STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215149	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denton Nursing and Rehab	420 Colonial Drive Denton, MD 21629

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview it was determined the facility failed to notify a resident's responsible party (RP) when a new treatment was started for a pressure ulcer. This was evident for 1 (#65) of 4 residents reviewed for pressure ulcers. The findings include: A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). On 10/29/24 at 11:34 AM a review was conducted of Resident #65's medical record which revealed Resident #65 was sent out to the hospital on 10/7/23 and was readmitted to the facility on [DATE]. Review of the nursing admission assessment documented Resident #65 had a pressure ulcer on the coccyx that was utd unable to determine length, width, depth, and stage. Review of a 10/25/23 wound note documented Resident #65 had a stage 3 pressure ulcer. Treatment orders were placed for the area to be cleansed with a wound cleanser, apply Medical grade honey, calcium alginate to the base of the wound, secure with a bordered gauze and change daily. Further review of the medical record failed to reveal documentation that the responsible party was notified of the Stage 3 pressure ulcer and treatment. An interview was conducted with the Director of Nursing on 10/31/24 at 4:15 PM who confirmed the findings.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of complaints, observation of resident rooms and equipment, and resident and staff interview, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was evident on 3 of 4 nursing units observed. The findings include: On 10/30/24 at 8:30 AM a review of complaint MD00201981 alleged that there was black mold in the rooms on the 400 wing. On 10/30/24 at 9:00 AM an environmental tour was conducted, and the following was observed: Room: 401/403 bathroom: Observed in the shared bathroom on the wall was a 1 ft. by 4-inch hole in the wall where the plaster was busted through to the wood studs. Room: 407 - (A) bed: the over the bed light on the wall was rusted from top to bottom. (B) bed area on back wall by the head of the bed was a 3 ft. by 2 ft. area of spackle that was not painted. The Resident stated it has been that way for a least 8 months. The trim on the wall under the television area was pulled away from the wall. The front of the counter of the sink was chipped approximately 1 1/2 inches by 1 inch. There was a gap around the radiator that had no molding. Room: 408 - The wall in the bath had spackle approximately 8 ft. by 20 inches that was not painted over. In the bedroom under the sink was a 2 ft. area of black appearing mold. Room: 410 - black mold appearing spots on the wall under the sink that covered a 2 ft. area. Room: 412 - the toilet was constantly running and the housekeeper stated it had been like that for 1 week. Room: 400 - there was black appearing mold ingrained on the inside of the wood bathroom door. Room: 307 - there was black appearing mold under the sink counter on the wall that covered approximately 3 ft. Room: 200 - there was missing base molding in the bathroom to the left of the toilet approximately 3 ft. in length. Room: 203 - the wall by the hand sanitizer was missing paint approximately 6 inches by 3 inches. Room: 204 - in the bathroom the cover to the smoke detector was missing and the cover to the ceiling ventilation fan was missing. Room: 205 - there was black appearing mold on the wall under the sink. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24 at 9:22 AM an interview was conducted with Staff #14 who stated, the maintenance guy didn't do anything last week. Last Friday was his last day. Staff #14 stated, there was massive mold in room [ROOM NUMBER] on the toilet. Maintenance was aware of all the mold and didn't take care of it. On 10/30/24 at 9:45 AM an interview was conducted with Resident #8 who stated she had been telling the Maintenance Director about the mold, but he wouldn't do anything about it. Resident #8 had a yellow sticky note on the bathroom door where the mold was located. On 10/30/24 at 11:00 AM a tour was conducted with the Regional Director of Maintenance (RDM) who was shown all areas of concern. The RDM confirmed the surveyor's findings and stated there was a lot of work to be done.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on interviews, record reviews, and review of the facility's policy, the facility failed to protect the resident's right to be free from physical abuse for one of six residents (Resident (R) 39) reviewed for abuse out of a total sample of 31. Findings include: Review of the facility's policy titled, Compliant with Reporting Allegations of Abuse/Neglect/Exploitation, with an implementation date of 02/20/24, revealed, the purpose of . assuring the facility is doing all that is within its control to prevent occurrences [of abuse] . The policy recorded that abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include . certain resident to resident altercations. Review of R39's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included chronic hepatitis, alcoholic cirrhosis of the liver, anxiety disorder, panic disorder, and dementia. Review of R39's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/22/24 and located under the MDS tab of the EMR, revealed R39 had long and short-term memory problems. Review of R63's EMR revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, vascular dementia, and altered mental status. R63's care plan was reviewed and revealed a focus, initiated on 07/25/24, that recorded R63 had the potential to be physically aggressive related to dementia. Interventions included medications as ordered, to analyze triggers, and try to assess and anticipate his needs. Review of R39's EMR revealed a Practitioner Note, dated 08/07/24 at 1:00 AM. The note stated that R39 was in an altercation with another resident. Per the note, R39 was punched in the face by R63, then the residents were separated and redirected. The note also indicated that R39 had no pain or bruising. An interview was conducted with the Administrator and the Nurse Practitioner (NP) on 10/29/24 at 2:47 PM, and they indicated that they were not aware of an incident between R39 and R63. The Administrator confirmed that she was not aware of report being made regarding the resident-to-resident incident. The Director of Nursing (DON) was interviewed on 10/30/24 at 2:19 PM, and she stated that she was not familiar with the incident as she has only been the DON for about a month. She stated she would gather more information. At 2:42 PM the DON confirmed that there was no internal investigation into the incident and the State Agency had not been notified. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) 3, a nurse supervisor, was interviewed on 10/30/24 at 2:49 PM, and she stated that she did not witness the incident but had been told R39 wandered into R63's room. RN3 stated R63, who had a BIMS of 15, could be aggressive and hard to redirect at times. RN3 stated R63 was very particular about his space. RN3 stated a stop sign had been placed in front of R63's door to help prevent other residents from entering the room. She stated she could not be sure that R39 understood the purpose of the sign. Continuing with the interview on 10/30/24 at 2:49 PM, RN3 stated that R39 appeared to be agitated, wandered the unit, and at times wandered into other residents' rooms. She stated that she had been advised that R39 was found in R63's room and was removed and placed near the nurses' station. RN3 started approximately 10 minutes later, R63 approached R39 and punched him in the face. She stated that R63 was immediately removed from the area and taken back to his room. RN3 stated R39 was assessed and no injuries were noted. She added that R39 was kept at the nurses' station for monitoring. RN3 confirmed that both resident representatives and physicians were contacted. RN3 was asked if she had reported the incident. She stated that she was not sure, but it was the facility's policy to report. She stated she believed she did report the incident but could not remember when or to whom she reported it. The Minimum Data Set Coordinator (MDSC), who was the Unit Manager (UM) of the 500-unit when the incident occurred, was interviewed on 10/30/29 at 2:57 PM. She stated she remembered hearing of the incident but was not present at the facility when this incident occurred. She stated that she was pretty sure the previous DON was notified of the incident. The MDSC stated that R63 was a high functioning dementia patient that could be triggered at times by the other residents on the unit. Geriatric Nursing Assistant (GNA) 8 was interviewed on 10/31/24 at 09:03AM. GNA8 confirmed that she witnessed the incident. GNA8 stated that R39 was a wanderer and had a habit of wandering into other residents' rooms. GNA8 stated that R39 could be difficult to redirect and was able to move fast. She stated that at the time of the incident, she did not witness R39 in R63's room, but she did see R63 approach R39 as he stood near the nurses' station and pinch punch [hit with a closed fist] R39 in the face. GNA8 stated that the residents were separated immediately, and the nurse on duty was advised of the incident. GNA8 was asked if she had received any formal abuse training given by the facility, and she confirmed that she had and knew who and where to report any abuse related concerns. Review of R39's Care Plan revealed a focus that stated that the resident wandered due to his diagnosis of dementia with behaviors. The interventions included offering pleasant diversions to distract the resident. The care plan also revealed a focus, dated 09/19/23, that R39 had the potential to be physically and verbally aggressive towards others. Interventions included providing medications as ordered and intervening before any escalations.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16177 Based on review of the facility's investigations, medical record reviews, interviews, and policy review, the facility failed to fully implement their abuse policy for an allegation of physical abuse and verbal abuse and misappropriation of property three of five residents (Resident (R) 233, R11, and R232) reviewed for abuse out of a total sample of 31 residents. This failure to fully implement the abuse policy, including timely and thorough investigations and and timely reporting, increased the risk of continued abuse to residents. Findings include: Review of the facility policy, Abuse Neglect and Exploitation, dated 02/02/24, revealed abuse means the willful infliction of injury . intimidation . with resulting physical harm, pain, or mental anguish which can include staff to resident abuse and certain resident to resident altercations . instances of abuse of all residents . cause mental anguish . It includes verbal abuse . and mental abuse . alleged violation is a situation or occurrence that is observed or reported by staff, resident, or others but has not yet been investigated . mental abuse includes, but is not limited to . threats of punishment . misappropriation of resident property means the deliberate misplacement , exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent . physical abuse includes, but is not limited to hitting, slapping, punching . verbal abuse means the use of oral . or gestured communication or sounds that willfully includes disparaging . terms to residents . the facility will develop and implement written policies and procedures that prohibit and prevent abuse . and misappropriation of resident property; establish policies and procedures to investigate any such allegations . possible indicators of abuse include . physical abuse of a resident observed . sudden or unexplained changes in behaviors and/or activities such as fear of a person . an immediate investigation is warranted when suspicion of abuse . reports of abuse . identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . providing complete and thorough documentation of the investigation . protection of resident . to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation . responding immediately to protect the alleged victim . the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. 1. Review of the Facility Reported Incident (FRI) MD00201316 revealed R233 reported an allegation of physical and verbal abuse to Registered Nurse (RN)1 that Geriatric Nursing Assistant (GNA)15 was rough during care and threatened him if you touch your diaper you will regret it for the rest of your life and if I come back in the morning you better not have messed with your diaper. Review of the electronic medical record (EMR) Face Sheet revealed R233 was admitted to the facility on [DATE] status post stroke. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EMR Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R233 was cognitively intact. Further review of this MDS revealed R233 was dependent on staff for toileting and displayed no physical or verbal behaviors of agitation or refusal of care. Review of the facility's investigation, provided by the Administrator, revealed a Witness Statement, dated 01/08/24 and written by the former Director of Nursing (DON)2. The nature of the incident per the witness statement was alleged verbal abuse. The date of the incident was recorded as 01/06/24 on the 11PM-7AM shift. The statement read, Upon entering my office this am [sic], I had found a written statement that was slid under my door. The statement was regarding an abuse allegation against an aide on 11-7. I immediately notified the administrator [sic] of the facility and went to speak with the resident. The resident reported that the aide was allegedly very rough with him during his care and his arms and neck were sore as a result. He said he was threatened and was scared. He mentioned that she had allegedly told him if he kept playing with his diaper, he would 'regret it for the rest of his life.' I asked if he knew the name of the aide that was providing care and he told me he did not. I asked him to describe her and he told me she had glasses. I then looked at the schedule to see who was working on that unit overnight and scheduled aide for unit [number] was [GNA15]. I contacted [GNA15] and asked her to send me her statement in which she began to make statements about how she is being targeted by everyone, including myself [sic]. I also requested statements from other staff that were working at this time, awaiting those statements as well . Resident was evaluated by supportive care for mental health evaluation and placed on daily safety check to assure [sic] resident's safety and comfort within the facility. Resident reports he is not sleeping well as a result of this and is scared every time someone comes through the door. Further review of the facility's investigation revealed a Witness Statement, dated 01/11/24 and written by RN1. The nature of the incident per the witness statement was alleged abuse. The statement read, patient stated to me that his aide the previous night had threatened him. He asked if anything could be done about it, so I filled out the grievance form with him. Further review of the facility's investigation revealed a Concern Form. dated 01/07/24 and written for R233 by RN1. The description of the concern read, Per the resident-She came in and looked down my face and said, 'If you touch your diaper you will regret it for the rest of your life.' She said, 'I better not come in the morning and you've messed with your diaper.' I think she's mad because they brought me over here [to that unit]. She scared me a little bit, and I thought she was going to get a hold of me. The Concern Form was signed by R233 and RN1. Review of the Maryland Department of Health Office of Health Care Quality (OHCQ) Facility Reported Incident Initial Report Form, submitted by DON2 and dated 01/08/24 at 10:15 AM, revealed DON2 stated the alleged incident occurred on Saturday 1/6/24 11-7 shift (technically Sunday morning 11/7/24 [sic-1/7/24] but that she was made aware on 01/08/24 at 8:45 AM when she found the written statement under her office door. During a telephone interview on 10/30/24 at 4:45 PM, RN1 stated that he was told on 01/07/24 during the 3-11 PM shift by R233 that the previous night his aide was rough, threatened him, and he was afraid to go to sleep. RN1 stated, I texted the DON and she said to write a statement and slip it under her door, which I did. I didn't see the aide after that [her 11-7 shift on 01/07/24]. When asked when he texted the DON about the allegation, RN1 stated, That evening as soon as [R233] told me. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 10/30/24 at 5:10 PM, DON2 stated she first found out about the abuse allegation on Monday morning (01/08/24) when she found the written statement under her door. After the interview, DON2 called this surveyor back on 10/30/24 at 5:23 PM and stated that RN1 did text her the evening of 01/07/24 and I told him to put a written statement under my door and to not allow that aide to take care of that resident [R233]. DON2 verified that she did not report the abuse allegation until Monday morning 01/08/24 although she was notified via text message on 01/07/24. Review of the Maryland OHCQ Facility Reported Incident Follow-Up Investigation Report Form, submitted by DON2 and dated 01/12/24 at 12:00 PM, revealed, Due to there being no visible injuries on the resident we could not confirm that the aide was rough with the resident during care despite resident reporting it and saying he was very sore. We also could not prove the verbal abuse as the statements [by the three staff] were contradictory and there was no other proof . Allegation unsubstantiated. Further review of the facility's investigation revealed written statements from GNA15, GNA16 (no longer employed by the facility), and RN2. All three staff statements denied any verbal or physical abuse during the 3PM-11PM or the 11PM-7AM shifts that GNA 15 worked on 01/06/24 - 01/07/24. There were no other staff statements or resident statements obtained as part of the investigation for the allegation of verbal and physical abuse against GNA15. Cross Reference: F609 Reporting, F610 Investigate Protect Alleged Violation. 