was an infection concern. Later that day, the DON revealed that she provided education to the staff on [DATE] on capping needles for infection control and prevention when preparing and administering medications. 48470 3) A tour of the facility's laundry room was conducted on [DATE] at 1:50 PM with the Housekeeping and Laundry Manager (Staff #30). During the tour, Staff #30 explained their process with laundry and reported that soiled laundry arrives in the laundry room in plastic bags tied from the top and transported in bins with wheels. Once the soiled laundry is ready for processing, staff sorts them in the same area, then loaded the laundry into the washer. It was observed that there was no physical separation between the clean and soiled area of the laundry room to prevent cross contamination. Shortly after at 1:58 PM, the surveyor observed a bin with soiled laundry that was ready to be processed. A Housekeeper (Staff #36) indicated that she was about to process that bin. Staff #30 helped Staff #36 sort the soiled laundry. Both staff were observed not wearing appropriate Personal Protective Equipment (PPE) while sorting soiled laundry to prevent cross contamination. Both Staff #30 and #36 continued to report their process with the laundry and was observed moving through the laundry room up to the area where they fold and store clean linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The concern was discussed with Staff #30 that the clean linens were vulnerable to cross contamination since the laundry room had no physical separation between the clean and soiled area of the laundry room. Staff #30 reported that to her knowledge, the facility does not have a waiver regarding the laundry room's physical set up and indicated that the Nursing Home Administrator (NHA) may have more knowledge about it. Furthermore, the concern was discussed with both Staff #30 and #36 that they were sorting through the soiled laundry without appropriate PPE. Staff #30 stated, I thought about that. We are still learning. We weren't taught that when we started here. On [DATE] at 12:28 PM, the concerns were discussed with the Infection Preventionist (IP) nurse that the facility did not have a process in place to prevent the spread of infection as evidenced by the staff processing laundry without appropriate PPE and having no physical separation between the clean and soiled area of the laundry room. The IP nurse acknowledged the concern. 4) On [DATE] at 4:00 PM, the Maintenance Director (Staff #39) was interviewed about water management. Staff #39 reported that he sends water samples to an outside company for testing and indicated that he would get his documents about water management. Later at 4:46 PM, Staff #39 brought all his documents regarding the facility's water management. A review of the documents provided by Staff #39 revealed the results from the water samples sent to [NAME] County Labs where Legionella was not detected, Diagrams with pictures showing the flow of water in the facility, and printed guidance from the Centers for Disease Control and Prevention (CDC) regarding water management. Staff #39 was iquestioned if the facility had identified areas where pathogens like Legionella could potentially grow and if so, what measures did they have in place to prevent them from growing? Staff #39 answered by indicating that he sends water samples every 3 months to the lab for monitoring and results come back after a week. After further questioning about the facility's process, Staff #39 confirmed that they had not studied the flow of water in the facility to identify areas for potential pathogen growth and no process in place to prevent them from growing. The concern was discussed with the IP nurse on [DATE] at 12:28 PM, that the facility does not have a process in place to identify areas and prevent the growth of legionella in the facility. The IP nurse acknowledged the concern. 5) The policies and procedures of the facility's IPCP (Infection Prevention Control Program) was provided after the entrance conference of the survey. The document consisted of 3 pages and indicated that it was revised in August of 2012. On [DATE] at approximately 8 AM, the policies and procedures for IPCP were reviewed and failed to specify when and whom communicable diseases or infections should be reported and when and how isolation should be used for a resident. On [DATE] at 9:17 AM, the IP nurse was asked how often the policies and procedures for IPCP were reviewed? The IP nurse stated, I don't know, it just says on the bottom when they were revised and I'm assuming they were reviewed then. The IP nurse indicated that she would look if there was anything more current. After approximately 2 minutes, the IP nurse reported that she found a newer one and provided a copy to the surveyor. This document indicated that it was revised in October of 2018. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	After further review of the policies and procedures for IPCP, the concerns were discussed with the IP nurse on [DATE] at 12:01 PM, that they did not specify when and whom communicable diseases or infections should be reported, when and how isolation should be used for a resident, and that they were not reviewed at least annually. The IP nurse acknowledged the concerns.

