STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215117	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stella Maris, Inc.	2300 Dulaney Valley Road Timonium, MD 21093

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 34484 Based on medical record review and interview, the facility staff failed to obtain consent from the Resident's representative prior to administering a new medication to a resident (Resident # 33). This was evident for 1 of 71 residents reviewed during a complaint survey. The findings include: Review of Resident #33's medical record on 3/27/25 the Resident was admitted to the facility in September 2023 with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident's medical record revealed the Resident was seen by the Psychiatric Practitioner (Staff #70) on 9/18/23 and at that time Staff #70 ordered Depakote 125 mg twice a day for dementia with behavioral disturbances. Depakote is a medication that can treat seizures and bipolar disorder. Staff #70 documented at that time unable to reach resident's representative to discuss progress and plan. Further review of Resident #33's medical record revealed the facility staff assessed the Resident on 9/23/23 to have a BIMS (Brief Interview Mental Status) of 4 of 15. A BIMS of 4 indicates severe cognitive impairment. Interview with Resident #33's representative on 4/2/25 at 10:12 AM, the representative stated the facility staff administered medications to the Resident without a meeting to discuss the behavior or the plan. Further review of the Resident's medical record revealed no evidence the Resident's representative was notified prior to the administration of Depakote on 9/18/23. Interview with the Assistant Director of Nursing on 4/3/25 at 8:50 AM confirmed there was no evidence the facility staff notified Resident #33's representative prior to the administration of Depakote on 9/18/23.

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31145 Based on medical record review and interview, it was determined the facility staff failed to notify the physician of the inability to obtain an opthamology consult. This was evident for 1 (#7) residents reviewed for 40 complaints reviewed during a complaint survey. The findings include: On 3/31/25 at 8:34 AM a review of complaint MD00212199 was conducted. The complainant alleged that Resident #7 was hit by his/her aide. The complaint alleged Resident #7 had a bruise on his/her face from the incident. Review of a 11/22/24 at 2:30 PM SBAR (change in condition note) documented, around 0815 writer was called to room by GNA. GNA had just walked into the room and noticed bruising to left peri-orbital region with a small gash to left eyebrow. Resident initially stated that [he/she] was hit with a dish. Then stated that [he/she] was turned over (in bed) and hit [his/her] head. A 11/22/24 at 7:11 PM provider note documented, Note: Patient noted with left periorbital swelling, erythema, tenderness and hematoma extending towards nasal bridge and inner canthus of left eye. The assessment and plan documented, left eye hematoma: Unknown etiology. Nursing staff believe this might have likely occurred during repositioning. Will obtain ophthalmology consultation for further evaluation. A 11/26/24 at 10:19 PM provider note documented, left eye hematoma: unclear etiology. Ecchymosis extending to left jaw, periorbital area and nasal bridge. Ophthalmology consult pending for further evaluation. Review of nursing progress notes, physician notes, and the entire medical record failed to produce an ophthalmology consult for the eye injury. On 4/4/25 at 1:00 PM NP #56 stated the resident had dementia so couldn't follow instructions. It was a significant bruise. I am not sure how it got there. I could not say it was from the side rail. That is why I wanted [him/her] to be seen by an ophthalmologist. I am not really sure what happened. For the appointment I would expect it to be ASAP. If they could not get an appointment right away, I would expect them to notify me. On 4/7/25 at 2:19 PM an interview was conducted with the DON about eye consultation. The DON confirmed there was no documentation that the NP was notified of the failure to obtain an ophthalmology appointment.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 31145 Based on review of a facility reported incident with documentation, medical record review, and staff interview, it was determined the facility failed to protect a vulnerable adult from physical abuse. Due to this deficient practice Resident #34 suffered physical harm. This was evident for 1 (#34) resident reviewed for 27 facility reported incidents reviewed during a complaint survey. The facility implemented effective and thorough corrective measures following this incident prior to the start of this survey. The facility's plan and action were verified during this survey; therefore this deficiency was found to be past noncompliance with a compliance date of 10/16/23. The findings include: On 3/27/25 at 3:03 PM a review of facility reported incident MD00198080 alleged that on 10/5/23 at approximately 9:00 AM, GNA #16 was providing morning care to Resident #34. Resident #34 was swinging his/her arms at GNA #16, and LPN #15 witnessed the interaction. According to GNA #16, LPN #15 came running in the room, got close to Resident #34, then walked back to close the door. LPN #15 came back rushing and slapped Resident #34 in the face hard on the right side at the top of the face. LPN #15 allegedly stated, don't you ever [expletive] do that again. Isn't there something you need to say? You need to apologize. Review of the documentation in the facility report revealed that Resident #34 was a resident with a diagnosis of paraplegia, epilepsy, intellectual disability and aphasia following a nontraumatic subarachnoid hemorrhage in 2019 along with multiple co-morbidities. Review of the facility's investigation documented a written statement from GNA #16 dated 10/6/23 that stated, yesterday, on October 5, 2023, I [name of GNA #16] witnessed the nurse [name of LPN #15] slap the resident [name of Resident #34] in the face. It was between 8:30 AM and 9:00 AM. The note continued to document that GNA #16 was getting Resident #34 dressed for breakfast and the resident wanted his/her socks on because his/her feet were getting cold. GNA #16 told the resident no because his/her foot had to get a bandage. Resident #34 kept asking and GNA #16 kept saying no. GNA #16 documented that the resident turned to the side and when he/she turned around he/she went to swing at GNA #16 but wasn't close enough. LPN #15 saw what was going on and came running in. LPN #15 came close to Resident #34 then walked back to close the door. LPN #15 came back rushing and slapped Resident #34 in the face hard on the right side at the top. Resident #34 became quiet. After LPN #15 yelled at the resident he left and GNA #16 finished getting Resident #34 ready. GNA #16 documented, I was scared to speak because of retaliation. GNA #16 documented that LPN #15 created a hostile environment and was always loud and yelling, so she didn't want him to do anything to her. GNA #16 documented that Resident #34, didn't deserve that. No matter how mad you get that the resident hitting is wrong and should never happen. [He/she] didn't deserve that. I had to speak up, so it didn't happen again. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	GNA #58 documented in a written statement that she saw LPN #15 slam the door. When [name of GNA #16] came to me the next day and told me what happened, I told her to report the incident immediately. GNA #58 also documented that she was joking with a resident and asked the resident if he/she was staying up past 2 PM and the resident stated no because when he/she did the other day, LPN #15 yelled at him/her. Review of Resident #34's medical record revealed a 10/6/23 at 10:47 AM physician's progress note that documented, chief complaint, patient was seen for c/o (complaint of) headache after being struck in [his/her] head. The assessment/plan documented, headache after being struck - pending ER transfer to r/o (rule out) head injury or other acute process. Continue Acetaminophen. A 10/7/23 at 10:34 AM physician's note documented, I was asked to evaluate the patient. Patient was reportedly abused by a staff member. Patient was not reported to have any significant injuries. Patient however was referred to the emergency room for evaluation. Patient has returned from the emergency room . No significant abnormalities were found. Patient had a CT scan of the head and C-spine which were unremarkable. On 3/31/25 at 2:45 PM an interview was conducted with GNA #16. GNA #16 stated that she was trying to clean Resident #34 up and the resident was in a mood and was trying to hit her. GNA #16 stated she tried to redirect. GNA #16 stated the power had gone out and all of a sudden she saw LPN #15 in the room and LPN #15 slapped Resident #34 in the face and she was stunned. He cussed at the resident and left the room. GNA #16 stated Resident #34 was holding his/her face, and his/her face was red, and Resident #34 had a look on his/her face like he/she was used to it, and it wasn't the first time it happened. GNA #16 stated she asked Resident #34 if he/she was ok. GNA #16 stated, I had never seen that before. The surveyor asked GNA #16 if she reported it immediately and she stated, no, I did not tell anyone because I was scared because [name of LPN #15] was very confrontational, revenge, he is tit for tat. The next day when I came to work is when I reported it. It happened between 8 and 9 in the morning. The rest of the day [name of LPN #15] went on carefree like nothing happened. GNA #16 stated, I told the nurse the next day and I just went to administration because I was so nervous. I reported it to the infection nurse first. I asked for the DON (Director of Nursing) and then I reported it to the Nursing Home Administrator. I was very emotional. They took the necessary steps, and I wrote my statements. I had to go to the Board of Nursing and give my statement again. GNA #16 stated that she was educated after the incident about reporting immediately. Cross Reference F609 On 4/1/25 at 10:47 AM an interview was conducted with the DON who confirmed the incident was not reported timely by the staff member. The DON was not employed at the facility at the time of the incident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of LPN #15's personnel file revealed LPN #15 was initially a GNA back in 2012 at the facility. On 10/28/13 he was written up for behavior. On 4/11/13 he was written up for being rude and insubordinate and on 11/19/13 was given a written warning with suspension due to intimidation and insubordination. On 3/25/14 he was written up because he was overheard using language that was not appropriate to one of the residents. On 4/11/17 he received verbal counseling for speaking harshly. LPN #15 became an LPN, and on 1/9/19 was put on an action plan for performance as he left medications in a resident's bed. On 8/12/21 he refused to acknowledge an RN, ICP (infection control practitioner) when instructed on the requirement for wearing a face shield while the facility was in a COVID-19 outbreak. He had an insubordinate attitude. On 8/28/23 he received a performance management write up. The facility's administration reported LPN #15 to the Board of Nursing after the incident on 10/6/23. Review of the nurse educator's binder for sign-in sheets for education revealed abuse training in October 2023. There was a paper that said, please read and sign! All staff! The training began on 10/6/23 and continued to 10/16/23.