2. Review of FRI MD00196438 revealed missing narcotics for R11 (one oxycodone) and R232 (one oxycodone and one oxycontin) on 08/29/23. Final report. Medication became unaccounted for indefinitely. Employee states the medication was correct on count . Employee terminated . Nurses educated on narcotic count policy and safe handling of controlled medications. Facility is unable to determine what happened with the missing medication. However, residents remain safe and pain is controlled. Review of the EMR Progress Notes, Medication Administration Records (MARs), and Physician Orders for R11 and R232 verified that on 08/29/23 three pills total were unaccounted for but the residents did not have any complaints of unrelieved pain. Review of the Corrective Action Notice, provided by the facility and dated 08/26/23, revealed RN4 had three missing narcotics that were unaccounted for on shift change. [RN4] reports unsure of where they [missing narcotics] went. Agrees cart was correct during hand off. Nurse [RN4] walked out of the building with staff . Termination. During an interview on 11/01/24 at 3:00 PM, the Administrator and the [NAME] President of Clinical Operations (VPCO), were asked for all the documentation for this investigation. Review of the facility investigation, provided by the facility Administrator and the VPCO revealed no written statements from R11 or R232 or other residents or from staff concerning the missing narcotics. The investigation included an audit of all residents in the facility, background checks on RN4, in-services of the nursing staff on medication administration and narcotic counts, and a copy of an Attorney General Subpoena State of Delaware for information on RN4. Review of the documentation revealed the administrative staff at the time of the incident were no longer employed at the facility. The Interim DON was unfamiliar with the incident since she had been employed at the facility for a month prior to the survey. Cross Reference: F610 Investigate Protect Alleged Violation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 16177 Based on the facility's investigations, medical record reviews, interviews, and policy review, the facility failed to timely report allegations of physical abuse and verbal abuse for 5 (Resident (R) 233, R32, R28, R65, R62) of 31 residents reviewed for abuse. This failure increased the risk of continued abuse to these residents. Findings include: Review of the facility policy, Abuse Neglect and Exploitation, dated 02/02/24, revealed . abuse means the willful infliction of injury . intimidation . with resulting physical harm, pain, or mental anguish which can include staff to resident abuse and certain resident to resident altercations . instances of abuse of all residents . cause mental anguish . It includes verbal abuse . and mental abuse . alleged violation is a situation or occurrence that is observed or reported by staff, resident, or others but has not yet been investigated . mental abuse includes, but is not limited to . threats of punishment . physical abuse includes, but is not limited to hitting, slapping, punching . verbal abuse means the use of oral . or gestured communication or sounds that willfully includes disparaging . terms to residents . the facility will develop and implement written policies and procedures that prohibit and prevent abuse . establish policies and procedures to investigate any such allegations . possible indicators of abuse include . physical abuse of a resident observed . sudden or unexplained changes in behaviors and/or activities such as fear of a person . the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. 1. Review of the Facility Reported Incident (FRI) MD00201316 revealed R233 reported an allegation of physical and verbal abuse to Registered Nurse (RN)1 that Geriatric Nursing Assistant (GNA)15 was rough during care and threatened him if you touch your diaper you will regret it for the rest of your life and if I come back in the morning you better not have messed with your diaper. Cross Reference: F610 Investigate, Protect Alleged Violation. Review of the electronic medical record (EMR) Face Sheet revealed R233 was admitted to the facility on [DATE] status post stroke. Review of the EMR Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R233 was cognitively intact. Further review of this MDS revealed R233 was dependent on staff for toileting and displayed no physical or verbal behaviors of agitation or refusal of care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation, provided by the Administrator, revealed a Witness Statement, dated 01/08/24 and written by the former Director of Nursing (DON)2. The nature of the incident per the witness statement was alleged verbal abuse. The date of the incident was recorded as 01/06/24 on the 11PM-7AM shift. The statement read, Upon entering my office this am [sic], I had found a written statement that was slid under my door. The statement was regarding an abuse allegation against an aide on 11-7. I immediately notified the administrator [sic] of the facility and went to speak with the resident. The resident reported that the aide was allegedly very rough with him during his care and his arms and neck were sore as a result. He said he was threatened and was scared. He mentioned that she had allegedly told him if he kept playing with his diaper, he would 'regret it for the rest of his life.' I asked if he knew the name of the aide that was providing care and he told me he did not. I asked him to describe her and he told me she had glasses. I then looked at the schedule to see who was working on that unit overnight and scheduled aide for unit [number] was [GNA15]. I contacted [GNA15] and asked her to send me her statement in which she began to make statements about how she is being targeted by everyone, including myself [sic]. I also requested statements from other staff that were working at this time, awaiting those statements as well . Resident was evaluated by supportive care for mental health evaluation and placed on daily safety check to assure [sic] resident's safety and comfort within the facility. Resident reports he is not sleeping well as a result of this and is scared every time someone comes through the door. Review of the Maryland Department of Health Office of Health Care Quality (OHCQ) Facility Reported Incident Initial Report Form, submitted by DON2 and dated 01/08/24 at 10:15 AM, revealed DON2 stated the alleged incident occurred on Saturday 1/6/24 11-7 shift (technically Sunday morning 11/7/24 [sic-1/7/24] but that she was made aware on 01/08/24 at 8:45 AM when she found the written statement under her office door. Review of the Maryland OHCQ Facility Reported Incident Follow-Up Investigation Report Form, submitted by DON2 and dated 01/12/24 at 12:00 PM, revealed, Due to there being no visible injuries on the resident we could not confirm that the aide was rough with the resident during care despite resident reporting it and saying he was very sore. We also could not prove the verbal abuse as the statements [by the three staff] were contradictory and there was no other proof . Allegation unsubstantiated. During a telephone interview on 10/30/24 at 4:45 PM, RN1 stated that he was told on 01/07/24 during the 3-11 PM shift by R233 that the