STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215142	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesapeake Shores Nursing Center	21412 Great Mills Road Lexington Park, MD 20653

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 48168 Based on a review of facility records, interviews with facility staff, and interviews with residents, it was determined that the facility staff 1) failed to ensure that all allegations of abuse, medication storage issues, and unusual incidents were thoroughly investigated and 2) failed to provide interventions to avoid repeated allegations. This was evident for 4 residents (Residents #36, #343, #345, #347) of 18 reported resident incidents reviewed during the survey. The findings include: 1) On 4/30/24 at 10:00 am during the entrance conference of the recertification survey, a request for the facility's investigation files for self-reported incidents was made to the Nursing Home Administrator (NHA). On 5/08/24 at 9:04 AM a review of the facility reported incident # MD00188190 dated 1/24/23 was conducted. The report described the discovery on 1/23/24 of a bruise on Resident #36's arm and an allegation by Resident #36 that a black male GNA had hit the resident a few days before. On 5/08/24 at 9:15 AM a review of the facility's investigation file for #MD00188190 revealed witness statements from staff and residents which asked about any witnesses for the day bruise was discovered on Resident #36's arm, 1/23/24, including a statement from GNA #36, the only black male GNA working on 1/23/24. However, none of the statements asked about any time prior to that day, even though the incident was alleged to have occurred prior to 1/23/24 per the facility's own report statements. During an interview on 5/08/24 at 9:58 AM the NHA was asked if there were any statements from staff and residents that addressed the days before 1/23/24 when the alleged incident occurred. She said there were no statements that asked about that time frame. The surveyor then asked for staff assignments for 1/15/23-1/23/23 and requested GNA #36's employee file. The NHA's response was that GNA #36 no longer worked at the facility and that GNA #36 did not care for the resident during the time of the alleged incident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/08/23 at 10:45 am the NHA brought Resident #36's care documentation that showed GNA #36 documented that he provided care to Resident #36 on 1/18/23 and 1/19/23 on evening shift. The documentation indicated that GNA #36 assisted the resident with bed mobility, dressing, toilet use, personal hygiene, and other tasks. The NHA acknowledged that Resident #36's care documentation was not reviewed during the investigation and should have been. When the surveyor asked to speak to GNA #36 the NHA replied that he no longer worked at the facility and that he was terminated in April 2023 for misconduct. 43096 2) A review of the facility's self-reported incident, MD00182614, on 5/13/24 at 12:40 PM revealed that Resident #343 reported that he/she had been physically and verbally abused by staff on 4/27/23. Further review of the facility's investigation revealed that the facility conducted a head-to-toe assessment for Resident #343 and obtained other residents' interviews and staff interviews, including the alleged perpetrator. However, the investigation packet did not have a statement from the resident. During the review of Resident #343's medical record on 5/13/24 at 3:30 PM, it was revealed that the resident's BIMS (Brief Interview for Mental Status is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility: 0-7 means severe cognitive impairment, 8-12 means moderate cognitive impairment, and 13-15 means intact cognition) was 15 out of 15 on 3/28/22. In an interview with the Nursing Home Administrator (NHA) on 5/13/24 at 4:00 PM, the NHA confirmed that Resident #343 was alert, oriented, and able to be interviewed. The surveyor asked if the facility had any statement from him/herself regarding the incident. The NHA said, The facility staff put details in the self-report form but did not document or obtain a separate statement form from the resident. On 5/15/24 at 11 AM, the surveyor shared concerns about the above issue with the NHA, which she validated. 3) Alprazolam (Xanax) is a controlled substance, which means that it's more likely to be misused or cause dependence. The Alprazolam used for anxiety and panic as psychotropic medication. Nursing home facility nursing staff are required to document controlled medication use on their sheet, which is called a count sheet. On 5/06/24 at 5:12 PM, the surveyor investigated the facility's self-report, MD00196024, about Resident #345's medications (Alprazolam) which were brought from home upon admission was taken by a former employee (Registered Nurse #46) on 8/22/23. Further review of the facility's investigation revealed that the facility obtained two statements from Staff #47 and #48 about the incident. The statements explained that Staff #48 did not feel comfortable having Resident #345's medication in the medication cart without a count sheet. Then, they asked RN #46 (a unit manager) to keep them until Resident #345's family could retrieve the meds. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Nursing Home Administrator (NHA) on 5/07/24 at 11:03 AM, the NHA was asked for any written statement from RN #46 regarding the incident. The NHA said, RN #46 was already terminated for another reason when the incident occurred. There was no written statement from her. The NHA added, Since RN #6 was the Director of Nursing (DON) when the incident occurred, she may have the statement. The surveyor interviewed RN #6 on 5/08/24 at 10:18 AM. RN #6 confirmed that since the facility staff were not able to find Resident #345's Alprazolam on his/her discharge date , they contacted RN #46 via phone. On the phone call, RN #46 stated that she accidentally took the medications. RN #46 returned all pills, and they were counted. RN #46 verified that RN #6 did not write any statement about the incident. Also, RN #46 confirmed that she had reported the details to the nursing board but did not write any statements regarding how to contact RN #6, how to receive the medications back, and/or how the incident occurred. A review of the facility's training records related to Resident #345's brought-in-home medication (Alprazolam) on 5/08/24 at 10:55 AM revealed that the facility provided in-service to nursing staff from 8/30/23 to 9/05/23. There were 30 nursing staff signed off on the attending sheet. The Nursing Home Administrator (NHA) was asked about the total number of nursing staff in the building. The NHA stated that approximately 120 nursing staff work in the building, including approximately 70 aides and 50 nurses. The surveyor informed the NHA that education was only provided to some staff to prevent repeated incidents. In an interview with the NHA on 5/08/24 at 11:00 AM, the surveyor shared concerns about the above issue, which the NHA validated. 4) A rectal probe is a thin, long wire that monitors the internal body at a safe rectal temperature. A review of a facility self-reported incident, MD00201894, on 5/06/24 at 10:02 AM revealed that facility staff found Resident #347 had a rectal probe wire attached to their sacral dressing on 1/24/24. Further review of the facility's investigation contained a Geriatric Nursing Aide's (GNA #39) written statement on 1/30/24, On 1/22/24, I was changing [Resident #347], and I saw a patch on his/her bottom, and I just figure it was something that was supposed to be there. So I was very careful when cleaning him/her cause I figure it was supposed to be there. Also, GNA #38 wrote a statement on 1/29/24 as on 1/24/24, I was washing up [Resident #347], turned him/her over I saw something sticking out of his/her butt. I went and told the nurse. The review of the facility's investigative documentation on 5/06/24 at 2:40 PM revealed that the facility provided in-service training on 'checking for foreign objects in or on residents' on 1/25/24. The training attending sheet listed eleven staff members. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor asked about the incident during an interview with the Geriatric Nursing Aide (GNA #39) on 5/07/24 at 6:45 AM. GNA #39 said, A nurse asked me to write a statement about the white patch; I wrote it. No one explained what it was or what was wrong. The surveyor shared the in-service training form related to Resident #347's rectal probe issue, which GNA #39 signed. GNA #39 said, I can't remember what it was. I thought something happened to other residents. No one told me it was related to [Resident #347]. In an interview with the Nursing Home Administrator (NHA) on 5/07/24 at 8:33 AM, the NHA stated that the facility provided in-service to prevent further incidents. The surveyor asked how many nursing staff, including aides, work in the building. The NHA confirmed the facility has more than one hundred nursing staff. The NHA validated that the facility failed to educate nursing staff to prevent similar incidents.