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on reviews of facility reported incidents, complaint, record review, and interview, it was determined the facility failed to report allegations of abuse to the regulatory agency, the Office of Health Care Quality (OHCQ) within 2 hours of the allegation and failed to report bruises of unknown origin to OHCQ. This was evident for 12 (#22, #24, #47, #4, #56, #34, #42, #7, #21, #25, #19, #36) of 71 residents reviewed during a complaint survey. The findings include: 1) On 3/26/25 at 11:47 AM a review of facility reported incident MD00195422 was conducted. The Executive Director was contacted by licensed practical nurse (LPN) #84 who stated the family of Resident #22 alleged that geriatric nursing assistant (GNA) #85 handled Resident #22 abruptly while providing care on 8/10/23. Review of the facility's investigation revealed the alleged incident happened on 8/10/23 at 11:00 AM. This is when the nurse became aware of the incident. Review of the email confirmation to OHCQ revealed the initial report was not submitted until 8/10/23 at 7:02 PM, which was not within 2 hours of alleged abuse. On 4/1/25 at 10:43 AM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed the findings. 2) On 3/26/25 at 1:30 PM a review of facility reported incident MD00204743 was conducted. Resident #24 alleged on 4/13/24 at approximately 7:30 PM the GNA pushed him/her onto the bed and then lifted Resident #24's legs up into the bed and said the resident needed to go to bed. The resident felt the GNA should not have put him/her to bed. Review of the facility's investigation revealed the charge nurse was informed on 4/15/24 at approximately 11:00 AM. The Nursing Home Administrator was notified on 4/15/24 at approximately 12:45 PM. Review of the email confirmation revealed the initial report was not sent to OHCQ until 4/15/24 at 6:12 PM, which was not within 2 hours of alleged abuse. On 4/1/25 at 10:42 AM an interview was conducted with the DON. The DON confirmed that it was not reported timely. Reviewed the regulation with the DON who stated she would start educating staff. 3) On 3/27/25 at 9:26 AM a review of facility reported incident MD00192305 was conducted. Resident #47 alleged to the weekend supervisor that on 5/14/23, LPN #77 grabbed and shouted at the resident. Review of the email confirmation to OHCQ revealed the initial report was not sent in until 5/15/23 at 12:32 PM. The weekend supervisor failed to notify the facility's administration on 5/14/23 when he became aware of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 10:47 AM an interview was conducted with the ADON. She stated the supervisor did not call right away and that he sent an email. We got notified on Monday. He should have called immediately. 4) On 3/27/25 at 10:40 AM a review of facility reported incident MD00213903 was conducted. Resident #4 alleged that staff tried to strangle him/her and choke him/her to death. This was reported to the nurse on 1/23/25 at 7:00 PM. Review of the facility's investigation revealed an email confirmation dated 1/24/25 at 12:12 PM of when the initial report was sent to OHCQ. The incident was not reported within 2 hours of alleged abuse. On 4/8/25 at 2:11 PM an interview was conducted with the DON who confirmed the findings. 5) On 3/27/25 at 11:10 AM a review of facility reported incident MD00189796 was conducted. On 3/3/23 the Director of Rehabilitation was made aware by a therapist working with Resident #56 that the resident was intimidated and afraid of GNA #82. On 3/6/23, upon receiving notification via email from the Director of Rehabilitation, the nurse manager brought GNA #82 into the office for an interview regarding the concerns and was suspended pending investigation. Review of the email confirmation for the initial self-report to OHCQ documented the report was sent on 3/6/23 at 5:02 PM. The Director of Rehabilitation failed to immediately report the concerns to administration. On 3/27/25 at 11:31 AM the NHA informed the surveyor that the Director of Rehabilitation was no longer at the facility and confirmed the findings. 6) On 3/27/25 at 3:03 PM a review of facility reported incident MD00198080 was conducted. GNA #16 alleged that LPN #15 slapped Resident #34 in the face, hard, on the right side at the top on 10/5/23 at approximately 9:00 AM. Review of the facility's investigation revealed administration did not become aware of the incident until the next morning on 10/6/23. On 3/31/25 at 2:45 PM an interview was conducted with GNA #16 who stated, no, I did not tell anyone because I was scared because [LPN #15] was very confrontational. GNA #16 stated, I told the nurse the next day and I just went to administration because I was so nervous. On 4/1/25 at 10:47 AM the DON confirmed the incident was not reported timely. 7) On 3/28/25 at 7:59 AM a review of facility reported incident MD00191414 was conducted. Resident #42 alleged on 4/17/23 that during care GNA #88 was screaming at the resident and was rough when she assisted Resident #42 in bed causing pain to the right wrist. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation revealed the incident happened on 4/17/23 at 6:30 PM. An email was sent to the previous Director of Nursing from RN #87 on 4/17/23 at 8:22 PM documenting the incident. Review of the email confirmation as to when the initial report was sent to OHCQ was dated 4/18/23 at 10:21 AM which was not within 2 hours of the alleged abuse. On 4/1/25 at 10:43 AM the DON confirmed it was not reported timely. 8) On 3/31/25 at 8:34 AM a review of complaint MD00212199 was conducted. The complainant alleged that Resident #7 was hit by his/her aide. The complaint alleged Resident #7 had a bruise on his/her face from the incident. The complaint also alleged that the story was changed and now was saying the aide hit the resident by accident while being changed. Review of a 11/22/24 at 2:30 PM SBAR (change in condition note) documented, around 0815 writer was called to room by GNA. GNA had just walked into the room and noticed bruising to left peri-orbital region with a small gash to left eyebrow. Resident initially stated that [he/she] was hit with a dish. Then stated that [he/she] was turned over (in bed) and hit [his/her] head. A 11/22/24 at 3:33 PM nursing progress note documented, Has bruising to left eye, inner canthus of eye and on bridge of nose and spreading to upper cheek. A 11/22/24 at 7:11 PM provider note documented assessment and plan, left eye hematoma: unknown etiology. Nursing staff believed this might have likely occurred during repositioning. A 11/26/24 at 10:19 PM provider note documented, left eye hematoma: unclear etiology. Ecchymosis extending to left jaw, periorbital area and nasal bridge. Ophthalmology consult pending for further evaluation. On 4/3/25 at 3:27 PM the DON was interviewed and asked if the incident was reported to OHCQ. The DON stated no because she determined it was from the side rail, the way the resident was lying in bed, and she stated that they put padding on the side rails. On 4/4/25 at 1:00 PM Nurse Practitioner (NP) #56 was interviewed and stated she did a head to toe assessment on the resident and that the resident had dementia so really couldn't follow instructions. NP #56 stated it was a significant bruise. I am not sure how it got there. I could not say it was from the side rail. That is why I wanted [him/her] to be seen by an ophthalmologist. I am not really sure what happened. On 4/7/25 at 9:50 AM an interview was conducted with LPN #60. LPN #60 was asked why she put a late note in the medical record. The note was dated 11/21/24 at 9:23 AM but not put into the medical record until 11/27/24 at 10:31 AM. LPN #60 stated, I felt like I needed to protect myself. When I came back to work and I saw the bruise I thought, what happened to [him/her], and I know the family would make a big deal. I was told that when they got [him/her] up from the bed that [he/she] hit her eye on the side rail. [He/she] is the type of person that fights. On 4/7/25 at 3:20 PM the issue was discussed with the NHA who stated, we know how it happened; it was because of the way [he/she] was leaning up against the side rail. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9) On 4/1/25 at 8:05 AM a review of facility reported incident MD00206143 was conducted. Resident #21 alleged to the unit manager and to security that a GNA on Saturday, May 25, 2024, on the 3:00 PM to 11:00 PM shift, assisted the resident with incontinency. According to the resident, the incontinent brief was left off and the resident urinated on him/herself. The resident alleged that after he/she put the call light on, GNA stated If you press the button again, I am going to drag you off this bed. Review of the facility's investigation documented that the facility staff became aware on 5/28/24 at 11:30 AM. Review of the email confirmation to OHCQ, the initial report was not submitted until 5/28/24 at 6:36 PM, which was not within 2 hours of the allegation of abuse. On 4/1/25 at 10:47 AM an interview was conducted with the DON. The DON confirmed that it was not reported within 2 hours. The DON stated she thought they had 24 hours to report alleged abuse. 