previous night his aide was rough, threatened him, and he was afraid to go to sleep. RN1 stated, I texted the DON and she said to write a statement and slip it under her door, which I did. I didn't see the aide after that [her 11-7 shift on 01/07/24]. When asked when he texted the DON about the allegation, RN1 stated, That evening as soon as [R233] told me. During a telephone interview on 10/30/24 at 5:10 PM, DON2 stated she first found out about the abuse allegation on Monday morning (01/08/24) when she found the written statement under her door. After the interview, DON2 called this surveyor back on 10/30/24 at 5:23 PM and stated that RN1 did text her the evening of 01/07/24 and I told him to put a written statement under my door and to not allow that aide to take care of that resident [R233]. DON2 verified that she did not report the abuse allegation until Monday morning 01/08/24 although she was notified via text message on 01/07/24. (continued on next page)

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	215149	A. Building B. Wing	11/01/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 9:15 AM, the Administrator stated DON2 reported the allegation to her via telephone after RN1 texted DON2 on 01/07/24. The Administrator stated, I told [DON2] to pull her [GNA15] off the floor meaning [GNA15] did not have to leave the facility but could not be on the same unit as [R233] while the investigation was ongoing. I also told [DON2] to get statements from [GNA15] and the resident. When asked when an allegation of abuse should be reported to the State Agency, the Administrator stated, Within two hours of learning of the allegation. 2. Review of R32's Admission Record, located under the Profile tab in the EMR, indicated that R32 was readmitted to the facility on [DATE] with diagnoses including dementia. During an initial observational tour of the facility on 10/29/24 at 12:30 PM, R32 attempted to be interviewed; however, R32 only looked up when her name was called, but was unable to answer any questions. Review of R32's quarterly MDS, assessment with an ARD of 08/06/24, indicated that R32 had short-term and long-term memory loss. Review of a facility provided Maryland Department of Health Office of Health Care Quality Facility Reported Incident Report Form (initial report), dated 06/10/24, indicated, . Allegation type: sexual . Director of Nursing (DON) notified on 06/10/24 at 3:34 PM, DON notified Administrator on 06/10/24 at 3:40 PM . Allegation was allegedly reported to [name of hospice nurse] by [R32] during her assessment . They raped me and it hurt, it did not feel good it hurt no matter what they say . Facility provider and Medical Director made aware. Resident interviewed to the best of our ability-[R32] has a history of dementia. Full head to toe assessment completed by two nurses. Family made aware. Review of a facility provided Maryland Department of Health Office of Health Care Quality Facility Reported Incident Follow-Up Investigation Report Form (5-day summary), dated 06/14/24, indicated, . [R32] was interviewed by Unit Manager . on 06/10/24. Notified Nurse Practitioner (NP) on 06/11/24 and Medical Doctor (MD) on 06/12/24. Neither of the interviewees were able to substantiate allegations . All support staff that provide care or worked on the unit with [R32] were interviewed. No one reported seeing or hearing anything that would substantiate [R32]'s claims. Five residents from [R32]'s unit were interviewed, none reported seeing or hearing anything that would substantiate claims of abuse. All nurses that provided care for [R32] were interviewed. None reported seeing or hearing that would substantiate [R32]'s claims .After interviews were completed from staff and residents, we were unable to substantiate claims of abuse made to hospice on the date in question. Review of the facility's investigation indicated no evidence that police were contacted about this allegation of sexual abuse. During an interview with the interim DON on 10/30/24 at 3:10 PM, she confirmed that the police were not contacted and indicated that the police should have been contacted. 3. Review of the EMR for R28 revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, Parkinson's disease, anxiety, and depression. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16177 Based on review of the facility's investigations, medical record reviews, interviews, and policy review, the facility failed to investigate allegations of physical abuse, verbal abuse, and misappropriation of property timely and thoroughly for 4 of 31 residents (Resident (R) 233, R11, R232, and R65) reviewed for abuse. The findings include: 1. Review of the Facility Reported Incident (FRI) MD00201316 revealed R233 reported an allegation of physical and verbal abuse to Registered Nurse (RN)1 that Geriatric Nursing Assistant (GNA)15 was rough during care and threatened him if you touch your diaper you will regret it for the rest of your life and if I come back in the morning you better not have messed with your diaper. Review of the electronic medical record (EMR) Face Sheet revealed R233 was admitted to the facility on [DATE] status post stroke. Review of the EMR Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/16/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R233 was cognitively intact. Further review of this MDS revealed R233 was dependent on staff for toileting and displayed no physical or verbal behaviors of agitation or refusal of care. Review of the EMR Care Plan tab revealed no care plan for behaviors was initiated upon admission. Further review of the EMR Care Plan tab revealed a care plan for Stressful Life Experience Resident has experienced a stressful life experience related to abuse allegation from 1/7/2024 Date Initiated: 01/08/2024 Created on: 01/10/2024 Resident will verbalize a sense of control and safety Interventions/Tasks: Actively listen to resident as they describe life's stressful events . Encourage verbalization of feelings, perceptions, and fears . Explore with resident previous methods of dealing with stress . Identify and avoid triggers for stresses (specify) . Review of the facility's investigation, provided by the Administrator, revealed a Witness Statement, dated 01/08/24 and written by the former Director of Nursing (DON)2. The nature of the incident per the witness statement was alleged verbal abuse. The date of the incident was