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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** 42507 Based on observation, medical record review, and interview, it was determined the facility staff failed to develop and initiate comprehensive person-centered care plans for residents residing in the facility. This was evident for 1 resident (Resident #71) of 5 residents reviewed for unnecessary medications, and for 1 resident (Resident #191) of 1 residents reviewed for falls during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. 1) On [DATE] at 9:25 AM during a review of the clinical record of Resident # 71's chart, the resident's MOLST dated [DATE] was located, but no advance directives. The MOLST noted No CPR, Option A-2 (Do Not Intubate (DNI): Comprehensive efforts may include limited ventilatory support by CPAP or BIPAP, but do not intubate). Resident's face sheet had DNR/DNI under the Advance Directive section. On [DATE] at 10:13 AM, a review of Resident #71's care plan was completed: A plan of care was developed for Resident #71 with a Focus on Advanced Directives General: Full Code initiated on [DATE] with goals Resident's Advanced Directives wishes will be known initiated on [DATE], revision date of [DATE] and target date [DATE]. The interventions included Complete/update Advanced Directives document and Review advanced Directives on file, if applicable date initiated [DATE]. Full code means that if a person's heart stopped beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. This process can include chest compressions, intubation, and defibrillation and is referred to as CPR. However, the care plan did not address Resident #71's current code status of No CPR, Option A-2 (Do Not Intubate) as indicated on the MOLST and/or face sheet (DNR/DNI). The care plan was not comprehensive, and resident centered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:54 AM, an interview was completed with the Director of Nursing (DON) and Nursing Home Administrator (NHA) regarding care plans. They stated that the Interdisciplinary Team (IDT team) was responsible for residents' care plans and reviewed them: Everybody has access to enter stuff in the residents' care plans. Social worker arranges care plan meetings. During a review of Resident #71's medical record conducted on [DATE] at 12:29 PM, surveyor noted active physician orders dated [DATE] for Advanced Directive: DNR/DNI (Do not Resuscitate/Do not intubate). On [DATE] at 12:35 PM, additional review of Resident #71's medical record was completed: a copy of the resident's advance directives was not located in the medical records. On [DATE] at 2:36 PM, an interview was completed with Registered Nurse, RN #35, who has worked in the facility for over a year and 4 months. Regarding resident's code status, RN #35 stated that on the resident's profile in PCC (electronic record), the code status was documented under the banner of the resident's picture. She stated that when a resident becomes unresponsive, staff looks in PCC for the resident's code status. She further stated that the code status was documented in their report sheet and on the MOLST form. Resident #71's code status reviewed under profile picture indicated DNR/DNI. On [DATE] at 2:57 PM, in an interview with Licensed Practical Nurse (LPN #24), s/he stated that s/he has worked in the facility since [DATE] (8 months). LPN #24 stated that the Code status was on the top left corner where the resident's picture was in PCC and can be found in the Report sheet and on the MOLST. LPN #24 verified that Resident #71's code status was DNR/DNI. On [DATE] at 8:50 AM, in a follow up interview with the Social Worker (SW #2), she stated that Resident #71 did not have a copy of advance directives on file. She stated that the resident had a MOLST which was considered an advance directive and SW #2 gave the surveyor a copy of the resident's MOLST including an incapacity form that indicated Resident #71 had capacity to make his/her own decision. SW #2 verified that the MOLST had the resident's code status as No CPR, Option A-2 (Do Not Intubate) which was different from Full Code indicated in the care plan. On [DATE] at 8:57 AM, in an interview with the DON and Nursing Home Administrator (NHA), the surveyor reviewed Resident #71's MOLST (DNI), active orders regarding code status (DNR/DNI), and care plan (Full code). NHA verified and confirmed that the care plan was not comprehensive, and resident centered and did not address the resident's current code status of DNR/DNI. NHA stated that is a problem. 2) On [DATE] at 3:20 PM, review of Resident #191's medical records revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included but not limited to Dementia, Parkinson's disease, Depression, Metabolic Encephalopathy, Urinary tract infection, and severe Sepsis with septic shock. On [DATE] at 11:10 AM, a review of admission falls risk assessments for Resident #191 on [DATE] documented a fall risk score of 15 (high risk for potential for falls). On [DATE], the fall risk evaluation score was 13, on [DATE] the score was 12, on [DATE] the score was 15, and on [DATE] the score was 17. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:20 AM, a review of change in condition evaluation dated [DATE] revealed the resident had a fall with no injuries noted. Pre and post fall assessments were done and fall risk scores documented. On [DATE] at 11: 45 AM, a review of Resident #191's Care plan was completed: Focus Resident is at risk for falls r/t: Medication use, Foley, cognition, weakness, unsteady gait, The resident has had an actual fall with no injury. initiated/created on [DATE] with revision on same date ([DATE]). However, further review of the care plan did not reveal that Resident #191 was care planned for being at risk for falls when s/he was assessed on [DATE] and had a falls risk score of 15. The care plan was not comprehensive, resident centered, and the interventions were inadequate. The interventions put in place included Neuro checks initiated, skin check completed, therapy dept notified of fall, nonskid socks provided to resident, Monitor/document/report PRN x 72h to MD for s/sx: pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, Provide activities that promote exercise and strength building where possible, and Resident sent to SMH ER for AMS Eval. There was no care plan goal and/or interventions put in place for being at risk for falls. On [DATE] at 1:55 PM, in an interview with the Director of Nursing (DON), surveyor reviewed Resident #191's fall risk assessments/scores. DON confirmed that a score of 15 on admission indicated that the resident was a high fall risk. The surveyor reviewed Resident #191's care plan with DON. DON verified and confirmed