10) On 4/1/25 at 9:21 AM a review of facility reported incident MD00204323 was conducted. Resident #26 alleged on 3/30/24 that the GNA was removing the resident's clothes for bed and the GNA pulled the resident's clothes hard. Resident #26 had a typed statement that documented, I do not want her again. She was rough. Resident #26 had multiple contractures due to spastic cerebral palsy. Resident #26 did not report the incident to the nurse manager until 4/2/24 at 9:00 AM. Review of the email confirmation of the initial report sent to OHCQ documented it was not sent until 4/3/24 at 7:51 PM. On 4/8/25 at 2:12 PM an interview was conducted with the DON who confirmed the incident was not reported timely. 11) On 4/1/25 at 10:21 AM a review of facility reported incident MD00194802 was conducted. Resident #42's daughter alleged to the facility that Resident #42 was in the hospital and informed the daughter that he/she was upset because of a relationship with a nurse at the facility and alleged possible elder abuse. Review of the facility's investigation revealed that the facility was notified on 7/25/23. Review of the email confirmation of when the initial report was sent to OHCQ documented it was sent on 7/26/23 at 4:06 PM, which was not within 2 hours of being notified. Additionally, review of the facility's investigation revealed a statement from GNA #78 that on 7/23/23 GNA #78 told LPN #79 that Resident #42 had a crush on him/her. I then told LPN #80 and LPN #81 to report this because the patient would report to someone. The incident was not reported to nursing administration. On 4/8/25 at 2:20 PM an interview was conducted with the ADON. The ADON stated they found out the next day. The ADON stated that staff should have reported it immediately. On 4/1/25 at 10:42 AM the report was reviewed with the DON. The DON confirmed that it was not reported timely. Reviewed the regulation with the DON who stated she would start educating staff. 12) On 4/1/25 at 2:16 PM a review of facility reported incident MD00206651 was conducted. Resident #19 alleged that GNA #86 was rough when helping the resident while trying to stand. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation revealed an email from RN #87, dated 6/12/24 at 8:42 PM, that was sent to the Nursing Home Administrator that stated Resident #19 alleged GNA #86 was rough with the resident. Review of the email confirmation that was submitted to OHCQ when the initial report was sent was dated 6/13/24 at 2:56 PM. The report was not submitted within 2 hours of alleged abuse. On 4/3/25 at 12:21 PM the DON confirmed that the report was not sent to OHCQ within 2 hours of alleged abuse. 34484 13). Review of Resident #36's medical record on 3/27/25 revealed the Resident was admitted to the facility in 2017 with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident's medical record revealed from 8/29/23 until 9/26/23 the Resident was observed to have 3 different bruises. a) A nurse's note on 8/29/23 at 2:21 PM stated GNA (geriatric nursing assistant) reported new area on patient's right side of neck. RN assessed 1.2 cm by 6 cm. Bruise noted with no swelling or pain. b) A nurse's note on 9/5/23 at 12:19 PM stated reported by hospice aide that resident has a bruise to bottom lip. Upon assessment a 0.2 cm bruise observed to the center of bottom lip. c) A nurse's note on 9/26/23 at 10:40 AM stated at 7:05 AM Resident observed to have a bruise 1.5 cm by 1. 0 cm to left outer eye. No swelling or evidence of pain. Interview with the Administrator on 4/2/25 at 8:00 AM confirmed the facility had no evidence 3 injuries of unknown origin were reported to the Office of Health Care Quality.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 31145 Based on review of facility administrative records, facility investigations, complaint, medical record review, and staff interview, it was determined the facility failed to thoroughly investigate incidents of alleged abuse, neglect, and bruises of unknown origin. This was evident for 10 (#22, #65, #47, #4, #56, #42, #7, #26, #19, #36) of 71 residents reviewed during a complaint survey. The findings include: 1) On 3/26/25 at 11:47 AM a review of facility reported incident MD00195422 was conducted. The Executive Director was contacted by licensed practical nurse (LPN) #84 who stated the family of Resident #22 alleged that geriatric nursing assistant (GNA) #85 handled Resident #22 abruptly while providing care on 8/10/23. Review of the facility's investigation revealed a typed statement from a Sister that documented Resident #22 kept saying, I hate that woman; I don't want her to touch me again. When the nurse went in the room with GNA #85, Resident #22 appeared frightened when she saw GNA #85. A written statement from the nurse documented that the resident said he/she was hit and afraid he/she was going to fall. The resident got visibly upset and documented that GNA #85 was the aide. There were no other resident or staff interviews about the care that GNA #85 gave to residents to be able to determine if this was a pattern with GNA #85 and if other residents felt the same way. On 4/1/25 at 10:43 AM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) confirmed the findings. 2) On 3/26/25 at 11:47 AM a review of complaint MD00205135 was conducted. On 4/27/24 Resident #22 stated, she beat me up. Review of the facility investigation revealed the 2 Sisters that oversaw the residents on the unit were interviewed along with GNA #89. There was 1 written statement from LPN #90. There were no other staff or resident interviews or assessments done. On 4/3/25 at 12:39 PM an interview of both the DON and ADON was conducted. The DON stated that they felt the bruising was from the way the resident gripped the armrests of the wheelchair, and that the resident was always very anxious and afraid of falling. Since they determined that the bruising was from how the resident gripped the wheelchair, they did not feel the need to interview other residents or staff. 3) On 3/27/25 at 7:56 AM a review of facility reported incident MD00177782 revealed the family member of Resident #65 and Resident #65 alleged that Geriatric Nursing Assistant (GNA) #4, who took care of Resident #65 in the morning, used foul language and hurt the resident's arm. Staff #5 wrote a statement on 4/19/22 that documented on 4/19/22 at 7:45 AM Staff #5 walked into Resident #65's room and the resident was teary and stated the GNA yelled at the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #6 wrote a statement on 4/19/22 that documented that Resident #65 was taken closer to the manager's office and offered to tell the manager what happened with Resident #65. Staff #6 documented the resident said no because the resident told others and nothing happened. This made the resident afraid that the person would find out. Staff #6 documented that the resident expressed that the person has been doing this and the resident has told before and the person is still allowed to work with the resident. Further review of the investigative packet failed to produce documentation that any other residents on the unit were interviewed about the care they received from GNA #4. On 3/27/25 at 8:08 AM an interview was conducted with the Nursing Home Administrator (NHA). The NHA was asked what the process was for investigating allegations of abuse. The NHA stated, see who the complaint involves, involve certain departments, but most of the time it is nursing. Typically nursing takes the lead, talk to resident, family member, staff. And then move forward. Look at employee personnel files to see if there is a history of allegations about the staff member. The NHA was asked if they ever interview other residents on the unit and she said it depended on the complaint. They will interview residents on a GNAs assignment but typically would look at the employee's personnel file to see if there were other write-ups or incidents regarding care. The NHA was asked if they did not do resident interviews how would they know if there were any other complaints. As in Resident #65, the resident was afraid to speak up. What if other residents were afraid to speak up. The NHA expressed understanding of interviewing other residents. 4) On 3/27/25 at 9:26 AM a review of facility reported incident MD00192305 was conducted. Resident #47 alleged to the weekend supervisor that on 5/14/23, LPN #77 grabbed and shouted at the resident. Review of the facility's investigation revealed a hand written statement from LPN #77 that documented the events of 5/14/23, an email from the social worker, and 2 typed interviews of Resident #47. There were no other staff interviews. There was no statement from the weekend supervisor and there were no other resident interviews from the unit that Resident #47 resided on. On 4/1/25 at 10:47 AM an interview was conducted with the ADON who confirmed the findings. 5) On 3/27/25 at 10:40 AM a review of facility reported incident MD00213903 was conducted. Resident #4 alleged that staff tried to strangle him/her and choke him/her to death. This was reported to the nurse on 1/23/25 at 7:00 PM. Review of the facility's investigation revealed a statement from a GNA on the 3-11 shift, a statement from staff coming on duty at 7:00 PM, a nurse that was on the medication cart, and a nurse that had just come on duty at 7:00 PM. The abuse investigation form documented, resident had a fall in the evening. When questioned about the fall, [he/she] reported to this writer that the GNA strangled [him/her] while changing [his/her] clothes and then hit [him/her] in the neck. There was no documentation that resident's on the unit were interviewed about the care that GNAs gave and if they felt safe or assessed if they were non-verbal or unable to cognitively communicate with staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/8/25 at 2:11 PM an interview was conducted with the DON. The DON confirmed that residents on the unit were not interviewed during the investigation. 6) On 3/27/25 at 11:10 AM a review of facility reported incident MD00189796 was conducted. On 3/3/23 the Director of Rehabilitation was made aware by a therapist working with Resident #56 that the resident was intimidated and afraid of GNA #82. On 3/6/23, upon receiving notification via email from the Director of Rehabilitation, the nurse manager brought GNA #82 into the office for an interview regarding the concerns and was suspended pending investigation. Review of the facility's investigation failed to produce any other staff or resident interviews. The investigation was incomplete. On 3/27/25 at 11:31 AM an interview was conducted with the NHA who stated that the information the surveyor had was the investigation. There were no other staff or resident interviews. 