STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215143	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Severna Park LLC	310 Genesis Way Severna Park, MD 21146

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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 0600 Level of Harm - Minimal harm or potential for 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. 30428 Based on the review of facility reported incidents,staff interview, and review of facility policy, it was determined that a facility staff member failed to treat a resident with respect and free from verbal and physical abuse. This was evident during the review of 2 (Resident #127 and #90) out of 21 Residents reviewed for allegations of abuse. The findings include: Review of the facility reported incident #MD00205993 on 5/9/25 at 8:15 AM revealed that on 5/24/24 there was a witnessed verbal altercation between Resident #127 and staff GNA #32. According to witness statements in the facility investigation packet GNA #32 overheard yelling and cursing at Resident #127 when the supervisor, staff RN #4 separated the 2 individuals and told GNA #32 that she needed to leave the facility immediately. According to a statement from Resident #127, s/he stated that GNA #32 was yelling at him/her because s/he didn't want to see the pictures on his/her phone about the previous staff. Resident #127 just wanted him/her to leave him/her alone and leave his/her room and s/she wouldn't until the supervisor staff RN #4 intervened. Resident #127 was unavailable for further follow up and interview. The facility DON was interviewed regarding the occurrence on 5/9/25 at 8:51 AM. She stated that the employee, GNA #32 was removed and reported to the Board of Nursing secondary to her conduct in the facility and training was implemented for all other staff on the abuse policy and conduct. This evidence was included in the facility investigation packet and reviewed on 5/9/25. The concern about the substantiated abuse was reviewed with the facility DON and Administrator on 5/9/25 and again during exit on 5/13/25. 42783 (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 05/05/25 at 11:03 AM, Resident #90 advised that he/she had a loose bowel movement, and a male Geriatric Nursing Assistant (GNA) came to clean him/her. The Resident stated that he/she told the male GNA that he was being very rough and it was hurting him/her. The GNA then placed the feces soiled washcloth close to the Resident's face and stated do you want to stay like this and then continued to hurt him/her while providing incontinent care. The resident stated that he/she reported the incident to the Unit Manager. During an interview conducted on 05/05/2025 at 11:27 AM, the Unit Manager #1 confirmed that she spoke with Resident #90 regarding the concern for rough care. The Unit Manager further stated that the Resident did not tell her that the GNA held a feces soiled wash cloth in the Resident's face. On 05/05/25 at 2:15 PM the Surveyors reported to the Director of Nursing (DON) the complaint of rough care and the feces soiled wash cloth shown in resident's face. The DON stated that she was unaware and would investigate it and report it to the State Agency Office of Healthcare quality (OHCQ). A review of the facility's investigation conducted on 05/13/2025 at 10:12 AM revealed a statement from GNA #33. The GNA stated that Resident #90 advised that he was hurting the Resident during incontinent care, the GNA replied I am not hurting you and continued to clean the Resident. During an interview with the DON conducted on 05/13/2025 at 10:33 AM, the DON stated that she educated GNA #33 on customer service. This Surveyor advised the DON that there was concern for abuse due to the GNA confirming that the resident complained that he was hurting him/her and he responded that he was not hurting the resident and continued to provide incontinent care. During a continued interview with the DON on 05/13/2024 at 11:20 AM, the DON stated that GNA #33 showed Resident #90 a feces soiled wash cloth to show the Resident that there were a lot of feces. This surveyor advised the DON that Resident #90 reported that GNA #33 held the feces soiled wash cloth close to his/her face. The DON stated that the behavior of the GNA was inappropriate and that's why she provided a one-to-one education on customer service. This Surveyor advised the DON again of the concern for abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42886 Based on medical record review and interview, it was determined that the facility staff failed to thoroughly investigate a complaint of abuse. This was evident for 1 (Resident #124) out of 64 residents reviewed during a complaint/annual survey. Findings include: Review of resident #124's facility reported incident (MD 00182893) on 5/13/25 at 8:30am revealed the resident made an allegation of abuse after the resident reported to the facility that a nursing staff member pushed and choked him/her on 8/29/2022. The surveyor review of the facility investigation on 5/13/25 at 1:10pm revealed that the facility failed to thoroughly investigate the events surrounding the allegation of abuse. The facility investigation did not contain other resident interviews disproving widespread abuse from staff. Interview with the Administrator on 5/13/25 at 1:35pm confirmed the facility investigation of resident #124's allegations did not contain resident interviews disproving widespread abuse from staff.