that the care plan for risk for falls and/or actual fall was initiated/created after the resident fell on [DATE], and the interventions were not adequate. DON acknowledged that any resident with a high score for risk for falls should have that addressed in their care plan. DON further stated that the admitting nurse failed to initiate the fall risk care plan when Resident #191 was admitted , and no one caught it until after the resident had a fall on [DATE]. On [DATE] at 8:14 AM, an interview was completed with the night shift supervisor (RN #11) who has worked in the facility for 1 year: Regarding fall risk care plan initiation, RN #11 stated that any resident on admission with a high fall risk score should have a fall risk care plan in place. She stated that the admitting nurse was responsible for initiating the care plan. However, RN #11 added that sometimes unit managers and the supervisors will initiate care plans if they know about the residents' issues beforehand. Regarding Resident #191's fall risk score of 15 on admission, RN #11 stated that a fall care plan should have been initiated as soon as they knew the resident was a fall risk. Regarding fall precautions put in place, RN #11 stated that all the beds should be in a low position, frequent checks by staff, offer toileting and make sure the residents' needs were met etc. (Of note, these precautions were not included in the resident's current care plan).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on a complaint, medical record review, and interview it was determined that the facility failed to ensure 1) staff properly assessed a resident on admission, and 2) staff monitored a resident's blood sugars . This was evident for 2 residents (Residents #347 and #24) of 40 residents reviewed during the recertification/complaint survey. The findings include: 1) A rectal probe is a thin, long wire that monitors the internal body at a safe rectal temperature. In a review of a facility self-reported incident, MD00201894, on 5/06/24 at 10:02 AM, facility staff found Resident #347 had a rectal probe wire attached to his/her sacral dressing on 1/24/24. Further review of the facility's investigation revealed that a Geriatric Nursing Aide (GNA #39) had written a statement on 1/30/24, On 1/22/24, I was changing [Resident #347], and I saw a patch on his/her bottom, and I just figure it was something that was supposed to be there. So I was very careful when cleaning him/her cause I figure it was supposed to be there. Also, GNA #38 wrote a statement on 1/29/24 as on 1/24/24, I was washing up [Resident #347], turned him/her over I saw something sticking out of his/her butt. I went and told the nurse. The surveyor reviewed Resident #347's medical records on 5/06/24 at 11:20 AM. The review revealed that the resident had been admitted to the hospital due to low blood pressure and low glucose levels on 1/19/24 from the facility and readmitted to the facility on [DATE]. The resident's medical record had a form named 'skin only evaluation' upon his/her readmitted (1/22/24) completed by a wound nurse (Staff #1). The form had a list of Resident #347's wounds: venous ulcer on Right lower extremity, Left lower extremity, and sacrum. Also, the 'admit/readmit screener' form was documented on 1/22/24 about Resident #347's overall health condition. However, there was no documentation about his/her rectal probe. During an interview with Staff #1 on 5/06/24 at 11:25 AM, the staff confirmed that she did a skin check for [Resident #347] but did not find any probe then. Staff #1 added, Maybe I didn't check deep enough to see the probe. In an interview with GNA #39 on 5/07/24 at 6:45 AM, the surveyor asked about the incident. GNA #39 stated that she could not recall the incident. After sharing her written statement, GNA #39 said, A nurse asked me to write a statement about the white patch; I wrote it. No one explained what it was or what was wrong. During an interview with the Nursing Home Administrator (NHA) on 5/07/24 at 8:33 AM, the NHA said, Resident #347 had had the rectal probe upon his/her readmission from the hospital on 1/22/24, for some reason, it came out two days later. Then we removed it and reported the unusual incident form. The surveyor asked the NHA why the probe was not found after initial assessment from the nurse and wound nurse, and why the staff who cared for Resident #347 for two days did not see the probe's end piece. The NHA said, I don't know. The NHA validated the above concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42507 2) The hemoglobin A1C (HbA1c or HgA1c) test is a simple blood test that measures your average blood sugar levels over the past 3 months. It's one of the commonly used tests to diagnose prediabetes and diabetes and is also the main test to help you and your health care team manage your diabetes. It is an important blood test that gives a good indication of how well your diabetes is being controlled (normal level below 5.7%, prediabetes 5.7% to 6.4 %, and diabetes 6.5% or above). Hemoglobin is part of your red blood cells that carries oxygen from your lungs to the rest of your body. Medical record review on 5/13/2024 at 2:38 PM revealed Resident #24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to type 2 diabetes mellitus, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side, cerebral infarction, pressure ulcer of right buttock, stage 3. On 5/14/2024 at 12:08 PM, a review of physician orders revealed no active orders for blood sugar monitoring. However, further review revealed the following discontinued order: Fasting blood sugar in the morning every Mon, Thu Notify MD if BS <60 or >400. Other: Discontinued 11/7/2022 07:00 3/20/2024 11/3/2022 On 5/14/2024 at 12:45 PM, a review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2024 revealed Resident #24's blood sugar was not documented when ordered Insulin was administered at bedtime. Review of the vital sign record on 5/14/2024 at 1:19 PM, revealed staff documented blood sugar results for Resident #24 on 4/5 (184mg/dl), 4/9 (188 mg/dl), 4/13 (166 mg/dl), 4/15 (211 mg/dl), 4/22 (164 mg/dl), 4/23 (188 mg/dl), and 4/27 (158 mg/dl). However, Resident #24's blood sugars were not monitored/documented daily/routinely even though s/he was getting long-acting Insulin at bedtime. On 5/14/2024 at 1:35 PM, a follow up observation was made of Resident #24 in their room. In an interview with Resident #24, surveyor asked if the resident was on Insulin and s/he said yes. When asked if her/his blood sugars were checked prior to giving her Insulin, the resident responded sometimes. In an interview with Licensed Practical Nurse, LPN #24, on 5/14/2024 at 1:40 PM, she stated that the expectation was to check blood sugars prior to giving