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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. 48470 Based on record review and interviews, it was determined that the facility failed to ensure that residents were offered the pneumococcal vaccine. This was evident in 1 (Resident #54) out of 5 residents reviewed for immunizations during the survey process. The findings include: Resident #54 has been a resident of the facility since July of 2023. On 8/5/24 at 9:28 AM, Resident #54's electronic health record (EHR) was reviewed and revealed no evidence that the pneumococcal vaccine was offered or administered. On 8/5/24 at 10:09 AM, the Assistant Director of Nursing (ADON) was interviewed about documentation for immunizations. The ADON reported that all vaccines administered in the facility should be documented in the resident's EHR under the immunization tab, and if it was a vaccine that they received outside, then the facility would request a copy of the record to be scanned in the EHR and saved under the miscellaneous tab. The DON further reported that when residents decline a vaccine and/or immunization, the documentation can also be found in the miscellaneous tab under the consent label. A review of the facility's policy for pneumococcal vaccine indicated that a vaccination status would be conducted within 5 working days from admission if it was not done prior to being admitted . Also, it would be offered within 30 days of admission to the facility. On 8/5/24 at 12:01 PM, the Infection Prevention (IP) nurse was interviewed about resident vaccinations/immunizations, and she reported that not all documentations are found in the EHR. Contrary to what the ADON had reported, some documents do not get scanned in the EHR and are kept in the resident's hard chart. The IP nurse was then given a list of 5 residents including Resident #54, whose pneumococcal vaccines were not documented in the EHR. Later at 12:33 PM, the IP nurse reported that 4 of the 5 residents in the list had documentation in the hard chart that they had declined the pneumococcal vaccine. However, Resident #54 had no documentation in the hard chart and after reviewing the EHR, the IP nurse confirmed that the resident had not received nor declined the vaccine. The concern was discussed with the IP nurse that the facility failed to offer the pneumococcal vaccine to Resident #54. The IP nurse acknowledged 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. 37276 Based on review of employee files, pertinent documents and interview, it was determined that the facility failed to include effective communications as mandatory training for direct care staff. This was evident for 5 of 5 (Staff #29, #31, #32, #33, #34) employees reviewed for the extended survey. The findings include: Effective communications describe a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand. On 7/30/24 at 1:35 PM, a review of 5 randomly selected employee files failed to reveal documentation to indicate that the employees had received effective communications training: a) Staff #29, GNA, with a date of hire (DOH) of 11/30/22, had no documentation in the employee file to indicate s/he received effective communications training. b) Staff #31, GNA, with a DOH 5/9/17, had no documentation in the employee file to indicate s/he received effective communications training. c) Staff #32, GNA, with a DOH 6/9/10, had no documentation in the employee file to indicate s/he received effective communications training. d) Staff #33, GNA, with a DOH 5/18/20, had no documentation in the employee file to indicate s/he received effective communications training. e) Staff #34, GNA, with a hire date of 9/21/20, had no documentation in the employee file to indicate s/he received effective communications training. On 7/31/24 at 9:33 AM, Staff #10, Human Resources (HR) was made aware there was no training found in the employee files and responded that the employee files were in place prior to her hire at the end of late 2023. Staff #10 indicated she was unsure how the HR staff previously tracked mandatory inservice training but was told they had a book. Staff #10 stated she could not confirm training that occurred prior to January 2024, within the past few months, the corporate office had sent training materials to HR which she then sends to the department heads. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/31/24 at 11:25 AM, the above concerns were discussed with the Director of Nurses (DON). The DON indicated that, in the past, staff, training had been kept in a book, and, until recently, staff training was not occurring. The DON stated that, since April 2024, the corporate office had sent the facility monthly training materials, which is kept in a binder, and the DON provided the training to the clinical staff. On 7/31/24 at 11:47 AM, review of the corporate training materials failed to reveal documentation to indicate that the facility staff received effective communication training. The surveyor was provided a binder labeled Annual Education Fair which had evidence of limited training for some facility staff which occurred prior to 2024. In the binder were employee Annual Education In-Service Attendance Record forms with a list of training topics, and documentation to indicate when training was completed. There were education inservice attendance records for Staff #29, Staff #32, #33 and #34, however, the attendance records did not include documents for effective communication training. On 8/1/24 at approximately 4:00 PM, the DON and Staff #16 were made aware of the concerns. The DON and Staff #16 acknowledged the concerns at that time and offered no further comments. As of time of exit from the facility on 8/5/24, no documentation was provided to the surveyor to indicate the facility staff received communications training.