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42886 Based on medical record reviews and staff interviews is was determined that the faciliy failed to ensure Care Plans were revised and Care Plan meetings were held as required. This was found to be evident for 2 (Residents #91 & #61) out of 2 Residents reveiwed for Care Plan revisions and 2 (Residents #110 and #56) out of 2 Residents reviewed for Care Plan meetings during the annual survey. The findings include: According to Centers for Medicare and Medicaid (CMS) a care plan meeting is a regularly scheduled gathering where healthcare professionals, residents (or their family representatives), and relevant staff from a facility discuss and review a resident's individual care plan, ensuring it accurately reflects their needs, preferences, and any necessary adjustments based on their current health status; these meetings are typically held quarterly and are a key part of quality care in nursing homes. 1) Surveyor review of a complaint (MD00216698) and facility reported incident (MD00216700) alleging that a facility nursing staff member sexually abused resident #91 when he/she was providing ADL care on 4/12/25. Resident #91 reported the allegation to facility administration on 4/14/25. 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. Review of Resident #91's medical records on 5/7/25 at 11:10am revealed the resident had a behavioral care plan that provided interventions for observed behaviors including making false allegations of abuse. The last update to the resident's behavioral care plan was on 4/1/25. There was no evidence that the facility updated the resident's behavioral care plan after the resident's allegations on 4/14/25. Interview with the Director of Nursing (DON) on 5/12/25 at 9:30am regarding the facility's failure to update resident #91's behavioral care plan after the resident reported an alleged abuse incident on 4/14/25. The DON confirmed that the facility failed to update resident #91's behavioral care plan. 50504 2) Resident #61 was admitted with diagnoses including Heart Failure, History of Transient Attack and Cerebral Infraction. On 05/08/25 at 7:30 AM a review of Resident #61's medical record revealed that the resident received an anticoagulant, Clopidogrel (Plavix) daily from 11/20/23 to 12/16/24. The medication was discontinued on 12/21/24. Further review of Resident #61's medical record revealed that a care plan for anticoagulant therapy was initiated 11/12/23 and remained active. The care plan was not updated to reflect that the medication was discontinued on 12/21/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/09/25 at 8:03 AM in an interview, the Unit Manager Staff #13 confirmed the findings by reviewing the resident's medical record. Staff #13 stated I will take care of it now. On 05/09/25 at 08:52 AM the Director of Nursing was made aware of the findings. On 05/09/25 at 10:28 AM Staff #13 gave the surveyor an updated copy of Resident # 61's care plans which showed that the care plan for anticoagulant therapy was resolved. 51491 3) During an interview with a family member for Resident #110 on 5/05/25 at 12:41 PM he/she reported having Care Plan Meetings regularly with social services and another lady. During a review of Resident #110 Medical Records on 5/06/25 at 7:47 AM it was discovered that Resident #110 had regular Care Plan Meetings, and the attendees did not include the members required for the interdisciplinary team. A Care Plan Meeting Progress note on 4/11/25 showed the attendees were the Social Services Director, Nursing Manager and the Dietician. The family was notified but did not attend. A Care Plan Meeting Progress Note on 1/09/25 reported the attendees were the Social Services Director, Nursing and Family. A Care Plan Meeting Progress note on 10/10/24 stated the attendees included the Social [NAME] Director and Nursing. The family declined to attend the meeting. A Care Plan Meeting Progress note on 7/24/25 listed the Social Services Director, Nursing, Therapy and family as attending the meeting. During an Interview with the Social Service Assistant on 05/07/25 at 10:32 AM, she advised Care Plan Meetings and Attendance to the meetings were documented in the Electronic Medical Record. She also reported the Care Plan Meetings would typically include Social Work, nursing, therapy if resident was on their caseload and the dietician if the resident has any issues. 