recorded as 01/06/24 on the 11PM-7AM shift. The statement read, Upon entering my office this am [sic], I had found a written statement that was slid under my door. The statement was regarding an abuse allegation against an aide on 11-7. I immediately notified the administrator [sic] of the facility and went to speak with the resident. The resident reported that the aide was allegedly very rough with him during his care and his arms and neck were sore as a result. He said he was threatened and was scared. He mentioned that she had allegedly told him if he kept playing with his diaper, he would 'regret it for the rest of his life.' I asked if he knew the name of the aide that was providing care and he told me he did not. I asked him to describe her and he told me she had glasses. I then looked at the schedule to see who was working on that unit overnight and scheduled aide for unit [number] was [GNA15]. I contacted [GNA15] and asked her to send me her statement in which she began to make statements about how she is being targeted by everyone, including myself [sic]. I also requested statements from other staff that were working at this time, awaiting those statements as well . Resident was evaluated by supportive care for mental health evaluation and placed on daily safety check to assure [sic] resident's safety and comfort within the facility. Resident reports he is not sleeping well as a result of this and is scared every time someone comes through the door. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the facility's investigation revealed a Witness Statement, dated 01/11/24 and written by RN1. The nature of the incident per the witness statement was alleged abuse. The statement read, patient stated to me that his aide the previous night had threatened him. He asked if anything could be done about it, so I filled out the grievance form with him. Further review of the facility's investigation revealed a Concern Form, dated 01/07/24 and written for R233 by RN1. The description of the concern read, Per the resident-She came in and looked down my face and said 'If you touch your diaper you will regret it for the rest of your life.' She said 'I better not come in the morning and you've messed with your diaper.' I think she's mad because they brought me over here [to that unit]. She scared me a little bit, and I thought she was going to get a hold of me. The Concern Form was signed by R233 and RN1. Further review of the facility's investigation revealed written statements from GNA15, GNA16 (no longer employed by the facility), and RN2. All three staff statements denied any verbal or physical abuse during the 3PM-11PM or the 11PM-7AM shifts that GNA 15 worked on 01/06/24 - 01/07/24. There were no other staff statements or resident statements obtained as part of the investigation for the allegation of verbal and physical abuse against GNA15. Review of the Maryland Department of Health Office of Health Care Quality (OHCQ) Facility Reported Incident Initial Report Form, submitted by DON2 and dated 01/08/24 at 10:15 AM, revealed DON2 stated the alleged incident occurred on Saturday 1/6/24 11-7 shift (technically Sunday morning 11/7/24 [sic-1/7/24] but that she was made aware on 01/08/24 at 8:45 AM when she found the written statement under her office door. Review of the Maryland OHCQ Facility Reported Incident Follow-Up Investigation Report Form, submitted by DON2 and dated 01/12/24 at 12:00 PM, revealed Due to there being no visible injuries on the resident we could not confirm that the aide was rough with the resident during care despite resident reporting it and saying he was very sore. We also could not prove the verbal abuse as the statements [by the three staff] were contradictory and there was no other proof . Allegation unsubstantiated. During a telephone interview on 10/30/24 at 4:45 PM, RN1 stated that he was told on 01/07/24 during the 3-11 PM shift by R233 that the previous night his aide was rough, threatened him, and he was afraid to go to sleep. RN1 stated, I texted the DON and she said to write a statement and slip it under her door, which I did. I didn't see the aide after that [her 11-7 shift on 01/07/24]. When asked when he texted the DON about the allegation, RN1 stated, that evening as soon as [R233] told me. During a telephone interview on 10/30/24 at 5:10 PM, DON2 stated she first found out about the abuse allegation on Monday morning (01/08/24) when she found the written statement under her door. After the interview, DON2 called this surveyor back on 10/30/24 at 5:23 PM and stated that RN1 did text her the evening of 01/07/24 and I told him to put a written statement under my door and to not allow that aide to take care of that resident [R233]. DON2 verified that she did not start an investigation of the abuse allegation until Monday morning 01/08/24 although she was notified via text message on 01/07/24. DON2 verified that she was not aware that GNA15 was not in the facility after her 11PM-7 AM shift on 01/07/24 when she instructed RN1 to not allow GNA15 to take care of R233. DON2 verified that since the investigation was not started immediately to determine what happened and who the alleged perpetrator was, R233 and other residents were at risk for being abused. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/31/24 at 9:15 AM, the Administrator stated DON2 reported the allegation to her via telephone after RN1 texted DON2 on 01/07/24. The Administrator stated, I told [DON2] to pull her [GNA15] off the floor meaning GNA15 did not have to leave the facility but could not be on the same unit as R233 while the investigation was ongoing. I also told DON2 to get statements from [GNA15] and the resident. When asked how she ensured that GNA15 was not still working with R233, the Administrator stated, I hope she [GNA15] was pulled [removed from caring for F233] because that was a directive. During a telephone interview on 10/31/24 at 10:15 AM, GNA15 denied being rough and threatening R233. GNA15 stated she provided incontinence care for R233 on 01/07/24 (review of the task report on 01/07/24 showed care provided by GNA15 at 2:27 AM) without an issue. GNA15 stated she went home sick on 01/07/24 at 6:00 AM and did not return to the facility until after her planned surgery on 02/04/24. GNA15 stated she was not told she was on administrative leave until 01/10/24, three days after the abuse allegation against her. Review of the Progress Notes tab in the EMR revealed the following notes: 01/08/24 11:15 AM . At this time resident reports that he is feeling safe at this time but is scared for her to come back. 01/08/24 12:21 PM DAILY SAFETY CHECK This writer went to check on resident due to pending abuse allegations. Resident anxious and reports that he did not sleep well last night. He is reporting that he is scared every time someone comes in the door it will be her. He does not want to be threatened anymore . Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Daily safety checks and urgent mental health evaluation. Review of a psychiatric evaluation, provided by the facility, date 01/08/24, revealed in the history, [R233] . presents for evaluation of potential abuse. Patient reports that an aide has been very rude to him and handles him roughly when she helps him with ADLs [activities of daily living]. Patient reports that yesterday morning, she threatened that if he touched his diaper again, he would 'regret it.' . He is frightened of her and is anxious she will come in the room again. Not sleeping well either as a result . Suspected aide is on administrative leave pending investigation . Further review of the EMR Progress Notes revealed the following: 01/9/24 at 1:08 PM Note Text: patient safety check: spoke with patient, upon approaching, patient noted to pull back as if afraid of approaching nurse. Asked patient how he was feeling, maintained distance so patient felt safe and ease in presence of nurse. listened to patients concerns regarding incident over weekend. patient confided that he was scared that he would be hurt and retaliated against. patient stated he is afraid someone would come in his room and rummage through and take his things. this nurse listened to patients fears and concerns, was able to reassure patient that he was safe and would not be retaliated against . patient visibly shaken and upset regarding event. reassured patient that if he had any other concerns to please let myself [sic] know and that it would be handled appropriately and timely. patient thanked me and smiled, confided that he felt safe at this time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/24 at 4:22 PM, Licensed Practical Nurse (LPN) 2 verified she wrote the note dated 01/09/24 at 1:08 PM. LPN2 stated, He [R233] was very pleasant and never withdrawn and I came in one day and there was an allegation that an aide had been rough with him, so they wanted us to do safety checks on him. He seemed very withdrawn, and he pulled back when I approached him and that was a new behavior . I remember him being afraid of staff [after the allegation of abuse was made]. Further review of the EMR Progress Notes revealed the following: 01/11/24 at 11:13 AM Note Text: Daily Safety Check. This writer spoke with resident this am [sic] with administrator present regarding how he is feeling. Resident states 'I ain't ever going to get over that, I could have been dead'. I asked if resident feels safe and comfortable in the building today, he states 'yes, thank god [sic] there isn't anyone else coming in and doing that.' Reports he slept a little better last night and wants to thank everybody for all that they have done for him. 01/11/24 at 3:00 PM DISCHARGE NOTE . GENERAL CONDITION OF RESIDENT UPON DISCHARGE: Resident clean, calm and cooperative. Alert and oriented x3. R233 was discharged to another nursing facility. 2. Review of FRI MD00196438 revealed missing narcotics for R11 (one oxycodone) and R232 (one oxycodone and one oxycontin) on 08/29/23. Final report. Medication became unaccounted for indefinitely. Employee states the medication was correct on count . Employee terminated . Nurses educated on narcotic count policy and safe handling of controlled medications. Facility is unable to determine what happened with the missing medication. However, residents remain safe and pain is controlled. Review of the EMR Progress Notes, Medication Administration Records (MARs), and Physician Orders for R11 and R232 verified that on 08/29/23 three pills total were unaccounted for but the residents did not have any complaints of unrelieved pain. Review of the Corrective Action Notice, provided by the facility and dated 08/26/23, revealed RN4 had three missing narcotics that were unaccounted for on shift change. [RN4] reports unsure of where they [missing narcotics] went. Agrees cart was correct during hand off. Nurse [RN4] walked out of the building with staff . Termination. During an interview on 11/01/24 at 3:00 PM, the Administrator and the [NAME] President of Clinical Operations (VPCO), were asked for all the documentation for this investigation. Review of the facility investigation, provided by the facility Administrator and the VPCO, revealed no written statements from R11 or R232 or other residents or from staff concerning the missing narcotics. The investigation included an audit of all residents in the facility, background checks on RN4, in-services of the nursing staff on medication administration and narcotic counts, and a copy of an Attorney General Subpoena State of Delaware for information on RN4. Review of the documentation revealed the administrative staff at the time of the incident were no longer employed at the facility. The Interim DON was unfamiliar with the incident since she had only been employed at the facility for a month prior to the survey. 31145 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 10/29/24 at 11:34 AM a review of Resident #65's medical record revealed an 8/7/24 physician's progress note that documented Resident #65 was seen by the Nurse Practitioner the day prior and Resident #65's daughter noticed bruising and swelling of the right hand. The physician documented, no known new injury. There have been no reports of new falls. The physician documented that when he saw the resident the previous week he did not notice any pain, swelling, or bruising of the hands and the family was not concerned last week regarding the resident's hands. No notification by any nursing staff regarding patient having a new injury from now until my last visit. The patient is in no distress at this time. [He/She] tells me [he/she] has some mild discomfort of [his/her] right hand. [He/She] cannot answer me whether [he/she] fell or not. I again asked nursing staff, and they report no known history of new injuries. X-ray was ordered by