7) On 3/28/25 at 7:59 AM a review of facility reported incident MD00191414 was conducted. Resident #42 alleged on 4/17/23 that during care GNA #88 was screaming at the resident and was rough when she assisted Resident #42 in bed causing pain to the right wrist. Review of the facility's investigation revealed the incident happened on 4/17/23 at 6:30 PM. Review of the investigation revealed 6 staff members were interviewed including the accused GNA. There were no interviews of residents that resided on the unit to determine if they felt safe and if they ever had any abuse issues. On 3/28/25 at 9:16 AM an interview was conducted with the DON and ADON. The ADON stated, I immediately let the DON know if there are any accusations and I do a self-report, skin assessment, do interviews of GNAs and prior GNAs that worked with the resident prior to the assigned GNA, to validate at what point the incident could have occurred. I make notifications to the provider, and I let the family know. The self-report has to be done within 2 hours. I check in with other residents. Say it is other residents that have not spoken up and the social worker can get involved and interview them. On 4/1/25 at 10:43 AM the DON confirmed the findings. 8) On 3/31/25 at 8:34 AM a review of complaint MD00212199 was conducted. The complainant alleged that Resident #7 was hit be his/her aide. The complaint alleged Resident #7 had a bruise on his/her face from the incident. The complaint also alleged that the story was changed and now was saying the aide hit the resident by accident while being changed. Review of a 11/22/24 at 2:30 PM SBAR (change in condition note) documented, around 0815 writer was called to room by GNA. GNA had just walked into the room and noticed bruising to left peri-orbital region with a small gash to left eyebrow. Resident initially stated that [he/she] was hit with a dish. Then stated that [he/she] was turned over (in bed) and hit [his/her] head. A 11/22/24 at 3:33 PM nursing progress note documented, Has bruising to left eye, inner canthus of eye and on bridge of nose and spreading to upper cheek. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 11/22/24 at 7:11 PM provider note documented assessment and plan, left eye hematoma: unknown etiology. Nursing staff believed this might have likely occurred during repositioning. A 11/26/24 at 10:19 PM provider note documented, left eye hematoma: unclear etiology. Ecchymosis extending to left jaw, periorbital area and nasal bridge. Ophthalmology consult pending for further evaluation. On 4/3/25 at 3:27 PM the DON was interviewed and asked if the incident was reported to OHCQ. The DON stated no because she determined it was from the side rail, the way the resident was lying in bed, and she stated that they put padding on the side rails. The DON stated, there was not an investigative report or anything. What is in the chart is what we investigated. On 4/4/25 at 1:00 PM Nurse Practitioner (NP) #56 was interviewed and stated she did a head to toe assessment on the resident and that the resident had dementia so really couldn't follow instructions. NP #56 stated it was a significant bruise. I am not sure how it got there. I could not say it was from the side rail. That is why I wanted [him/her] to be seen by an ophthalmologist. I am not really sure what happened. On 4/7/25 at 3:20 PM the issue was discussed with the NHA who stated, we know how it happened; it was because of the way [he/she] was leaning up against the side rail. On 4/8/25 at 9:25 AM the NHA gave the surveyor a write up of the situation. The concern on the write-up documented, we did not report to OHCQ as we were able to interview staff, ask the resident immediately on finding the bruise, and the bruise matched to the area of the bedrail. The note continued, While at first [he/she] said a dish was thrown, [he/she] then said [he/she] thought [he/she] hit [his/her] head on the bedrail. There were no staff interviews provided. The NHA documented in the write up, Two officers came in to the facility, spoke to the DON, LNHA, Nurse manager and saw the resident. With the level of dementia, the resident could not state what happened. The NHA stated that the police could not substantiate the allegation. Cross reference F609 9) On 4/1/25 at 9:21 AM a review of facility reported incident MD00204323 was conducted. Resident #26 alleged on 3/30/24 agency GNA #83 was removing the resident's clothes for bed and GNA #83 pulled the resident's clothes hard. Resident #26 had a typed statement that documented, I do not want her again. She was rough. Resident #26 had multiple contractures due to spastic cerebral palsy. Review of the facility's investigation revealed a typed statement from the resident. There were no staff interviews and there were no other resident interviews that resided on the unit. On 4/8/25 at 2:12 PM an interview was conducted with the DON who confirmed that other residents on the unit were not interviewed if they felt safe or had any problems with GNA #83 and there were no staff interviews. 10) On 4/1/25 at 10:21 AM a review of facility reported incident MD00194802 was conducted. Resident #42's daughter alleged to the facility that Resident #42 was in the hospital and informed the daughter that he/she was upset because of a relationship with a nurse at the facility and alleged possible elder abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation revealed the facility conducted staff interviews but failed to conduct any interviews of residents that were under the care of LPN #79. On 4/8/25 at 2:20 PM the ADON confirmed that they did not interview any residents under the care of LPN #79. 11) On 4/1/25 at 2:16 PM a review of facility reported incident MD00206651 was conducted. Resident #19 alleged that GNA #86 was rough when helping the resident while trying to stand. Review of the facility's investigation revealed an email from RN #87, dated 6/12/24 at 8:42 PM, that was sent to the Nursing Home Administrator that stated Resident #19 alleged GNA #86 was rough with the resident. A concern form was filled out by the previous social worker that documented the Resident #19's daughter emailed the unit social worker and unit manager with direct care staff concerns. The daughter reported a GNA gripped the resident too hard and was rough with the resident. The daughter reported she would call the police if incidents continue. There was a typed statement from the unit manager and 2 typed statements from the DON. There were no other staff interviews and there were no interviews of residents that resided on the unit asking if they felt safe or if anyone had ever been rough with them. The investigation was incomplete. On 4/3/25 at 12:21 PM an interview was conducted with the DON who stated that they did not have any resident interviews or any other staff interviews. 34484 12) Review of Resident #36's medical record on 3/27/25 revealed the Resident was admitted to the facility in 2017 with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident's medical record revealed from 8/29/23 until 9/26/23 the Resident was observed to have 3 different bruises. a) A nurse's note on 8/29/23 at 2:21 PM stated GNA (geriatric nursing assistant reported new area on patient's right side of neck. RN assessed 1.2 cm by 6 cm. Bruise noted with no swelling or pain. b) A nurse's note on 9/5/23 at 12:19 PM stated reported by hospice aide that resident has a bruise to bottom lip. Upon assessment a 0.2 cm bruise observed to the center of bottom lip. c) A nurse's note on 9/26/23 at 10:40 AM stated at 7:05 AM Resident observed to have a bruise 1.5 cm by 1. 0 cm to left outer eye. No swelling or evidence of pain. Interview with the Administrator on 4/2/25 at 8:00 AM confirmed the facility had no evidence 3 injuries of unknown origin were thoroughly investigated to include staff and resident interviews. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/7/25 at 9:18 AM an interview was conducted with the social worker (SW). The SW was asked if she was involved in abuse investigations. The SW stated that they would ask her if she could talk to the resident. The SW stated, I don't always hear if something has happened. They usually want me to ask the resident particular questions. They have had me interview other residents. It has not been all the time and not standard to interview other residents on the unit. They will have me interview aides. To be honest, unless I am directed to do it, I am not involved.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (#30, #24, #15, #29) of 71 residents reviewed during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 3/31/25 at 10:00 AM Resident #30's medical record was reviewed and revealed a 2/2/24 progress note that documented Resident #30 had an unwitnessed fall and was bleeding from the head. Resident #30 was sent to the emergency room and returned to the facility on [DATE] at 5:30 AM. Resident #30 had a left front scalp laceration with staples. Review of the MDS with an assessment reference date (ARD) of 3/1/24, Section J, falls, captured the fall but failed to capture the fall with injury. According to the Resident Assessment Instrument (RAI) Manual, it is important to ensure the accuracy of the level of injury resulting from a fall. If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Internet Quality Improvement and Evaluation System (iQIES), the assessment must be modified to update the level of injury that occurred with that fall. Continued review of Resident #30's medical record revealed a 1/6/24 progress note that documented Resident #30 had erythema noted to bilateral buttocks and a rash to the bilateral upper/posterior thighs. Review of Resident #30's January 2024 Medication Administration Record (MAR) documented the order, in house antifungal powder to posterior upper & inner thighs BID (twice per day) until resolved every day and night shift for rash. The start date was 1/8/24 and the nurses initialed that treatment had started on 1/8/24. Review of the admission MDS with an ARD of 1/12/24, Section M1200,ointments/medications other than to treat feet, failed to capture the use of the antifungal powder. On 4/3/25 at 12:51 PM the MDS was reviewed with MDS Coordinator #45 who confirmed the errors. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MDS with an ARD of 11/17/23 coded there were no falls since the previous MDS assessment. Resident had a fall on 8/23/23. According to the RAI manual, a fall is defined as an unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). An intercepted fall occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person - this is still considered a fall. The facility failed to capture the fall. On 4/7/25 at 3:50 PM MDS Coordinator #45 was interviewed and reviewed MDS with the surveyor. MDS Coordinator #45 confirmed the findings.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on record review and interview it was determined that the facility failed to have a process in place to ensure that a baseline care plan was provided to the resident and resident representative within 48 hours of admission to the facility (Resident #33 and #65). This was evident for 2 of 71 residents reviewed during a complaint survey. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. 1. During interview with Resident #33's representative (RP) on 4/2/25 at 10:12 AM, the RP stated he/she was never given a baseline care plan or had a meeting with the facility staff to discuss. Review of Resident #33's medical record on 4/2/25 revealed the Resident was admitted to the facility in September 2023 with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident #33's medical record revealed there was no evidence in the medical record of a baseline care plan that was reviewed and given to Resident #33 and the Resident's RP. The medical record review failed to reveal evidence that the facility offered the Resident and their representative a summary of the baseline care plan that included initial goals, physician orders, therapy services, dietary services, and social services within 48 hours of the resident's admission to the facility. Interview with the Assistant Director of Nursing (ADON) on 4/2/25 at 10:45 AM stated the process is for baseline care plans is for the nurse manger, therapy and social work to discuss with the resident and family within 72 hours of admission the goals for the Resident. The ADON was asked if anything is given to the Resident and RP in writing and the ADON stated no. During interview with the Director of Nursing (DON) on 4/3/25 at 9:20 am, the DON confirmed there is no evidence in the medical record the facility staff reviewed and provided a copy to Resident #33 and the RP of the Resident's baseline care plans. 2. During review of a complaint from Resident #65's representative (RP) on 4/2/25 revealed the RP stated he/she was at the facility daily and never given a baseline care plan or had a meeting with the facility staff to discuss. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #65's medical record on 4/2/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident #65's medical record revealed there was no evidence in the medical record of a baseline care plan that was reviewed and given to Resident #65 and the Resident's RP. The medical record review failed to reveal evidence that the facility offered the Resident and their representative a summary of the baseline care plan that included initial goals, physician orders, therapy services, dietary services, and social services within 48 hours of the resident's admission to the facility. Interview with the Assistant Director of Nursing (ADON) on 4/2/25 at 10:45 AM stated the process is for baseline care plans is for the nurse manger, therapy and social work to discuss with the resident and family within 72 hours of admission the goals for the Resident. The ADON was asked if anything is given to the Resident and RP in writing and the ADON stated no. During interview with the Director of Nursing (DON) on 4/3/25 at 9:20 am, the DON confirmed there is no evidence in the medical record the facility staff reviewed and provided a copy to Resident #65 and the RP of the Resident's baseline care plans.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation, medical record review, and staff interview it was determined that facility staff failed to develop and a comprehensive, resident centered care plans for altered skin integrity. This was evident for 1 (#30) of 71 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 3/31/25 at 10:00 AM a review of complaint MD00201834 alleged that Resident #30 received a pressure ulcer due to care issues in the facility. Review of Resident #30's medical record revealed a 1/6/24 progress note that documented Resident #30 had erythema noted to the bilateral buttocks and a rash to the bilateral upper/posterior thighs. An anti-fungal powder was ordered Review of Resident #30's January 2024 Medication Administration Record (MAR) documented the order, in house antifungal powder to posterior upper & inner thighs BID (twice per day) until resolved every day and night shift for rash. The start date was 1/8/24 and the nurses initialed that treatment had started on 1/8/24. A 1/22/24 progress note documented Resident #30 had IAD/pressure injury. IAD is an inflammatory skin condition that occurs when the skin is exposed to urine or stool, leading to irritation, inflammation, and potentially, skin lesions. On 1/23/24 Nystatin-Triamcinolone External Ointment (Nystatin-Triamcinolone) was ordered to be applied to the right buttock topically every day and night shift for wound care and Mycolog II ointment. On 1/24/24 Santyl External Ointment (Collagenase) was ordered to be applied to the left buttock wound every day A 1/30/24 skin assessment documented an unstageable pressure ulcer to the left buttock. There were treatments that were done by staff and skin assessments done weekly until discharge on [DATE]. Review of Resident #30's care plan, has potential for impairment to skin integrity r/t immobility, laceration on the head, which was initiated on 1/7/24, had the intervention, encourage ROM (range of motion) exercises and weight-bearing mobility when possible to increase blood flow to all areas. There were no other interventions on the care plan. The care plan was not resident centered and was not updated as it did not address the skin integrity issues that were documented on readmission to the facility on [DATE] or the change in the skin condition on 1/22/24. The care plan did not have specific interventions in place to heal and prevent further decline in the resident's skin integrity. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 9:53 AM an interview was conducted with Staff # 44 and Staff #45. They both stated that the care plan was initiated by the admitting nurse and then the electronic medical record system would autotrigger other areas on the care plan. On 4/7/25 at 11:35 AM the incomplete care plan was discussed with the Director of Nursing and the Assistant Director of Nursing. They confirmed the findings.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide treatment and care in accordance with professional standards of practice. This was evident for 3 (#5, #38, #14) of 71 residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to administer medications to Resident #5 as ordered by the eye doctor. Review of Resident #5's medical record on 4/3/25 the Resident was admitted to the facility in December of 2024 with a diagnosis to include legal blindness. Further review of Resident #5's medical record revealed the Resident went to the Eye Doctor on 2/7/25 and at that time was assessed to have a diagnosis of Glaucoma, Entropion and dry eye. Glaucoma is a group of eye diseases that damage the optic nerve, potentially leading to vision loss or blindness, often due to increased eye pressure. Entropion is a condition where the eyelid turns inward, causing eyelashes to rub against the eye, leading to irritation, pain, and potentially, corneal damage. Dry eye syndrome, also known as dry eye disease, is a condition where the eyes don't produce enough tears or the tears produced are of poor quality, leading to discomfort and potentially vision problems. Review of the 2/7/25 Eye Doctor's plan revealed the Eye Doctor ordered the Resident to receive Refresh ointment to the right eye at bedtime indefinitely and Refresh tears solution 1 drop to both eyes twice daily indefinitely. The Resident was to follow up with the eye doctor in 3 to 4 months. Review of Resident #5's February, March and April 2025 Medication Administration Records on 4/3/25 revealed the Resident has not been ordered or administered the Refresh ointment and eye drops per the Eye Doctor's orders. Interview with the Director of Nursing and Assistant Director of Nursing on 4/7/25 at 2:09 PM confirmed the Surveyor's findings. 2. The facility staff failed to properly perform neuro checks after falls on 6/22/23 and 6/25/23 for Resident #38. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. Review of Resident #38's medical record on 4/3/25 revealed the Resident was admitted to the facility in 2019 with diagnosis to include history of falling. a) Further review of Resident #38's medical record revealed on 6/22/23 the Resident had an unwitnessed fall without injury. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the neuro checks after the fall revealed on 6/22/23 at 7:15 AM the Staff did not complete the COMA scale. COMA scale is a system to score or measure how conscious you are. On 6/22/23 at 1:15 PM the neuro check did not include an assessment of left hand grip. On 6/22/23 at 10:15 PM and 6/23/23 at 2:15 AM and 6:15 AM neuro checks did not include vital signs. After the 6/23/25 at 2:15 PM, the facility staff failed to document a neuro check on 6/23/25 at 10:15 PM and 6/24/25 at 6:15 AM. b) Further review of Resident #38's medical record revealed on 6/25/23 at 2 PM the Resident had an unwitnessed fall without injury. Review of the neuro checks after the fall revealed on 6/25/23 at 2:00 PM the staff began neuro checks. Review of the neuro checks after the fall revealed on 6/25/23 at 7:15 PM the Staff did not include current vital signs. On 6/26/23 at 2 AM the neuro checks did not include a COMA scale, if there was a change in baseline and a current respirations and oxygen saturation. On 6/26/23 the 6:15 AM neuro checks did not include current vital signs. Interview with the Director of Nursing on 4/4/25 at 10:45 AM confirmed the facility staff failed to complete all parts of the neuro checks for Resident #8 after falls on 6/22 and 6/25/23. 