51790 4) On 05/06/25 at 9:36 AM, an interview was conducted with Resident #56. During the interview, the Resident stated that he/she does not recall ever being asked to attend a care plan meeting. On 05/07/25 at approximately 8:00 AM, a review of Resident #56 ' s electronic health record revealed that he/she had only attended one care plan meeting since admission, which occurred on 05/13/2024. For all other care plan meetings, his/her daughter was noted as the attendee. A total of five care plan meetings had been held for the Resident since his/her admission. There was no documentation found indicating that the Resident had been invited to these meetings, nor was there any documentation showing that he/she declined to attend. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/07/25 at 10:32 AM, an interview was conducted with the Social Worker Assistant. She explained that she participates in the care planning process for long-term care residents. She stated that residents are invited to care plan meetings through invitation letters, which are hand-delivered by the staff responsible for distributing resident mail. She also explained that attendance at care plan meetings is documented in the electronic health record (EHR), and a physical binder is maintained with care plan meeting sign-in sheets. She added that if a resident refuses to attend a care plan meeting, that refusal is also documented in the EHR. At that time, the surveyor requested documentation showing care plan meeting attendance and copies of invitations sent to Resident #56. On 05/08/25 at approximately 5:45 AM, the facility provided documentation for review. The documents included printouts of email invitations sent to Resident #56 ' s family, inviting them to participate in care plan meetings. However, these emails did not confirm that the Resident had been invited. Sign-in sheets for care plan meetings dated 01/03/2025, 04/03/2025, and 05/13/2025 were also provided. According to these sheets, Resident #56 was only in attendance for the meeting held on 05/13/2025. On 05/08/25 at approximately 12:30 PM, an interview was conducted with the Social Worker Assistant to review the documentation provided. She acknowledged that the documentation only confirmed that the Resident ' s family had been invited, not the Resident. She reaffirmed that the facility ' s process is to invite residents through hand-delivered letters and to document this in the EHR. She also noted that in some cases, invitations may have been made verbally but could not confirm which residents were invited this way. At the conclusion of the interview, she confirmed that there was no documentation available to show that Resident #56 had been invited to attend any care plan meetings.

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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. 49815 Based on observation, facility staff and Resident interviews and surveyor record review it was determined that the facility staff failed to document the delivery of daily wound care for Residents with pressure ulcers. This was found to be evident in 2 (Residents #36 and #114) out of 2 Residents reviewed for treatment and services of pressure ulcers. The findings include: During the initial tour of the facility at 08:45AM on 05/05/2025 the surveyor observed Resident #36 sitting in the wheelchair with specialized heel protectors (Prevalon boots) on his/her lower extremities. Resident #36 stated that the heel protectors was for the wound that he/she had on the heel. The Medication and Treatment Administration Record (MAR/TAR) is a record used to keep track of every dose of medication or treatment that a Resident is administered. The MAR and TAR includes key information about the Resident's medication and treatment including the name, dose taken, special instructions and date and time. The surveyor conducted a record review of Resident #36's medical record on 05/09/2025 at 08:55 AM. The review of the medical record revealed that Resident #36 had a physician order for daily treatment for wound care to the left heel. Further review of the medical record, specifically the April 2025 treatment administration record (TAR), revealed that there was no documentation that the daily wound treatment was being provided to Resident #36 by the nursing staff on the following dates 4/4/25, 4/14/25 and 4/25/25. At 09:35 AM on 05/09/2025 the surveyor interviewed the Director of Nursing (DON) and asked the DON if Resident #36 had a pressure ulcer on the left heel. The DON stated yes. The surveyor conveyed to the DON that there was a physician order for daily treatment of the left heel wound but there was no documentation on the