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Creekside Center for Rehabilitation and Nursing	1183 Luther Drive Hagerstown, MD 21740

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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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 37276 Based on review of employee files, pertinent documents, and staff interviews, it was determined that the facility failed to ensure that required training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management was completed. This was evident for 3 (#29, #31, #41) of 5 staff members reviewed during the survey. The findings include: On 7/30/24 at 1:35 PM, a review of the employee files for Staff #29, GNA, with a date of hire of 11/30/22, Staff #31, GNA, with a date of hire of 5/9/17, Staff #32 GNA with a date of hire of 6/29/10, Staff #33, GNA, with a date of hire of 5/18/20, and Staff #34, with a date of hire of 9/21/29 failed to reveal documentation to indicate the employees had received abuse and dementia management training. On 7/31/24 at 9:33 AM, Staff #10, Human Resources (HR) was made aware there was no training found in the employee files and responded that the employee files were in place prior to her hire at the end of late 2023. Staff #10 indicated she was unsure how HR previously tracked mandatory in-service training but was told they had a book. Staff #10 stated she could not confirm training that occurred prior to January 2024, however, within the past few months, the corporate office sent training materials to HR which she then sends to the department heads. On 7/31/24 at 11:25 AM, the above concerns were discussed with the Director of Nurses (DON). The DON indicated that in the past, staff training had been kept in a book, and, until recently, staff training was not occurring. The DON stated that since April 2024, the corporate office had sent the facility monthly training materials, which are kept in a binder, and the DON provided the training to the clinical staff. On 7/31/24 at 11:47 AM, the DON provided the surveyor a binder with the corporate training materials. Together with the DON, a review of the binder revealed training materials for Resident Rights and training for Transmission Based Precautions (TBP). There were no other training materials in the binder and no documentation to indicate the facility staff had received the training. At that time, the DON stated when the staff were trained, they completed a training-specific answer sheet attendance signature sheets were not obtained. The surveyor was provided a binder labeled Annual Education Fair which had evidence of limited training for some facility staff that occurred prior to 2024. In the binder were Annual Education In-Service Attendance Record forms that had the attestation, I attest that my signature below for each topic represents the education I received, and a place to record the employee's name and date. On the forms were 4 columns, labeled Topic, Print Name, Signature and Department, followed by rows that had a training topic, including abuse and dementia training, and space to document the employee's name, signature, and department. A review of the annual education fair binder revealed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1) Staff #29, GNA had an undated annual education inservice attendance record that indicated s/he received abuse training with no evidence of dementia training. In addition, the in-service attendance record was undated, with no indication that the abuse training was completed within the past 12 months. 2) Staff #31 did not have an annual education in-service attendance form in the binder, and did not have evidence of abuse and dementia training in the binder On 7/31/24 at 4:49 PM, the DON and Staff #16, Regional Director for Clinical Operations were made aware of the concerns with limited evidence of staff training. At that time, Staff #16 stated that within the past year, all facility staff, except clinical agency staff, had received abuse training and provided the surveyor with a folder containing abuse training answer sheets for the employees who had received the training. On 8/1/24 at 10:15 AM, a review of the staff-completed abuse training answer sheets were compared with the facility's active staff roster failed to reveal documentation that Staff #29 had received abuse training and no documentation to indicate Staff #31 received abuse training. In addition, the review for abuse training failed to reveal evidence that 7 (including Staff #29, and #31) of 13 active GNAs had received abuse training, and 19 of 62 active employees had not received abuse training On 8/1/24 at approximately 4:00 PM, the DON and Staff #16 were made aware of the concerns. The DON and Staff #16 acknowledged the concerns at that time and offered no further comments. 50573 3) On 8/2/24 at 7:48 AM, a review of Staff #41's employee record revealed a background check that was completed upon hire, however, the record failed to reveal that any abuse training was completed. Staff #41 was terminated on 7/5/24. On 8/2/24 at 12:03 PM, the surveyor reviewed the concern with the Director of Nursing (DON) regarding the failure to ensure abuse training was completed by all nurse aides and she said she would try and find abuse training for Staff #41. On 8/2/24 at 1:05 PM, the DON confirmed she was not able to find abuse training for Staff #41.