31145 3. The facility staff failed to follow up on a resident's request for nephrostomy tube flushes and failed to have a physician's order prior to a nephrostomy tube flush. A nephrostomy tube is a thin tube inserted into the kidney to drain urine when the urinary tract is blocked. Proper care is essential to prevent infection and ensure optimal drainage. Pyelonephritis, also known as a kidney infection, is a bacterial infection that affects one or both kidneys. It often starts as a urinary tract infection (UTI) that travels upwards from the bladder to the kidneys. On 3/27/25 at 1:15 PM a review of complaint MD00176106 alleged that Resident #14's nephrostomy tube had not been flushed since returning from the hospital. Review of Resident #14's medical record revealed a hospital discharge summary dated 4/25/22 that documented the resident was in the hospital due to septic shock with acute organ dysfunction, a urinary tract infection, and complicated pyelonephritis which resulted in a nephrostomy tube being placed on 4/15/22. Resident #14 was discharged to the facility on [DATE]. On 4/28/22 at 6:44 AM a behavior note documented, awake, expressed concerns of Xarelto d/c, change time of Protonix, and requests new orders for Nephrostomy tube flushing. On 5/10/22 at 12:45 PM a nursing progress noted documented, nephrostomy tube was flushed and is patent, draining well. Review of Resident #14's May 2022 medication administration record (MAR) documented an order, flush nephrostomy tube daily with 10 ml. of ns (normal saline) solution in the morning with a start date of 5/17/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident requested the flushing on 4/28/22 and there was no documentation that the resident's request was given to the physician until the order was written on 5/17/22. Additionally, on 5/10/22 the nephrostomy tube was flushed without a physician's order which would have dictated what to flush the nephrostomy tube with and how many times it was to be flushed. On 3/27/25 at 2:40 PM the Nephrostomy care and tubing care policy was given to the surveyor from the Assistant Director of Nursing (ADON). The policy was not effective until June 2022. The policy stated, A physician's order is required for the nephrostomy tube and its care. On 4/7/25 at 2:31 PM an interview was conducted with the Director of Nursing (DON) and ADON. The DON stated that the policy needed to be revised. The DON confirmed that there was no documentation of Resident #14's request being followed up on and that the nurse flushed the nephrostomy tube on 5/10/22 without a physician's order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #55). This is evident for 1 of 3 residents reviewed for pressure ulcers during a complaint survey. The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). A deep tissue injury (DTI) is a unique form of pressure ulcer. The National Pressure Ulcer Advisory Panel defines a deep tissue injury as A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. The findings include: Review of Resident #55's medical record on 3/27/25 revealed the Resident was admitted to the facility in April 2022. On admission the Resident was assessed to have a Stage IV pressure ulcer to the sacrum. Further review of Resident #55's medical record revealed the Resident was readmitted to the facility on [DATE] following a hospitalization . Review of the Resident's weekly wound assessments revealed the facility staff failed to conduct weekly skin assessment with measurements on 12/23/22, 12/30/22, 1/13/23, 2/17/23 and 3/3/23. The purpose of completing weekly wound assessments with measurements is to monitor the wound's progress, identify any issues that could impede healing, and ensure that the treatment plan is effective. Interview with the Assistant Director of Nursing on 4/2/25 at 10:40 AM confirmed the facility staff failed to document weekly wound assessments for Resident #55's sacral pressure ulcer.

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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. 34484 Based on medical record review, facility policy review and interview, the facility staff failed to obtain weekly weights on admission and failed to recognize a weight loss for a resident (Resident #33). This was evident for 1 of 71 residents reviewed during a complaint survey. The findings include: Review of Resident #33's medical record on 3/27/25 documented the Resident was admitted to the facility in September 2023 with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident's medical record revealed the facility staff documented a nutritional assessment was completed on 9/19/23. At that time the Dietitian (Staff #72) documented, intake is fair presently-weekly weights initiated to evaluate additional intervention. Review of the Resident's weights documented revealed the facility staff documented a weight on 9/27/23 of 232.8 pounds and on 10/17/23 of 222.8 pounds. No further weights were documented and the Resident was transferred to the hospital on 11/22/23. The facility staff failed to obtain a weekly weight on 9/22/23, 10/4/23, and 10/11/23. Review of the facility's Weight Policy provided by the Director of Nursing on 4/2/25 revealed it states, Newly admitted LTC (long term care) residents will be weighed on admission, weekly for 4 weeks, then monthly. Further review of Resident #33's medical record revealed the Resident had a 10 pound weight loss from 9/27/23 until 10/17/23 and there was no documentation the Resident was reassessed by the Dietitian to determine if further interventions needed to be put in place. Interview with the Director of Nursing on 4/3/25 at 12:20 PM confirmed the facility staff failed to obtain all the weekly weights for Resident #33 and there was no documentation of any further assessment of the Resident after a 10 pound weight loss in 3 weeks.

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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. 31145 Based on review of a complaint, medical record review, and interview, it was determined the facility failed to provide timely medication to meet the needs of the residents. This was evident for 1 (#14) resident reviewed for 40 complaints reviewed during a complaint survey. The findings include: On 3/27/25 at 1:15 PM a review of complaint MD00210066 alleged that there was a problem with the A&D ointment that was ordered for Resident #14. It was alleged that the ointment was received however the staff was not consistent with using the ointment and then kept telling the resident it was not available from the pharmacy and had been re-ordered. Review of Resident #14's medical record revealed an order for A and D Prevent External Ointment that was to be applied to the perineal area topically every shift for skin protectant with each incontinence care. The start date of the order was 9/1/24. Review of the September 2024 Medication Administration Record (MAR) documented each time the ointment was administered as evidence by the nurse's initials and a check mark. Whenever there were nurse's initials and the number 9, that indicated the ointment was not administered and there was an accompanying progress note. On 9/12/24 day shift the ointment was not administered and there was a corresponding note written on 9/12/24 at 1:02 PM that documented, re-ordered. On 9/16/24 for the evening and night shift there was a 9 documented, and a progress note written on 9/16/24 at 21:38 that stated, to be delivered. On 9/18/24 day shift another 9 and note, on order. From 9/22/24 evening shift until 9/25/24 day shift there were 9's documented each shift with progress notes that either documented, to be delivered or on order or awaiting delivery. Continued review of Resident #14's September 2024 MAR documented the medication Bio freeze Professional External Aerosol (topical analgesic) for knee pain 4 times a day that was written on 9/24/24. The analgesic was not available from 9/25/24 until it was cancelled on 10/1/24 and re-ordered as a roll-on external gel. Nursing notes documented that the medication was either on order or awaiting delivery. There were no physician notifications that the analgesic was not available until the order was changed 6 days later. On 4/4/25 at 11:05 AM an interview with geriatric nursing assistant (GNA) #57 revealed she changes the resident every 2 hours and sometimes more and she washes the resident and uses either A&D ointment or Greers Goo. GNA #57 stated, wipe, dry, and put cream on. We have to get the cream from the nurse. GNA #57 stated, we use so much so sometimes it is a small tube, and it takes time to get it after it is ordered. On 4/7/25 at 7:50 AM an interview was conducted with the Assistant Director of Nursing (ADON) about the Bio freeze (analgesic). The ADON stated that she talked to the pharmacist, and they had to have the strength changed. It took 2 attempts with the staff and that is when the Nurse Practitioner was notified, and the order was changed on 10/1/24. The ADON agreed that nursing should have acted quicker, and it should not have taken 6 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/25 at 7:55 AM an interview was conducted with the Director of Nursing (DON) related to the A&D ointment. The DON stated the unit requested refills as soon as the tube was empty. It took 2 days to change the order from a tub to a jar. The DON agreed that staff should have acted quicker about re-ordering the ointment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation, staff interview, and documentation review it was determined that facility staff failed to keep medication carts locked when unattended and date medications when opened. This was evident on 3 of 7 nursing units observed during random observations made during the complaint survey. The findings include: 1) On 4/2/25 at 9:48 AM observation was made on the 1 Knot unit of an unlocked medication cart sitting outside of room [ROOM NUMBER]. The surveyor was able to open the top drawer of the medication cart which contained resident medications. Licensed Practical Nurse (LPN) #32 stated she had just walked into the resident's room for a minute. 