April 2025 treatment administration record (TAR) that the wound care was provided on 4/4/25, 4/14/25 and 4/25/25. The Director of Nursing (DON) reviewed the TAR for Resident #36 and acknowledged that there was no documentation on the April 2025 TAR for the daily treatment of the left heel wound for 4/4/25, 4/14/25 and 4/25/25 and stated that the wound care treatment should be signed/initialed when it was done. During the tour of the nursing unit on 05/06/2025 at 07:15 AM the surveyor observed Resident #114 lying in bed. The surveyor conducted a record review of Resident #114's medical record on 05/09/2025 at 06:45 AM. The review of the medical record revealed that Resident #114 had a physician order for daily treatment for wound care to the right heel and sacrum. Further review of the medical record, specifically the March 2025 and April 2025 treatment administration record (TAR), revealed that there was no documentation that the daily wound treatment was being provided to Resident #114 by the nursing staff on the following dates for the right heel wound 3/6/25, 4/8/25, 4/12/25, 4/18/25, 4/19/25, 4/20/25 and 4/26/25, and for the sacral (buttock) wound 4/12/25 and 4/19/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 09:35 AM on 05/09/2025 the surveyor interviewed the Director of Nursing (DON) regarding Resident #114's pressure ulcers on the right heel and sacrum. The surveyor conveyed to the DON that there were physician orders for daily treatment of the right heel wound and sacral (buttock) wound but there was no documentation on the March 2025 and April 2025 treatment administration record (TAR) that the wound care was provided on 3/6/25, 4/8/25, 4/12/25, 4/18/25, 4/19/25, 4/20/25, and 4/26/25 for the right heel wound, and 4/12/25 and 4/19/25 for the sacral (buttock) wound. The Director of Nursing (DON) reviewed the TAR for Resident #114 and acknowledged that there was no documentation on the March 2025 and April 2025 TAR for the daily treatment of the right heel wound for dates 3/6/25, 4/8/25, 4/12/25, 4/18/25, 4/19/25, 4/20/25 and 4/26/25, and sacral (buttock) wound for dates 4/12/25 and 4/19/25 and stated that the wound care treatment should be signed/initialed when it was done by the nursing staff. At the time of exit no additional documentation was provided by the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on observation, facility staff interviews and record reviews it was determined that the facility failed to ensure residents were free from accidents. This was found to be evident in 2 (Residents #70 and #91) out of 2 Residents reviewed for accident hazards during the recertification survey. The findings include: 1) The surveyor observed Resident #70 sitting in the wheelchair in the lobby at the front entrance to the facility on [DATE] at 01:15 PM. On 05/12/2025 at 12:35 PM the surveyor conducted a record review of Resident #70's medical record. Review of the medical record revealed that Resident #70 was found on the floor in his/her room on 05/12/2024 at 18:12 PM which was documented in the progress notes of the medical record. Additionally, it was documented that Resident #70's bed had flipped over on the side, but not on the Resident. The surveyor requested from the Licensed Nursing Home Administrator (LNHA) at 06:30 AM on 05/13/2025 the facility's incident report for Resident #70's fall and incident for 05/12/2024. At 08:30 AM the LNHA stated that they were still looking for the incident report. The surveyor reviewed the facility's Fall Prevention Program policy and procedure dated 03/14/2023 and revised 09/05/2023. The policy indicated that a fall is an event in which an individual unintentionally comes to rest on the ground, floor or other level. The event may be witnessed, reported or presumed when a Resident is found on the floor or ground, and can occur anywhere. Additionally, the policy indicated that when a Resident experiences a fall, the facility will complete an incident report, and document all assessments and actions. In an interview with the Director of Nursing (DON) at 10:40 AM on 05/13/2025 regarding Resident #70's fall and incident on 05/12/2024, the DON stated that there was no incident report or investigation completed. The surveyor conveyed to DON that the facility's Fall Prevention Program indicated that an incident report was to be completed and all assessments and actions were to be documented when a Resident had a fall. The DON acknowledged the surveyor and stated, yes that an incident report should have been completed when Resident #70 had the fall. At the time of exit, no additional documentation was provided by the facility. 