insulin and follow sliding scale/ordered parameters prior to the administration. The surveyor reviewed Resident #24's MAR for April 2024 with LPN #24 who confirmed that staff did not monitor/document the resident's blood sugars when the Insulin was administered at bedtime. LPN #24 reviewed the vital signs flow sheet for blood sugar documentation and confirmed that blood sugars were not monitored and/or documented for most of the days in April. On 5/14/2024 at 1:50 PM, in an interview with the Director of Nursing (DON), the surveyor reviewed Resident #24's MAR for April 2024. DON responded by saying that How can you give Insulin without checking blood sugars? Staff know that you do not give Insulin without checking blood sugar. She added that will be addressed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2024 at 3:24 PM, in an interview with the Medical Director (MD #5), the surveyor reviewed Resident #24's orders and Insulin administration for April 2024. MD #5 stated that the resident was getting long-acting insulin at bedtime and their blood sugars should be monitored in the morning and not at the time of administration. However, MD #5 added that the surveyor should address the issue of not monitoring the resident's blood sugars with the nurses and/or DON. On 5/15/2024 at 10:28 AM, further review of physician orders by another surveyor revealed the following discontinued orders: - HgAIC q 3 months start 11/10/2022 and d/c on 3/20/2024 - AIC and BMP: one time order for 5/8/2023 d/c on 5/4/2023 - CMP start 11/10/2022 and d/c on 3/20/2024 On 5/15/2024 at 11:25 AM, in an interview with Nurse Practitioner (NP #16), surveyor reviewed Resident #24's orders regarding the above labs that were discontinued with no new orders for blood sugar monitoring. The surveyor reviewed resident's MAR for April 2024 where resident got long-acting Insulin, but their blood sugars were not monitored/documented: NP #16 stated that when the resident was sent out of the facility their orders were automatically discontinued. When they returned whoever re-entered their orders failed to put in the order for HgAIC q 3 months. She added that MD #5 oversees the resident's labs. However, she stated that she (NP #16) was going to put in new orders.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44441 Based on observation, medical record reviews and staff interviews it was determined that the facility failed to provide appropriate treatment, care, and services to residents with a urinary catheters. This was evident for 2 residents (Resident #19 and Resident #93) of 5 residents reviewed for urinary catheter or UTI during the recertification survey. The findings include: 1) On 4/30/24 at 11:31AM, during the initial assessment, the surveyor observed that Resident #19 had a Urinary Catheter, a device that drains urine from the bladder. The resident said they've had it for about 1-2 years and that the nurses and the Geriatric Nursing Assistants (GNA) are responsible for providing care associated with this device. Review of the physician's order on 05/03/24 at 08:20 AM revealed an order written on 3/17/24 as Foley Catheter: Obtain output every shift. and on 3/29/24 Enhanced Barrier Precautions. every shift. Further review did not yield any further orders associated with catheter care/ management. A review of the January 2024 Treatment Administration Record (TAR) on 5/03/24 at 8:30 AM revealed that is had on six orders related to care of the resident's urinary catheter that read: Change Foley Q monthly and PRN every night shifts every 31 day(s) Urinary Catheter: 16F / 10cc one time a day every 1 month(s) starting on the 3rd for 1 day(s) related to resident's medical condition. Urinary Catheter: Change Catheter. Anchor one time a day, every day. Urinary Catheter: Drainage Bag -Change one time a day every Monday. Check to make sure Foley Cath bag is covered every shift, every shift. A review of the resident's February 2024 TAR revealed only one order for Foley Catheter care that read: Urinary Catheter Care every shift. A review of the resident's March 2024 TAR revealed only one order associated with catheter care written as: Foley Catheter: Obtain output every shift. A review of the resident's April 2024 TAR also had only one order for catheter care which read: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Foley Catheter: Obtain output every shift. every shift. On 5/09/24 at 1:21 PM, Staff #17 a Registered Nurse (RN) was asked in an interview the process for taking care of residents with urinary catheter. She stated that residents with urinary catheter have orders in their medical records or TAR showing what kind of care they require. She was asked how the nurse or GNA's would know exactly what care was required if the order was not in the residents' medical records/ TAR. She responded that the nurse will just have to go and check and if it's not there, ask for an order to be placed. On 5/09/24 at 1:59 PM, the Director of Nursing (DON) in an interview was asked about residents with urinary catheters and what sort of associated orders they should have for care and management of their urinary catheters. She stated that orders should indicate catheter care and management. She was asked where the nurse would find these orders and she said in the TAR. She was made aware that Resident #19 with a urinary catheter did not have all the associated orders for the care of the urinary catheter to prevent UTI on the TAR for the months of February, March, and April 2024. 43096 2) Suprapubic catheterization refers to the placement of a drainage tube into the urinary bladder just above the pubic symphysis. This is typically performed for individuals who are unable to drain their bladder via the urethra. Suprapubic catheterization offers an alternative means to drain the urinary bladder when other methods are not clinically feasible, undesirable or impossible. This activity reviews the technique of suprapubic bladder catheterization, its indications, contraindications and role of the interprofessional team in the management of patients who are not able to void urine. (Suprapubic definition on National Library of Medicine) In April 2022, the Office of Health Care Quality received an anonymous complaint MD00175755 about Resident #93. The complaint indicated that Resident #93's catheter was not clean and managed. During the investigation of complaints on 5/09/24 at 11:43 AM, the surveyor reviewed Resident #93's medical records. The review revealed that Resident #93 had a suprapubic catheter due to obstructive uropathy from July 2021 until the resident was discharged in April 2022. Continued review of Resident #93's medical records revealed that the resident had an order written on 11/14/2021 for catheter care as 'clean catheter with normal saline and apply dry dressing,' and an order on 1/27/22 stating 'flush/irrigate catheter with 60cc of normal saline for leakage or blockage', and ordered on 10/22/21 'suprapubic output every shift.' On 5/09/24 at 3:20 PM, the surveyor reviewed Resident #93's Treatments Administration Records (TAR) for March 2022 and April 2022. Under the records of 'the suprapubic output every 8 hours,' there was no documentation for 16 days in March 2022 and 12 days in April 2022. Additionally, the records documented less than 100 cc (0cc, 5cc, 50cc, 60cc, and 75cc) five times in March 2022 and five times in April 2022. The surveyor interviewed a Geriatric Nurse Aide (GNA #34) on 5/10/24 at 7:44 AM. GNA #34 stated that they emptied and measured catheter output and then reported the results to the nurses. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the registered nurse (RN #11) on 5/10/24 at 7:50 AM, RN #11 confirmed that nurse aides emptied the catheter bag, reported it to nurses, and nurses documented it in the chart. Also, RN #11 added that if the output was less than 100cc, nurses should check the catheter, such as leaking, malfunctioning, twisting, etc. And nurses should document it. RN #11 added, As needed, nurses will contact the provider to resolve the issue. On 5/10/24 at 10:00 AM, the surveyor interviewed a registered nurse (RN #8) about residents' low catheter output. RN #8 said, nurses should document about it. The surveyor requested to provide any documentation about Resident #93's catheter output. In the afternoon of 5/10/24, RN #8 confirmed that there was no documentation and/or intervention documented about Resident #93's suprapubic catheter output. During an interview with the Nursing Home Administration (NHA) on 5/14/24 at 11:14 AM, the surveyor informed the NHA of the above concern. The NHA validated the concerns about no care/intervention provided for the resident with low output from the suprapubic catheter.

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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. 18819 Based on complaint, reviews of a closed electronic record, and staff interview, it was determined that 1) the nursing staff failed to obtain a physician's order for a specific diet, 2) notify a resident's physician when the nursing staff performed a daily concurrent review and a resident was not eating or consuming liquids, and 3) initiate a nutritional care plan to address a resident's history of choking. This was evident for 1 (Resident #339) of 40 residents reviewed during the survey process. The findings include: Review of complaint MD00175602 on 05/14/24 revealed an allegation Resident #339 left in his/her room, alone, and was unable to feed himself/herself. The complainant alleged Resident #339 was blind, severely sick, and needed 24-hour nursing care. In an interview with the complainant for complaint MD00175602 on 05/14/24 at 8:40 PM, the complainant stated that Resident #339 was his/her in-law and that Resident #339 had passed away at home 2 years ago. The complainant stated that Resident #339 was had been on hospice but after being admitted to the facility s/he would cry and beg for the family to remove him/her from the facility. Review of Resident #339's closed medical record on 05/14/24 revealed Resident #339 was admitted to the facility for respite care on 04/14/22 with a diagnosis of nutritional deficiency. Resident #339's payment source was listed as private pay, respite stay. Resident #339 had a history of malignant neoplasm of the prostate and blindness. At home before this admission, Resident #339 was receiving hospice services and was sent out to the hospital following a choking episode and UTI. A review of Resident #339's 04/14/22 admission orders failed to reveal a physician ordered diet. Other physician orders instructed the nursing staff to: 1) Diet: Meal consumption at Breakfast, Special Instructions: assign breakfast and fluids to the POC (point of care) task, Once A Day, 07:00 - 11:00. 2) Diet: Meal Consumption at Lunch, Special Instructions: Assign Lunch and Fluids to POC Task, Once A Day Mid-Day. 3) Diet: Meal consumption at Dinner, Special Instructions: add dinner and fluid consumption to the POC task, Once An Evening Meal 16:00 - 20:00. Further review of Resident #339's nursing documented meal percentages for breakfast, lunch and dinner revealed: 1) no documented meal intake for dinner on 04/14/22, 04/16/22, and 04/17/22. 2) zero meal intake for the lunch meals on 04/14/22, 04/15/22, 04/16/22, 04/17/22. 3) zero meal intake for the breakfast meal on 04/17/22 and 04/19/22. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) the nursing staff documented a 0-25% meal intake for the breakfast and dinner meal on 04/15/22, and the breakfast meal on 04/16/22. 5) staff documenting assisting Resident #339 with the meal on 04/15/22 for breakfast and lunch and on 04/19/22 for breakfast. Nursing staff documented that a staff member only assisted Resident #339 with set-up assistance on 04/14/22 for the lunch meal, 04/15/22 and 04/16/22 for the breakfast meal. Further review of Resident #339 closed medical record revealed a physician's order, dated 04/14/22, which instructed the nursing staff to: conduct a concurrent review for physical and/or mental changes, Every Shift, Day and Night. A review of the nursing staff concurrent review documentation revealed that the nursing staff were performing and documenting the day and night concurrent reviews, but the nursing staff failed to identify and report that Resident #339 was only consuming 0-25% of meals or not eating at all. A review of Resident #339's progress notes also failed to reveal any documentation that Resident #339's physician was made aware that Resident #339 was only consuming 0-25% of meals or not eating at all. A review of Resident #339's care plans on 05/15/24 revealed a care plan for Nutritional Status problem dated 04/14/22: Resident #339 is at nutritional risk as evidenced by: Consuming less than 75% of food and/or fluids at most meals. The nutritional goal for Resident #339 was: Resident will remain comfortable. Nursing approaches included: observe for signs and symptoms of dehydration and report to the nurse, provide diet as ordered (see current physician orders) Therapeutic diet, and weigh and observe results: on admission, then weekly x 2, and then monthly if stable. Further review of Resident #339's physician admission orders revealed an order, dated 04/14/22, instructing the nursing staff to not obtain any weights on Resident #339. In a face-to-face interview with the facility administrator on 05/15/24 at 4:25 PM, was facility administrator was made aware of the findings. The facility administrator had no questions regarding the findings. Cross reference F 842