2) On 4/2/25 at 10:08 AM observation was made on the 1P unit of an unlocked and unattended medication cart at the nurse's station. The surveyor walked up and opened the top drawer. The surveyor had previously seen the medication cart sitting at the nurse's station unlocked with LPN #22 sitting at a computer at the nurse's station and unit secretary #28 sitting at the other end of the nurse's station facing the computer doing computer work. The surveyor walked down the hallway and in the dining area. When the surveyor walked back up the hallway the medication cart was still unlocked. The nurse got up from the nurse's station and walked down the hall. The surveyor was able to walk up to the medication cart and open the drawers. Unit secretary #28 never turned to look over at the unlocked medication cart. The surveyor opened the top drawer and picked up a Heparin vial. LPN #22 walked up to the cart and grabbed the Heparin vial out of the surveyor's hands and was trying to throw it in the sharp's container. The surveyor stopped LPN #22 at that time. LPN #22 stated, I am agency, and I need to get the discharge medications out of the cart. At that time the surveyor said, you can get them out of the cart, and I will wait. LPN #22 appeared anxious and stated, No, I can wait. I am in trouble. I have to discharge a resident, and I am agency, and I don't have any help. 3) On 4/2/25 at approximately 10:20 AM observation was made of an unlocked medication cart in the hallway on 4P. The keys were sitting on top of the cart. When the cart was first observed the Hospice Nurse #25 was at the cart and observed putting something in her left pants pocket. The surveyor was at the end of the hall and saw Nurse #25 walk away from the cart. The surveyor walked up the hall and saw the cart unlocked and unattended with the keys on top of the cart. The surveyor observed another nurse in the hallway giving medications to a resident in a wheelchair further down the hall from the unlocked medication cart. The surveyor was able to open the top drawer and was looking at the insulin pens in the top drawer when LPN #24 walked up and grabbed the insulin pen out of the surveyor's hand. The surveyor informed LPN #24 that the medication cart was left unlocked, and she stated that she had just gone in that room across the hall emergently and did not lock the cart. In the top drawer of the unlocked medication cart were insulin pens that were opened and not dated as follows: Resident #69's Humalog Kwik pen not dated when opened (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #70's Admelog Solostar not dated when opened Resident #67's Lantus not dated when opened Resident #68's Lantus not dated when opened The insulin pens are only good for 28 days once opened. LPN #24 stated that the night shift normally gives insulins. LPN #24 grabbed a black marker and was getting ready to write dates on the insulin pens. The surveyor asked how she knew when the insulin pens were opened when she was not the one that administered the insulin. LPN #24 put the marker down. Review of the medication storage policy that was given to the surveyor on 4/2/25 at 2:55 PM from the Director of Nursing (DON) documented, the medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members authorized to administer medications. Number 2 of the policy documented, only licensed nurses, the Consultant Pharmacist, and those authorized to administer medications (e.g. medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. On 4/7/25 at 2:26 PM the DON was informed of the findings. The DON stated she had already heard and had started education.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to obtain laboratory services for a resident as ordered (Resident #33). This was evident for 1 of 71 residents reviewed during a complaint survey. The findings include: Review of Resident #33's medical record on 3/27/25, the Resident was admitted in September 2023 with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life. Further review of Resident #33's medical record revealed on 11/17/25 the Nurse Practitioner (Staff #71) ordered a c diff sample. To test for C. difficile, a stool sample is collected and sent to a lab for analysis, where they look for the presence of the bacterium and its toxins. Further review of Resident #33's medical record revealed a change of condition note on 11/22/23 at 6:50 PM that stated Resident's representative visited him/her at bedside at 2 PM today and requested he/she be transferred to hospital ER for evaluation secondary to diarrhea of over 2 weeks. Interview with Assistant Director of Nursing on 4/3/25 at 8:50 AM confirmed no specimen was sent for Cdiff as ordered from 11/17/23 until discharge on [DATE].

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on observations, interviews with staff, and review of complaint, it was determined that the facility failed to store food and monitor temperatures in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents eating food prepared in the facility's kitchen. The findings include: 1. The facility staff failed to ensure food is served to residents at temperatures to ensure food safety. On [DATE] at 12:29 PM the Surveyor observed lunch meal service to the Residents on the 1 [NAME] nursing unit. At that time the facility staff were setting up meal service and residents were seated in the dining room. After the residents were all served in the dining room the facility staff began to prepare trays for residents who dine in their room at 1:06 PM. At that time the Surveyor requested a test tray and took temperatures. At the same time Staff #36 also took temperatures of the same test tray using a facility's thermometer. Hot foods are to be maintained at 135 degrees or warmer and cold foods are to maintained at 41 degrees or below. The minestrone soup was measured by Staff #36 to be 119 degrees. The fried chicken was was measured by Staff #36 to be 119 degrees. The macaroni and cheese was measured by Surveyor to be 135 degrees. The broccoli was measured by Staff #36 to be 100 degrees. The pudding was measured by Staff #36 to be 74 degrees. The milk was measured by Staff #36 to be 46 degrees. Observation revealed the soup, fried chicken, broccoli, pudding and milk were not at the proper food safety temperatures on the test tray. The observations were confirmed by Staff #36. Findings were reviewed with the Administrator on [DATE] at 1:30 PM. 2. Food was not stored in the kitchen per professional standards. a) Observation in the kitchen freezer #3 on [DATE] at 10:59 AM with Staff #67 revealed chicken nuggets and hot dogs that were wrapped in plastic with no expiration date on the package. Findings were reviewed with the Administrator on [DATE] at 1:30 PM. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31145 On [DATE] at 1:00 PM a review of complaint MD00208499 alleged there was molded food and expired food constantly being handed out to residents and that the dinner area was very unsanitized. 3. Food was not dated and labeled in the kitchen refrigerator and freezer. On [DATE] at 1:30 PM a tour of the kitchen was conducted. Prior to touring the kitchen, the surveyor informed Staff #30, the Director of Dining and the Chef, Staff #29. Observation was made in refrigerator #7 of a storage cart inside the refrigerator to the right of the door that was holding boxes, eggs, and a container of brown ground meat. The second tray pan had mashed potatoes. There were no dates on the eggs, ground meat or mashed potatoes. There was left over ziti dated ,d+[DATE] on the shelf. Staff #29 and #30 stated that they were using those items for lunch and did not need to date them. Review of the menu that was given to the surveyor on [DATE] at 1:22 PM from Staff #67, documented for lunch was chicken rice soup, cheese pizza, tossed salad and dressing and pudding. The alternative was roast beef and Swiss cheese sandwich. Observation was made in Freezer #8 of a hamburger in a box that was open to air and not covered. On [DATE] at 1:22 PM Staff #67, the patient service manager, was interviewed and said, anything that goes in that refrigerator needs to be dated and labeled regardless of when it goes in the refrigerator. The surveyor explained to him what Staff #29 and #30 stated and he said, No, it must be dated and labeled. 4. Facility staff failed to store foods in nourishment/dining rooms on the units in a sanitary manner. On [DATE] at 1:25 PM in the 4 P dining room was a refrigerator/freezer. In the freezer was a Coke cup with red contents that was not dated or labeled. Next to the refrigerator was a counter where food was served. There was a cell phone on the counter and a Coke drink cup on the counter with no name or date. Dietary Aide #31 was interviewed and stated we don't know whose drink it is. The refrigerator is cleaned out about twice per week. On [DATE] at 2:10 PM observation was made in the 3P dining room of a black pocketbook, 2 drinks in plastic cups and a white plastic bag sitting on the counter where food was served. The cups and food were not dated and labeled. In the 3P refrigerator/freezer in the common room at the end of the hall (solarium) was a McDonalds cup filled to about an inch from the top with no name or date on the cup. The sign on the refrigerator door stated, for resident use only. There was also a blue/purple/orange lunch tote with an empty container on top of a half full Tupperware container. There was no name on the lunch tote. In the hallway outside of room [ROOM NUMBER]P sitting on the handrail was an air freshener, a Chobani peach yogurt and chocolate ensure that they were both warm to the touch. On [DATE] at 2:22 PM the unit manager was informed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 10:05 AM observation was made of the Unit P dining room. There was a cell phone on the food serving counter next to a plastic cup of mandarin oranges. On [DATE] at 2:26 PM the Director of Nursing was informed of all observations. On [DATE] at 8:35 AM an interview was conducted with the Infection control nurses, Staff #62 and #63. Both confirmed that personal items on the counter where food was being served was a sanitary and infection control concern. On [DATE] at 1:53 PM the Nursing Home Administrator was informed about food storage concerns.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 34484 Based on medical record review and interview, the facility staff failed to obtain outside services for residents in a timely manner. This was evident for 2 (#5, #7) of 71 residents reviewed during a complaint survey. The findings include: 1. Review of Resident #5's medical record on 4/3/25 the Resident was admitted to the facility in December of 2024 with a diagnosis to include chronic kidney disease. Further review of the Resident's medical record revealed on 12/10/24 the physician ordered a nephrologist consult for chronic kidney disease stage IV. Further review of the medical record revealed the Resident has not been seen by the nephrologist or has a appointment scheduled. Interview with the Director of Nursing and Assistant Director of Nursing on 4/7/25 at 2:09 PM confirmed the facility staff failed to schedule an appointment for Resident #5 to see a nephrologist. 