Nurse Practitioner yesterday and it came back showing a hairline nondisplaced fracture of the right second metacarpal. The physician documented there was musculoskeletal bruising and swelling over the dorsal surface of the right hand and mild pain with palpation of the right second metacarpal (finger). On 10/29/24 at 2:30 PM the Director of Nursing stated there were no reportable incidents related to Resident #65, therefore there was no investigation. On 10/31/24 at 7:45 AM an interview was conducted with the Nursing Home Administrator (NHA) about investigation of the new injury. The NHA stated she was told by Corporate that it wasn't a reportable because of the previous fall, therefore it was not investigated. The surveyor informed the NHA that the physician documented that no one knew how the resident got the bruise which was a week after the previous fall and the hand was swollen with a fracture. The NHA was asked how they could determine the cause of the bruise, swelling, and fracture if an investigation was not done. The NHA agreed that an investigation should have been done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215149	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Denton Nursing and Rehab	420 Colonial Drive Denton, MD 21629

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview it was determined the facility failed to provide timely treatment/services to prevent/heal pressures ulcers. This was evident for 1 (#65) of 4 residents reviewed for pressure ulcers. The findings include: A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). On 10/29/24 at 11:34 AM a review was conducted of Resident #65's medical record which revealed Resident #65 was sent out to the hospital on 10/7/23 and was readmitted to the facility on [DATE]. Review of the nursing admission assessment dated [DATE] documented Resident #65 had a pressure ulcer on the coccyx that was utd unable to determine length, width, depth, and stage. Review of a 10/25/23 wound note documented Resident #65 had a stage 3 pressure ulcer that was present on admission. Treatment orders were placed for the area to be cleansed with a wound cleanser, apply medical grade honey, calcium alginate to the base of the wound, secure with a bordered gauze and change daily. Review of Resident #65's October 2023 Treatment Administration Record (TAR) revealed the wound dressing was not started until 10/28/23. There were no treatments documented from 10/17/23 until 10/28/23. An interview was conducted with the Director of Nursing on 10/31/24 at 4:15 PM who confirmed the findings.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34484 Based on facility provided staffing documentation and interview, the facility failed to have a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days week. This was evident for 4 of 56 days reviewed during an annual survey. The findings include: Review of numerous complaints regarding low staffing from residents, staff and families during the annual survey, on 10/31/24 the Surveyor reviewed the following days for RN (Registered Nurse) coverage: 12/5/23-12/11/23, 12/29/23, 12/30/23, 1/24/24-1/30/24, 3/13-24/24, and 10/1/24-10/29/24. The following days did not have a RN as required on the staffing sheets provided by the Regional Director of Labor Management: 1/26/24 no RN coverage 1/28/24 no RN coverage 10/5/24 no RN coverage 10/20/24 no RN coverage Interview with the Regional Director of Labor Management on 11/1/24 at 8:40 AM confirmed the dates the facility failed to have a RN 8 consecutive hours a day.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards (Resident #19, #45 and #62). This was evident for 3 of 33 residents reviewed during an annual survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1. Review of Resident #19's medical record on 10/29/24 revealed the resident was admitted to the facility on [DATE]. On 10/30/24, Social Services Assistant was asked for evidence of care plan meetings for the last year. Social Services Assistant brought in evidence of care plan meetings in September 2023, November 2023, March 2024 and July 2024 on paper. Further review of Resident #19's medical record on 10/30/24 revealed the March and July 2024 care plan meetings are not in the resident's medical record. During interview with Social Services on 10/30/24 at 9:40 AM, Social Services stated she keeps evidence of care plan meetings in her office and tries to upload in the medical record when she can. Interview with the Director of Nursing on 10/31/24 at 2:20 PM confirmed the facility staff failed to include Resident #19's March and July 2024 care plan meetings in the medical record. 2. Review of Resident #45's medical record on 10/29/24 revealed the resident was admitted to the facility on [DATE]. On 10/30/24, Social Services Assistant was asked for evidence of care plan meetings for the last year. Social Services Assistant brought in evidence of care plan meetings in September 2023 and June 2024 on paper. Further review of Resident #45's medical record on 10/30/24 revealed the June 2024 care plan meetings are not in the resident's medical record. During interview with Social Services Assistant on 10/30/24 at 9:40 AM, Social Services stated she keeps evidence of care plan meetings in her office and tries to upload in the medical record when she can. Interview with the Director of Nursing on 10/31/24 at 2:20 PM confirmed the facility staff failed to include Resident #45's June 2024 care plan meeting in the medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #62's medical record on 10/29/24 revealed the resident was admitted to the facility on [DATE]. On 10/30/24, Social Services Assistant was asked for evidence of care plan meetings for the quarterly care plan meetings since admission. Social Services Assistant brought in evidence of care plan meetings in March, June and September 2024 on paper. Further review of Resident #62's medical record on 10/30/24 revealed the September 2024 care plan meetings are not in the resident's medical record. During interview with Social Services Assistant on 10/30/24 at 9:40 AM, Social Services stated she keeps evidence of care plan meetings in her office and tries to upload in the medical record when she can. Interview with the Director of Nursing on 10/31/24 at 2:20 PM confirmed the facility staff failed to include Resident #62's September 2024 care plan meeting in the medical record.