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 48168 Based on record review and interview it was determined that the facility failed to provide behavioral health monitoring for residents. This was evident for 1 facility reported incident (#MD00193233) of 18 facility reported incidents reviewed during the recertification survey. The findings include: On 5/08/24 at 3:11 PM a review of the facility reported incident #MD00193233 dated 6/07/23 was conducted. The report described staff witness of inappropriate physical contact with his/her genitals by Resident #61 to Resident #341's person. Further review of the facility's investigation report revealed that Resident #61 had a history of sexually inappropriate behavior prior to the incident and that staff were aware. On 5/08/24 at 3:22 PM a review of Resident #61's medical record revealed a lack of behavior monitoring documentation for any part of June 2023, although there were clinical notes that described the resident's behavior. On 5/09/24 at 1:37 PM an interview with Unit Manager (Staff #15) was conducted. He said that resident behavior issues were discussed in the facility's weekly behavior meetings which are held on Tuesdays. If the behavior was not already being monitored, the unit manager would update the order, and the unit nurses also had access to add the order if needed. Resident #61's orders and clinical documentation were reviewed with Staff #15, who confirmed that there was no documentation of monitoring the resident's inappropriate sexual behavior prior to the incident on 6/07/23 and that there was documentation that the resident had the behavior in May 2023. It was further noted that the order to monitor the resident's sexually inappropriate behavior was placed in July 2023. On 5/14/24 at 10:43 AM the Nursing Home Administrator was made aware of the deficiency.

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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. 44441 Based on a review of the medical record and interview with staff, it was determined that the facility staff failed to ensure narcotics removed from the resident's supply were administered to the resident, as evidenced by staff documenting the removal of narcotics without documentation of the need for the narcotic or documentation that the drug was administered to the resident. This was evident for 2 residents (#74, and #89) of 5 residents reviewed for pain management during the annual survey. The findings include: Acetaminophen/codeine (acetaminophen-cod #3) is a member of the narcotic analgesic combinations drug class and is commonly used for Cough, Osteoarthritis, and Pain. Opioid (also known as narcotics) pain medications are potent and effective at managing moderate to severe pain but have significant side effects and the potential for abuse. As a result, facilities are required to track the medication carefully and be able to reconcile administered doses of opioids with evidence of that medication's dispensation. A controlled medication utilization record (known as a count sheet) is a form to record controlled medication dispense. It documents the details for each use of any controlled substance amount removed from its original containers, including date, time, the dose given, the signature of the nurse administering medication, the amount remaining, wasted, and the signature of who checked. 1) On 5/06/24 at 10:00 AM review of Resident #74's physicians order revealed an order written on 3/23/24 as: Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug *Give 1 tablet by mouth every 4 hours as needed for PAIN. A copy of the January 2024 narcotic sign-out sheet and Medication Administration Record (MAR) were requested for review. Review on 5/06/24 at 1:00 PM of the January 2024 Narcotic sign out sheet and the MAR revealed some discrepancies with documentation of the narcotic medication Oxycodone. On 1/14/24 at 21:00 PM, 1/17 at 21:30 PM and 1/20 at 00:54 AM, the narcotic medication was not documented on the narcotic sheet as given. It was documented only on the MAR. Also, on 1/16/24 at 09:50 AM, 1/18 at 00:00 AM, 1/19 at 12:00 PM and 7:00PM, 1/22 at 12:00 PM, 1/23 at 05:00 AM and 10:30 PM, 1/25 at 02:00 AM and 10:30 PM, 1/27 at 05:00 AM and 1/31 at 12:00 PM it was documented on the narcotic count sheet that Resident #74 got this medication, but the documentation could not be found on the MAR. In an interview with staff #35 on 5/06/24 at 2:23 PM, she was asked the facility's process for documenting narcotic pain medications. She stated that once given, the nurse is required to document the narcotic medications on the narcotic sign out sheets and, on the MAR, simultaneously. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 2:05 PM, staff #15 a unit manager was asked if anyone provides oversight because the MAR and the narcotic sign out sheet times did not match, and staff were giving meds without signing it out. He stated that this was nursing doing what they are not supposed to do. He stated that when medications or narcotics are given, they are required to be signed out immediately on the MAR and the Narcotic count sheet. He was made aware that the nurses were not doing that and that this was a concern. 43096 2) During a portion of investigating complaints on 5/10/24 at 8:09 AM, the surveyor reviewed an intake MD00185048 reported in October 2022 regarding Resident #89's care. The complainant reported that Resident #89 contacted 911 requesting medical assistance and was in pain. A review of Resident #89's Medication Administration Records (MAR) for October 2022 on 5/10/24 at 10:34 AM revealed that the resident had prescribed scheduled pain medication for acetaminophen-codeine 300-30mg twice a day for pain in an unspecified joint. The MAR documented that Resident #89 received acetaminophen-codeine on 10/26/22 at 7 AM and 10/30/22 at 7 AM. However, the controlled drug record for Resident #89's acetaminophen-codeine did not include these two doses. Also, continued record review revealed that the controlled drug record documented that on 10/13/22 at 7:45 AM, the medication was removed for administration. However, the MAR did not have any record on 10/13/22 at 7 AM (left as blank) but documented it as given at 7 PM on 10/13/22. There was no record on the controlled drug record for the evening dose on 10/13/22. In an interview with a registered nurse (RN #17) on 5/10/24 at 11:56 AM, RN #17 confirmed that the controlled medication administration should document both residents' medical records (MAR) and controlled drug records (also known as count sheets). On 5/10/24 at 12:43 PM, the surveyor shared the above concerns with the Nursing Home Administrator (NHA), who validated them.