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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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 37276 Based on review of employee files, pertinent documents and interview, it was determined that the facility failed to provide infection prevention and control training mandatory training that included the written standards, policies, and procedures for the program. This was evident for 4 (Staff #29, #31, #32, #34) of 5 employee records reviewed for the extended survey. The findings include: A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program On 7/30/24 at 1:35 PM, a review of 5 randomly selected employee files failed to reveal documentation to indicate the employees had received mandatory infection prevention and control training. a) Staff #29, GNA, with a date of hire (DOH) of 11/30/22, had no evidence of training, including infection prevention and control training in his/her employee file. b) Staff #31, GNA, with a DOH 5/9/17, had no evidence of training, including infection prevention and control training in his/her employee file c) Staff #32, GNA, with a DOH 6/9/10, had no evidence of training, including infection prevention and control training in his/her employee file d) Staff #33, GNA, with a DOH 5/18/20, had no evidence of training, including infection prevention and control training in his/her employee file. e) Staff #34, GNA, with a hire date of 9/21/20, had no evidence of training, including infection prevention and control training in his/her employee file On 7/31/24 at 9:33 AM, Staff #10, Human Resources (HR) was made aware there was no training found in the employee files and stated the employee files were in place prior to her hire at the end of late 2023. Staff #10 indicated she was not sure how mandatory inservice training previously had been tracked but was told they had a book. Staff #10 stated she could not confirm training that occurred prior to January 2024, and within the past few months, the corporate office has sent training materials to HR which she then sends to the department heads. On 7/31/24 at 11:25 AM, the above concerns were discussed with the Director of Nurses (DON). The DON indicated that in the past, staff training had been kept in a book, and, until recently, staff training was not occurring. The DON stated that since April 2024, the corporate office sent the facility monthly training materials, which are kept in a binder, and the DON provided the training to the clinical staff. On 7/31/24 at 11:47 AM, review of the corporate training materials failed to reveal documentation to indicate the facility staff received behavioral health training. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor was provided a binder labeled Annual Education Fair which had evidence of limited training for some facility staff which occurred prior to 2024. In the binder were employee Annual Education In-Service Attendance Record forms with a list of training topics, and documentation to indicate when training was completed. There were education inservice attendance records for Staff #29, Staff #31, Staff #32, #33 and #34. The review of the Annual Education In-Service Attendance Record forms revealed an inservice attendance record dated 10/24/23 for Staff #33, that indicated s/he received infection control training, however, her signature was not noted on the document. Further review of the Annual Education In-Service Attendance Record forms failed to reveal documentation to indicate Staff #29, Staff #31, Staff #32, and Staff #34 had received infection control training. On 8/5/24 at 11:57 AM, Staff #10, HR was made aware of the findings, and stated that, since she has been at the facility, no infection control training for staff had occurred. On 8/5/24 at 12:02 PM, the DON was made aware of the above findings and stated that the corporate office had not provided infection control training for the facility staff.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 37276 Based on the review of employee records and staff interview, it was determined that the facility failed to have documentation that Geriatric Nursing Assistance's (GNA) were given 1) in-service training no less than 12 hours per year, 2) abuse prevention and dementia management training, 3) a yearly performance review, and 4) training for GNA's that provide services to residents with cognitive impairments. This was evident for 5 of 5 (Staff #29, #31, #32, #33, #34) GNA employee records reviewed for sufficient and competent nursing staffing reviewed during the survey and has the potential to affect the care received by all residents. The findings include: On 7/30/24 at 1:35 PM, the surveyor reviewed 5 randomly selected employee files of geriatric nursing assistants (GNAs) who were employed by the facility for more than 12 months. Review of the employee file for Staff #29, GNA, with a date of hire of 11/30/22, Staff #31, GNA, with a date of hire of 5/9/17, Staff #32 GNA with a date of hire of 6/29/10, Staff #33, GNA, with a date of hire of 5/18/20, and Staff #34, with a date of hire of 9/21/29 failed to reveal documentation to indicate the GNA's had received any training or education in the past 12 months or that an annual performance review had been conducted on each GNA within the past year. On 7/31/24 at 9:33 AM, Staff #10, Human Resources (HR) was made aware that no evidence of training, competency or performance evaluations found in the GNA employee files reviewed by the surveyor. Staff #10 acknowledged the concerns and stated that the employee files had been in place prior to her hire in late 2023. Staff #10 indicated she was not sure how HR previously tracked mandatory inservice training but had been told they had a book. Staff #10 stated she could not confirm the annual training or performance reviews that occurred prior to January 2024. Staff #10 stated that performance reviews on all staff were to begin in August, and in recent months, the corporate office started sending training materials to HR monthly which HR then sends to each department head. On 7/31/24 at 11:25 AM, the above concerns were discussed with the Director of Nurses (DON). The DON indicated that in the past, staff training had been kept in a book, and, until recently, staff training was not occurring. The DON stated that since April 2024, the corporate office had sent the facility monthly training materials, which are kept in a binder, and the DON provided the training to the clinical staff. On 7/31/24 at 11:47 AM, the DON provided the surveyor a binder with the corporate training materials. Together with the DON, a review of the binder revealed training materials for Resident Rights, and training for Transmission's Based Precautions (TBP). There were no other training materials in the binder and no documentation to indicate the facility staff had received the training. At that time, the DON stated when the staff were trained, they completed a training specific answer sheet, and attendance signature sheets were not obtained. The DON also indicated she has been in the DON since the end of 2023 and clinical staff competency evaluations and performance reviews had not been done since she has been in her role. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor was also provided binder labeled Annual Education Fair which had evidence of limited training for some facility staff which occurred prior to 2024. In the binder were Annual Education In-Service Attendance Record forms that had the attestation, I attest that my signature below for each topic represents the education I received, and a place to record the employee's name and date. On the forms were 4 columns, labeled Topic, Print Name, Signature and Department, with rows that had a training topic and space to document the employees' name, signature and department. The training topics listed were abuse, active shooter, ADL doc., COVID-19, infection control, cultural diversity, dementia, fire & disaster, planning, HIPPA, nutrition, hydration/oral, pain management, incontinence/skin care/cath, wounds, resident rights, restorative nursing and did not include cognitive impairment, communications or behavioral training. Review of the Annual Education Fair binder revealed: a) Staff #29, GNA had an undated annual education inservice attendance record that indicated s/he received abuse training. There was no evidence of dementia training and no documentation of the number of training hours completed. b) Staff #32, GNA had an annual education inservice attendance record dated 8/22/23, that indicated s/he received abuse and dementia training, with no documentation of the number of training hours completed. c) Staff #33, GNA had an annual education inservice attendance record, dated 10/24/23, that indicated s/he received abuse and dementia training, with no documentation of the number of training hours completed. d) Staff #34 had an annual education inservice attendance record, dated 8/22/23, that indicated s/he received abuse and dementia training, with no documentation of the number of training hours completed. e) There was no documentation in the binder to indicate Staff #31 had received annual training. On 7/31/24 at 4:49 PM, the DON and Staff #16, Regional Director for Clinical Operations were made aware of the concerns with limited evidence of staff training. At that time, Staff #16 stated that within the past year, all facility staff, including therapy, had received abuse training, however clinical agency staff were not included in the training. The surveyor was then provided a folder containing training answer sheets for the employees who had received the abuse training. On 8/1/24 at approximately 4:00 PM, the DON and Staff #16 were made aware of the concerns with failing to ensure the GNAs received the required in-service training for nurses' aides and failing to ensure the continuing competence of nurses' aides. The DON and Staff #16 acknowledged the concerns at that time and offered no further comments.

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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. 37276 Based on review of employee files, pertinent documents and interview, it was determined that the facility failed to include effective communications as mandatory training for direct care staff. This was evident for 5 of 5 (Staff #29, #31, #32, #33, #34) GNA employee records reviewed for during the survey. The findings include: Effective communications describe a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand. On 7/30/24 at 1:35 PM, a review of 5 randomly selected employee files failed to reveal documentation to indicate the employees had received effective communications training: a) Staff #29, GNA, with a date of hire (DOH) of 11/30/22, had no documentation in the employee file to indicate s/he received effective communications training. b) Staff #31, GNA, with a DOH 5/9/17, had no documentation in the employee file to indicate s/he received effective communications training. c) Staff #32, GNA, with a DOH 6/9/10, had no documentation in the employee file to indicate s/he received effective communications training. d) Staff #33, GNA, with a DOH 5/18/20, had no documentation in the employee file to indicate s/he received effective communications training. e) Staff #34, GNA, with a hire date of 9/21/20, had no documentation in the employee file to indicate s/he received effective communications training. On 7/31/24 at 9:33 AM, Staff #10, Human Resources (HR) was made aware there was no training found in the employee files and responded that the employee files were in place prior to her hire at the end of late 2023. Staff #10 indicated she was unsure how the HR previously tracked mandatory inservice training but was told they had a book. Staff #10 stated she could not confirm training that occurred prior to January 2024, however,within the past few months, the corporate office has sent training materials to HR which she then sends to the department heads. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/31/24 at 11:25 AM, the above concerns were discussed with the Director of Nurses (DON). The DON indicated that in the past, staff training had been kept in a book, and, until recently, staff training was not occurring. The DON stated that since April 2024, the corporate office had sent the facility monthly training materials, which is kept in a binder, and the DON provided the training to the clinical staff. On 7/31/24 at 11:47 AM, review of the corporate training materials failed to reveal documentation to indicate the facility staff received effective communication training. The surveyor was provided a binder labeled Annual Education Fair which had evidence of limited training for some facility staff which occurred prior to 2024. In the binder were employee Annual Education In-Service Attendance Record forms with a list of training topics, and documentation to indicate when training was completed. There were education inservice attendance records for Staff #29, Staff #32, #33 and #34, however the attendance records did not include effective communication training. On 8/5/24 at 2:30 PM, the DON and Staff #16 were made aware of the concerns. The DON and Staff #16 acknowledged the concerns at that time and offered no further comments. As of time of exit from the facility on 8/5/24, no documentation was provided to the surveyor to indicate the facility staff received communications training. Cross reference F940