51491 2) A Hoyer lift, also known as a patient lift, is an assistive device used to safely transfer individuals with limited mobility from one place to another, such as from a bed to a chair or wheelchair. It utilizes a sling to support the patient's body and a mechanical system (hydraulic or electric) to raise and lower them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #91 on 05/05/25 at 1:32 PM, he/she reported while being lifted from his/her wheelchair with a Hoyer Lift, the lift tilted, and he/she fell to the floor. The Resident reported going to the hospital the next day due to back pain. Resident #91 stated, Now they have a new Hoyer and now the Hoyer comes in the room with me. During a Record Review on 5/07/25 at 7:10 AM a Progress note dated 1/12/25 at 10:42 PM revealed Resident #91 was being lifted with a Hoyer Lift from his/her wheelchair and the Hoyer Lift tilted resulting in him/her falling to the floor. An ambulance came to the Resident, and he/she refused being transported to the hospital. A Transfer Notice written on 1/13/25 at 5:54 AM revealed Resident #91 was later transferred to the Emergency Department due to the fall, Resident fell yesterday, had no bleeding or injury and at approximately 2 AM resident woke up and complained of headache and back pain, resident was administered pain medication and went back to sleep, at 6 AM resident woke up again and complained of serious back pain and requested to be sent to the emergency room . During an interview with the Director of Nursing (DON) on 05/08/25 at 10:10 AM she reported the Resident was in his/her wheelchair in the hallway due to limited space in the Resident's room and staff members were transferring him/her to the bed. When going into the room, it shifted, and they lost control and lowered it down. She advised the Hoyer was working well but was taken out of service and sent to maintenance for inspection which is standard when an incident occurs involving equipment. She reported changes were made with transferring Resident #91 and staff members are now required to transfer Resident #91 inside his/her room. During an interview with the Maintenance Director 5/12/25 at 10:04 AM it was discovered the Hoyer Lift was taken out of service and replaced following the incident. He reported there was nothing found wrong with the Hoyer Lift, the facility was already phasing out older models of Hoyer Lifts and this one was due to be replaced.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 30428 Based on medical record review and interview with facility staff it was determined that the facility failed to have an order to address and medicate different pain levels in a resident. This was evident during the review of a complaint for Resident #132 and the review of 1 of 6 residents' medication orders. (#132). The findings include: Review of the medical record for Resident #132 on 5/5/25 at 11:12 AM revealed admission to the facility post fall with multiple fractures requiring healing and physical therapy. Further review of the medical record for Resident #132 revealed physician orders on admission for Oxycodone 5 milligrams (mg) 2 tablets every 4 hours as needed for severe pain, a documented score of 7-10. However, a review at this time failed to reveal an order for pain medication for pain scores below '7.' A review of the medication administration record (MAR) for December 2024 noted that the Oxycodone was administered 64 times, 19 for pain scores of 0-6, in addition to 45 times for the score of 7-10. This concern was reviewed with the facility DON on 5/5/25 and again at exit on 5/13/25.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 42886 Based on medical record review and interview, the facility failed to provide trauma-informed care after a resident expressed past traumas to a facility staff member. This was evident for 1 (resident #24) of 64 residents reviewed during a complaint/annual survey. Findings include: Review of resident #24's medical record on 5/12/25 at 7:40am an admission document dated 9/19/24, the date of the resident's admission. The document described the resident's past trauma with his/her family which caused him/her to run away from home at a young age. Further review of resident #24's medical record on 5/12/25 at 8:10am revealed no evidence that the resident's care plan was created with interventions for the resident's past trauma. On 5/12/25 at 11:30am, the surveyor interviewed the Director of Nursing (DON) regarding the trauma informed care policy. The DON confirmed resident trauma informed assessments should be done at admission and after a change in condition. The surveyor pointed out that resident #24 alleged that he/she had family trauma at a young age that caused he/she to run away from home. Review of the resident's medical record revealed no evidence that the facility created a care plan with interventions for the resident's past trauma. The DON and the Administrator reviewed the resident's medical record and confirmed that there was no evidence of a care plan created with interventions for the resident's past trauma.