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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. 43096 Based on record review and staff interviews, it was determined that the facility failed to properly store a patient's medication. This was evident for 1 (Resident #345) of 4 residents reviewed for personal property during an annual survey. The findings include: On 5/06/24 at 5:12 PM, the surveyor investigated the facility's self-report, MD00196024, about Resident #345's medications (Alprazolam: psychotropic medication for anxiety and panic, also known as Xanax), which were brought from home upon admission were taken by a former employee (Registered Nurse #46). Further review of the facility's investigation revealed that the facility obtained two written statements from Staff #47 and #48 about the incidents. Staff #47 wrote a statement on 8/24/23: Staff #48 didn't feel comfortable having Alprazolam in her cart without a count sheet, and she was told to give them to RN #46 to return to the family upon discharge. We were unable to find the medications, so we called RN #46 to ask about the location of the meds. RN #46 found the medications in her belongings that were taken out of her office when she was terminated. Also, Staff #48 reported in her written statement on 8/25/23 that she did not feel comfortable taking over the medication cart with an Alprazolam bottle for Resident #345 without a narcotic count sheet. She gave the medicine to her unit manager, RN #46, until Resident #345's family could retrieve the meds. During an interview with a Registered Nurse (RN #6, also previous Director of Nursing) on 5/08/24 at 10:18 AM, RN #6 confirmed that since the facility staff were not able to find Resident #345's Alprazolam, they contacted RN #46 via phone. During the phone call, RN #46 stated that she accidentally took the medications; all pills were accounted for. In an interview with the Nursing Home Administrator (NHA) on 5/08/24 at 11:00 AM, the surveyor shared concerns about Resident #345's home medication being taken by RN #46 without any permission and/or explanation to the resident. The NHA validated the concerns.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on medical record review, interviews, and observations, it was determined that the facility failed to 1) make electronic medical records available to the survey team and 2) maintain complete and accurate medical records. This was evident for 4 residents (Residents #4, #74, #90, and #339) of 40 residents reviewed during the recertification/complaint survey. The findings include: 1) During a review of Complaint MD00175602 on 05/14/24, the nurse surveyor was given access to the Matrix Care electronic medical record to perform a chart review. A username and password were obtained from the survey team leader. There were no issues accessing Resident #339's closed medical records on 05/14/24. A request for any paper chart records for Resident #339 was also requested on 05/14/24. In an interview with the facility BOM (business office manager) on 05/14/24 at 2:00 PM, the BOM stated that s/he was unable to locate any thinned/closed paper records for Resident #339 since the facility had been purchased by another owner and Resident #339 was discharged in April 2022. On 05/15/24 at 8 am, the nurse surveyor attempted to access Resident #339's closed Matrix Care electronic medical record. An error message was observed asking the surveyor to ask the administration for assistance in obtaining access to Resident #339's Matrix Care electronic record. In an interview with the facility administrator on 05/15/24 at 8:45 am, the surveyor requested access to the Matrix Care electronic medical record for Resident #339. In an interview with the facility director of nurses (DON) on 05/15/24 at 11:22 am, the DON stated that the business office manager was in the process of obtaining Matrix Care access specific to this surveyor. In a follow-up interview with the business office manager (BOM) at the conclusion of the exit conference on 05/15/24 at 4:30 PM, the BOM handed the nurse surveyor a document with a brand new username and password to the Matrix Care electronic medical record. 42507 2a.) Narcan (Naloxone) is a medication approved by the Food and Drug Administration (FDA) designed to rapidly reverse opioid overdose. For example, it is used to restore breathing after an opioid overdose. Effects begin within two minutes when given intravenously, five minutes when injected into a muscle, and ten minutes as a nasal spray. Naloxone blocks the effects of opioids for 30 to 90 minutes. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/10/2024 at 9:00 AM, a review of the investigation report of a facility reported incident (FRI), MD00204649, revealed that on 4/12/2024 at approximately 8:10 AM, Resident #4 was found unresponsive by staff in their room. The Nurse Practitioner (NP #16) was in the facility and assessed the resident: VS (vital signs) and BS (blood sugar) obtained. B/P (blood pressure) extremely low, resident put in reverse Trendelenburg (head is up and feet are positioned down), non-rebreather applied, and Narcan administered via right nasal. 911 was called and the resident transferred to the hospital. On 5/10/2024 at 10:05 AM, a review of active orders in April 2024 for Resident #4 revealed the following orders: Naloxone HCl Injection Solution 0.4 Mg/ML: Inject 0.4 mg intramuscularly (IM) as needed for possible overdose, may repeat times one ordered on 4/12/2024. On 5/10/2024 at 10:30 AM, Review of Medication Administration Record (MAR) for April 2024 was completed. Staff did not document giving Resident #4 ordered Narcan 0.4 mg/ml IM on 4/12/2024 (as indicative of an open slot on the MAR with no check mark/staff initials). Based on record review of the facility report of the FRI, Resident #4 was given Narcan via right nasal route. However, there was no documentation of the administration of the Narcan in the MAR. On 5/13/2024 at 12:30 PM, an interview was completed with A-Wing Unit Manager (UM #15), who is a Licensed Practical Nurse (LPN) and has worked in the facility for about 4 years. Regarding the administration of Narcan, UM #15 stated that Registered Nurse (RN #6) who was the DON at the time of the incident, administered the Narcan via the nasal route. UM #15 added that he was the one who went and got the nasal Narcan for the then DON to administer to the resident. Surveyor reviewed the orders for Narcan on the day of the above incident with UM #15. UM #15 verified that the order was for IM Narcan. UM #15 confirmed that the ordered route of the medication was not followed. He stated that they should have had NP #16 who was present to switch the route from IM to nasal to reflect the actual route that the med was given to the resident. He added that NP #16 had stated it was ok to give the nasal Narcan and he (UM #15) went and got it. The surveyor further reviewed the MAR for April 2024 with ordered Narcan slot blank. UM #15 confirmed that Narcan was given via the nasal route on 4/12/2024 but not documented on the MAR. He stated that the nurse must have forgotten to sign it. He added that was the first time they had to give Narcan in the facility. On 5/14/2024 at 8:10 AM, surveyor attempted to contact the former DON, RN #6 (who administered the Narcan) by phone but no answer. The surveyor was unable to interview RN #6 as s/he did not call back. Per the Nursing Home Administrator, RN #6 was on PTO (personal time off). 