31145 2. The facility failed to obtain an ophthalmology consult as requested by the Nurse Practitioner (NP) for a resident with orbital bruising and swelling. On 3/31/25 at 8:34 AM a review of complaint MD00212199 was conducted. The complainant alleged that Resident #7 was hit by his/her aide. The complaint alleged Resident #7 had a bruise on his/her face from the incident. Review of a 11/22/24 at 2:30 PM SBAR (change in condition note) documented, around 0815 writer was called to room by GNA. GNA had just walked into the room and noticed bruising to left peri-orbital region with a small gash to left eyebrow. Resident initially stated that [he/she] was hit with a dish. Then stated that [he/she] was turned over (in bed) and hit [his/her] head. A 11/22/24 at 3:33 PM nursing progress note documented, Has bruising to left eye, inner canthus of eye and on bridge of nose and spreading to upper cheek. A 11/22/24 at 7:11 PM provider note documented,Note: Patient noted with left periorbital swelling, erythema, tenderness and hematoma extending towards nasal bridge and inner canthus of left eye. The assessment and plan documented, left eye hematoma: Unknown etiology. Nursing staff believe this might have likely occurred during repositioning. Will obtain ophthalmology consult for further evaluation. A 11/26/24 at 10:19 PM provider note documented, left eye hematoma: unclear etiology. Ecchymosis extending to left jaw, periorbital area and nasal bridge. Ophthalmology consult pending for further evaluation. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing progress notes, physician notes, and the entire medical record failed to produce an ophthalmology consult following the eye injury. On 4/4/25 at 1:00 PM NP #56 stated the resident had dementia so couldn't follow instructions. It was a significant bruise. I am not sure how it got there. I could not say it was from the side rail. That is why I wanted [him/her] to be seen by an ophthalmologist. I am not really sure what happened. For the appointment I would expect it to be ASAP. If they could not get an appointment right away, I would expect them to notify me. On 4/7/25 at 2:19 PM an interview was conducted with the DON about the eye consultation. The DON stated the resident was seen by the retinal specialist on 12/23/23. The surveyor informed the DON that the retinal specialist appointment was preplanned as the resident received scheduled injections into the retina. The 12/23/23 appointment was a month from when the injury happened. The DON agreed that the resident could have been sent to an eye clinic or the emergency room .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34484 Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards (Resident #20). This was evident for 1 of 71 residents reviewed during a complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. Review of Resident #20's medical record on 4/3/25 revealed the Resident was admitted to the facility in August 2023 and admitted to hospice services on 6/20/24. Further review of the Resident's medical record revealed no documentation from hospice to include progress notes, assessments and plan for Resident #20 from hospice. Interview with the Director of Nursing (DON) on 4/4/25 at 12:54 PM confirmed Resident #20's medical record did not include documentation from hospice and the DON was able to obtain the documentation from hospice on 4/4/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 31145 Based on complaint review, observation, and staff interviews it was determined that the facility failed to implement an effective infection control program by failing to follow infection control guidlines during the handling and storage of linens and other patient care items. This was evident for 2 of 7 units observed during random observations made while touring the facility during a complaint survey. The findings include: On 3/31/25 at 7:40 AM a review of complaint MD00214733 revealed the facility did not follow infection control guidelines. On 4/2/25 at 9:32 AM observation was made on the 1 Knot unit, outside of room K188, of a soiled linen cart. On top of the soiled linen cart was a box of gloves, cleanser, silicone cream ointment, and an opened Pepsi bottle. There was also a list of resident names with names and weights. There was a pink pen next to the paper. The patient care items were not stored properly. Observation was made in the hallway, across from 1K, room K180, of a resident's over the bed tray table with clean linen, sheets, towels, and diapers sitting on top of the table. The linens were not covered. There was a soiled linen cart with a green diaper and a clean washcloth sitting on top of the cart. On 4/2/25 at 9:35 AM RN #33, the nurse manager, was shown the soiled linen carts and the tray tables with clean linen. RN #33 stated, this is not supposed to be like this. This is unacceptable. On 4/2/25 at 9:45 AM observation was made on the Ground Knot Unit: Outside of room GK76 was a tray table with towels, washcloths, unused diapers, and lotion. The linens were not covered. On 4/8/25 at 8:35 AM the Nursing Home was made aware of the observations. At that time the infection control nurses, Staff #62 and Staff #63 confirmed that uncovered clean linen was an infection control issue. They stated they just ordered linen carts with covers.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on review of the facility's and vendor's pest control logs and interviews, the facility failed to maintain an effective pest control program. This was evident for 3 of 8 nursing units (1P, 3P and 3S) and the kitchen during a complaint survey. The findings include: During investigation of multiple complaints from resident families regarding mice sightings in the facility on nursing units 1P, 3S and 3P, the surveyor reviewed on 4/7, 4/8 and 4/9/25 the facility's and vendor's pest control logs from 1/1/25 until 4/8/25 and completed interviews. 1. Review of the facility's pest control logs revealed the following: a) On 1/10/25 facility staff stated they disposed of a dead mouse in room [ROOM NUMBER] last evening b) On 1/30/25 facility staff stated moving recliner chairs in Rooms 315 & 324 there were a lot of mouse droppings. c) On 3/7/25 facility staff stated night nurse stating residents complaining about mice in rooms. d) On 4/4/25 facility staff stated residents states seeing 2 mice in room [ROOM NUMBER] and 148. e) On 4/4/25 facility staff stated mouse seen in room [ROOM NUMBER] last evening ran behind dresser. 2. Review of vendor's pest control logs revealed the following: a) 1/7/25 3 dead mice in kitchen b) 1/14/25 7 dead mice in kitchen c) 1/25/25 3 dead mice in kitchen d) 1/28/25 4 dead mice in kitchen e) 2/4/25 4 dead mice in kitchen e) 2/11/25 2 dead mice in kitchen f) 2/18/25 3 dead mice in kitchen e) 2/25/25 1 dead mouse in kitchen f) 3/4/25 rodent droppings in kitchen, activity in bait stations (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g) 3/11/25 4 dead mice in kitchen h) 3/18/25 mice captured in upstairs chapel area along with holes found in wall under radiators i) 3/25/25 3 dead mice in kitchen j) 4/1/25 3 dead mice in kitchen k) 4/8/25 2 dead mice in kitchen 3. Interview with Residents on 1P, 3S and 3P nursing units. a) 4/4/25 Resident in room [ROOM NUMBER] stated in the last week, saw a mouse twice run under my bed b) 4/8/25 Resident in room [ROOM NUMBER]A stated 2 days ago saw mouse running in room c) 4/8/25 Resident in room [ROOM NUMBER]A stated couple weeks ago saw a mouse about inch long run under dresser d) 4/8/25 Resident in room [ROOM NUMBER] stated when staff were in room few nights ago the staff told me they saw a mouse e) 4/8/25 Resident in room [ROOM NUMBER] states has 3 bait stations in room and has asked to be checked but doesn't believe anyone has. f) 4/8/25 Resident in room [ROOM NUMBER] states saw a mouse in room few weeks ago g) 4/8/25 Resident in room [ROOM NUMBER]A states saw a mouse 2 days ago h) 4/8/25 Resident in room [ROOM NUMBER]A states saw a mouse 2 days ago at night i) 4/8/25 Resident in room [ROOM NUMBER] states has seen mice in the room running on the floor under dresser but 3 weeks ago looked over and there was a mouse in his/her wheelchair j) 4/9/25 Resident in room [ROOM NUMBER] states has seen mice recently in the evening and night. 4. Interview with resident's family member 4/3/25 8:34 AM Anonymous-the family took a video of the mice chasing each other in the resident's room and just saw 2 mice in the room the other night so they kept their feet off the ground. 5. Interviews with Staff. a) 3/31/25 at 10:17 AM Interview with Staff #52 states they have mice off and on but more since the construction. b) 4/2/25 at 10:40 AM Interview with Staff #26 states has seen mice from time to time. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) 4/2/25 at 10:42 AM Interview with Staff #27 states there are mice off and on but has seen them more recently. During interview with Director of Environmental Services (Staff #61) on 4/7/25 at 12:09 PM, Staff #61 states the pest control vendor comes once a week and more often if needed. The areas we are have problems with mice currently are 3S, 1P and the kitchen. During interview with Staff #61 on 4/9/25 at 10:45 AM, after reviewing vendor pest control logs, the Surveyor reviewed the concerns noted by vendor that are not addressed timely. Staff #61 states he gets the vendor reports and shares the findings with Director of Facilities. Reviewed the vendor report on 3/5/25. Reviewed with Staff #61 on 3/5/25 the vendor had an observation of a gap in the floor in the kitchen. Staff #61 stated it is being fixed today. Of note over 1 month from when vendor observed. During interview with Director of Facilities (Staff #69) on 4/9/25 at 12:12 PM reviewed concerns noted by vendor that are not addressed timely. Staff #69 states he does not get the reports from the vendor but does communicate with Staff #61. Staff #69 shown vendor reports and reviewed on 3/18/25 the vendor noted mice in the chapel and holes in wall by the left and right radiator. Staff #69 shown vendor reports on 3/25/25, 4/1/25 and 4/8/25 that show the same picture of a hole in the wall in the kitchen. At that time Staff #69 took photos of the reports and stated would request to receive the vendor reports in the future so he can ensure all items are addressed timely. The findings were reviewed with the Administrator on 4/9/25 at 12:35 PM.