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	215143	A. Building B. Wing	05/13/2025

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 30428 Based on the review of a facility reported incident (FRI) #MD00205993 related to an allegation of abuse, a review of employee files and interviews, it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) were competent with their skill sets. This was found to be evident for 1 out of 3 employee files reviewed for competencies and skill sets. The findings include: Review of the FRI #MD00205993 on 5/9/25 at 8:15 AM revealed a substantiated allegation of verbal abuse occurring between Resident #127 and GNA #32. A review of the facility investigation and concurrent review of the employee file for GNA #127 revealed that upon hire the month prior, there was no competency skills evaluations or check off sheets completed and available in her record for review. The DON was interviewed on 5/9/25 at 10:46 AM. This concern was brought to her attention as she was present and had completed this investigation and investigation packet. She was not aware of the blank competency check list. She was asked at this time for anything further or any education or training that was completed with staff GNA #32 since her hire. She stated that staff are not assessed on new hire for their competencies. The facility does orientation on hire, however, only does competencies when and if something happens-they will assess nursing skills at that time. There were 60 day and 90 day evaluations found in new employee files, however, this employee did not make it to the 30 day mark before they were terminated and reported to the board for witnessed and substantiated verbal abuse to a resident in the facility during a night shift. This concern was reviewed at that time and again during exit on 5/13/25.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 50504 Based on medical record reviews and staff interviews, it was determined that the facility failed to: 1) monitor the behaviors of a resident on antipsychotic medications. 2) ensure residents were free from unnecessary medications. This was evident by 2 (Residents #61 and #111) out of 6 residents reviewed for unnecessary medication during the recertification and compliant survey. The findings include: 1) Resident #61 diagnoses included Bipolar Disorder, Psychosis, Major Depressive Disorder and Schizoaffective Disorder. 05/06/25 at 11:38 AM a review of Resident #61's medical record revealed that the resident was receiving antipsychotic medications Fluphenazine daily for Bipolar Disorder and Olanzapine at bedtime for Schizoaffective Disorder. The resident's psychiatry notes dated 2/16/25, 2/16/25, 4/4/25 and 4/16/25, revealed an increase in hallucinations and other behaviors. Further review of Resident #61's medical record revealed that a Care Plan was initated on 11/17/23 for visual/auditory hallucinations, increased anxiousness and agitation. However, the medical record failed to reveal that the resident's behaviors were monitored by the facility. On 05/08/25 at 08:16 AM in an interview, the Unit Manager Staff #13 stated that the behaviors of residents who are on antipsychotic medications were monitored by the nurses and documented in the Medication Administration Record or Treatment Administration Record. However, the Unit Manager Staff#13 after reviewing Resident #61's medical record failed to provide evidence that the resident's behaviors were being monitored. Unit Manager Staff#13 stated, I would take care of it. On 05/08/25 at 10:03 AM in an interview, the Director of Nursing (DON) was informed of the facility's failure to monitor Resident #61's behaviors. The DON informed the surveyor that she was already notified by the Unit Manager. 51899 2) A psychotropic medication is a drug that affects a person ' s mental state, mood, behavior, or perception by acting on the central nervous system. These medications are commonly used to treat psychiatric disorders such as depression, anxiety, schizophrenia, bipolar disorder, and other mental health conditions. On 05/12/2025 at 1:00 PM, a review of the resident#111 ' s Medication Administration Record (MAR) revealed an incorrect documented reason for the use of a psychotropic medication. Further medical record review on 05/12/2020 at 1:10 PM revealed that Resident #111 had a medical diagnosis supporting the use of Seroquel, which was documented as being prescribed for sundowning and as a supplement. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 05/12/2025 at 1:40 PM, the Surveyor and Director of Nursing (DON) reviewed the MAR. The DON stated that the Physician ' s reason for use of Seroquel was inappropriate for Sundowning and Seroquel should never be ordered as a supplement. The DON was made aware of the above concerns and acknowledged receipt of the information.