2b.) On 5/1/2024 at 8:16 AM, an observation was made of Resident #4 in their room. The resident was in bed awake, alert, and oriented to person, place, time, and situation. Resident #4 was observed lying on a regular mattress and stated s/he was very pleased to go back to it because his/her left leg wound was caused by the air mattress s/he was on before. On 5/14/2024 at 8:29 AM, in an interview with wound nurse, Licensed Practical Nurse (LPN #1), she confirmed that Resident #4 was placed on an air mattress but recently refused it and was currently on a regular mattress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215142	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesapeake Shores Nursing Center	21412 Great Mills Road Lexington Park, MD 20653

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/2024 at 9:34 AM, a review of the Treatment Administration Record (TAR) for May 2024 was completed. Staff documentation revealed Resident #4 was on an air mattress (LAL Mattress for pressure management, unit nurse to verify proper use and placement every shift), which was not the case. On 5/14/2024 at 9:45 AM, a follow up observation was made of Resident #4 in their room. The resident was awake, alert, and oriented to person, time, place, and situation. Resident was observed lying in bed on a regular mattress. Resident #4 confirmed that s/he had requested to have a regular mattress because s/he did not like the air mattress. On 5/14/2024 at 9:49 AM, Resident #4's nurse, LPN #23 accompanied the surveyor to the resident's room and verified/confirmed that the resident was on a regular mattress. On 5/14/2024 at 9:55 AM, in an interview with the A-Wing Unit Manager (UM #15), he went into Resident #4's room and confirmed that the resident was on a regular mattress. Surveyor reviewed staff documentation on the TAR with staff signing that the resident was on an air mattress (LAL Mattress for pressure management). UM #15 stated that Resident #4 used to have an air mattress but requested that it be changed to a regular mattress which was done. UM #15 stated that they failed to discontinue the order when the mattress was changed, and staff has just been signing without paying attention. He added that he was going to discontinue the order and put in an order for the right mattress. On 5/14/2024 at 10:55 AM, surveyor discussed the above findings with the Nursing Home Administrator (NHA). Regarding Narcan administration route and med not being signed off as given, NHA stated that the unit manager, UM #15, had told her about it and they would have NP #16, correct the order to reflect the nasal route of administration. NHA further acknowledged that Resident #4 had requested a regular mattress which was provided. Surveyor reviewed TAR documentation for May 2024 with NHA. NHA stated that was not right because the resident was currently on a regular mattress and not on an air mattress as per staff documentation. 44441 3) On 5/6/24 at 10:00 AM review of Resident #74's physicians order revealed an order written on 3/23/24 as Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug *Give 1 tablet by mouth every 4 hours as needed for PAIN. A copy of the January 2024 narcotic sign-out sheet was requested for review. Review of the January 2024 narcotic sign out sheet on 5/6/24 at 1:00 PM revealed that a portion of the narcotic sign out sheet from 1/3/24 - 1/12/24 was not in the medical records. The facility was asked to provide the missing copy. On 5/6/24 at 3:00 PM the Director of Nursing (DON) was asked if anyone audits the narcotic drug count sheets. She stated that no one does. She was made aware that a portion of the narcotic drug count sheet could not be found in the medical records and was asked to look further. She said she will check with the unit manager. (continued on next page)

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	215142	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chesapeake Shores Nursing Center	21412 Great Mills Road Lexington Park, MD 20653

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 2:05 PM Staff #15 a unit manager was asked if the sign out sheets were kept anywhere else other than the electronic medical records. He stated that once the last pill was given, the nurses would hand him the top of the medication card for name verification. These are then placed on the scan box for the medical records office to download into the electronic medical records and papers copies thrashed. He was made aware of the missing portion of the narcotic count sheet, and he stated that there was a period when they did not have anybody, and things got stacked up. That there was a possibility that it was missed or not uploaded. He was made aware that this was a concern. 43096 4) During a portion of investigating complaints and self-report incident (MD00197490) on 5/01/24 at 2:07 PM, the surveyor reviewed Resident #90's medical records. The review revealed that Resident #90 was transferred to an acute care facility for evaluation of shortness of breath on 9/11/23 around 11 AM and readmitted to the facility on [DATE]. Continued medical record review for Resident #90 revealed that a progress note written by the activity director (Staff #7) on 9/11/23 at 6:14 PM said, [Resident's name] is alert and oriented with moderate cognitive impairment. He/she enjoys doing a puzzle, watching Hallmarks Movies . In an interview with Staff #7 on 5/02/24 at 3:18 PM, the staff stated that she wrote her notes after assessing residents. The surveyor shared her written note on Resident #90's medical record dated 9/11/23 at 6:14 PM, at which time the resident was not in the facility. Staff #7 said, I should put ' late entry. ' An additional review of Resident #90's medical record review on 5/02/24 at 3:30 PM revealed that the resident transferred to an acute care facility on 9/24/23 at 8:14 PM due to abnormal blood glucose. However, the transfer form documentation dated 9/24/23 documented that Resident #90 transferred to the hospital on 9/11/23 at 1 PM. During an interview with the Nursing Home Administrator (NHA) on 5/02/24 at 3:45 PM, the NHA confirmed that Resident #90 transferred to the hospital on 9/24/23 due to an abnormal glucose level. The surveyor transfer form dated 9/24/23 recorded the transfer detail as 9/11/23. The NHA said, Maybe the data was not updated in this form. The NHA validated inaccurate data recorded in the form.