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 30428 Based on observation, staff interviews, and review of medical record documentation it was determined that the facility failed to maintain a safe and effective system for securing medication in their designated carts on nursing units with residents with documented cognitive deficits and wandering behaviors. This practice was noted on 2 separate random observations on 2 of 2 units. The findings include: 1. During a tour of the secure dementia unit on 5/6/25 at 9:06 AM a medicine cup with a clear liquid in it was identified on an unoccupied medicine cart. There were 2 residents identified in the immediate area. Resident #80's room was immediately to the right of the medication cart where the medication was located. Resident #80 was observed walking around in his/her room and coming in and out of the room looking around and talking to the surveyor. Additionally, another resident identified as #125 was also observed in the hallway walking up and down to the cart and the door to the exit. During this time there were no staff observed in the area. At 9:12 AM staff RN #2 appeared. This surveyor introduced herself and asked if the medication cart was hers. She stated 'yes.' She was then asked about the medication that was on top of the cart. She stated that it was [86's]. I verbalized my concern to her at that time of the unattended medication in addition to the 2 residents that were present. This surveyor exited the unit and met with the facility DON who was immediately told of the observations. Record review on 5/6/25 at 9:30 AM of Resident #80 revealed a BIMS assessment completed on 3/10/25 of 01 meaning that s/he has severe cognitive deficits. A review of the BIMS assessment for Resident #125 revealed a BIMS completed on 2/17/25 with a BIMS score of 00, meaning the assessment could not be completed as the resident is 'rarely understood' per documentation. 2. Subsequent tour of the facility occurred on 5/8/25 at 6:05 AM. Upon approaching the first nursing station desk, a blister pack of medication could be observed. A closer observation and review of the blister pack revealed that it was 28 tablets of an antibiotic for Resident #98. This surveyor continued observation of the unattended medication until 6:12 AM when staff RN #4 came out of the office and was questioned about the unattended medication. He stated that it was delivered earlier and was for the other nurse. He said they had separated the medications for the different halls, and she did not take hers to the cart. He then took the medication to her cart where that nurse had been observed working during this observation period. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concerns were then reported to the facility Administrator immediately after the medication was secured by the actual facility staff.

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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. 51899 Based on medical record review and staff interview, it was determined that the facility failed to maintain complete and accurate resident records. This was found to be evident for 2 (Resident #111, #119) out of 2 residents reviewed for documentation accuracy during the survey during the survey process. The findings include: Neurological checks (neuro-checks) are a series of assessments conducted at regular intervals after a fall, especially when a head injury is suspected or cannot be excluded. Their purpose is to monitor changes in neurological status that may indicate complications such as concussion, intracranial bleeding, or increased intracranial pressure. These assessments typically include evaluation of level of consciousness and orientation, pupil size and reactivity, motor strength and movement, speech and behavior, as well as vital signs. Frequency and duration of neuro checks are guided by facility protocol, physician orders, and the resident ' s condition, often beginning with frequent intervals (e.g., every 15-30 minutes) and tapering as the resident remains stable. 1) On 05/09/25 at 10:56 AM, a record review indicated the resident #119 experienced a fall on 05/04/25. Neurological checks were documented with incorrect dates, beginning on 04/04/25 and continuing through 04/05/25. Although one entry was corrected to 05/06/25, subsequent notes continued to reflect dates of 04/06/25 through 04/07/25, demonstrating ongoing inconsistencies in documentation. On 05/09/25 at 11:05AM record review revealed on 05/04/2025 03:00 Primary physician ordered neurological checks per facility fall protocol. On 05/09/25 at 11:15 AM, the surveyor interviewed the Director of Nursing (DON) regarding staff expectations for accurate documentation. The DON stated that staff are expected to document any change in condition accurately. She was informed of the documentation concern, acknowledged the issue, and confirmed receipt of the information. 2) A review of Resident #111 ' s medical record was conducted on 05/12/25 at 1:30 PM. The review of the Psychiatric notes revealed inaccurate documentation for Seroquel. The psychiatric notes dated for 12/03/24 & 02/05/25 stated that Seroquel 25 mg (milligram) had been discontinued on 10/02/24 therefore a GDR was not attempted. However a review of the Medication Administration Record (MAR) for 10/2024 did not show an order for Seroquel. A review of the MAR dated 1/2025 showed an order for Seroquel for the first time dated 01/07/25. During an interview conducted on 05/12/25 at 1:40 PM, the Director of Nursing (DON) and the Surveyor reviewed Resident #111 ' s Psychiatric notes and Mars and confirmed the inaccurate documentation for Seroquel.