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	215149	A. Building B. Wing	09/04/2025

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, it was determined the facility failed to ensure that the resident's call light was within reach, per the individualized care plans, to allow access to assistance when needed. This was evident for 1 (#13) of 14 residents reviewed during a complaint survey. The findings include: On 9/3/25 at 10:00 AM observation was made of Resident (R) #13 lying in bed. R #13 asked the surveyor to hand him/her the hair brush that was on the night stand. At that time observation was made of the call bell lying on the floor in front of the oxygen concentrator. R #13 was asked how he/she called the nurse. R #13 stated that the call bell was usually on the top of the bed, but [name] took it away from him/her because he/she was ringing it too much. At that time the surveyor showed Certified Medicine Aide (CMA) #23 the call bell that was lying on the floor. CMA #23 placed the call bell on the bed.Review of R #13's medical record revealed an ADL (activities of daily living) care plan related to hemiplegia (paralysis or weakness on one side of the body) that was initiated on 10/21/24. The intervention on the care plan stated, encourage the resident to use bell to call for assistance.A second care plan, at risk for falls had the intervention, be sure the resident's call light is within reach on [his/her] right side and encourage the resident to use it for assistance.On 9/3/25 at 10:55 AM the acting Director of Nursing (DON) and Assistant DON were informed of the observation. They stated that they were made aware and they were investigating the incident.

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, facility documentation and interviews, it was determined the facility staff failed to notify a physician promptly when a resident had a change of condition (Resident #12) and failed to notify a resident's representative when a resident had medication changes (Resident #6). This was evident for 2 of 14 residents reviewed during a complaint survey.The findings include:1.Review of Facility Reported Incident 295918 on 8/27/25 revealed the facility reported to the Office of Health Care Quality (OHCQ) that on 11/28/24 the facility staff reported to the Resident's nurse (Staff #34) that Resident #12 was declining, and Staff #34 failed to assess the Resident timely. Review of Resident #12's medical record on 8/27/25 revealed the Resident was admitted to the facility in 2015 had diagnosis to include traumatic brain injury, heart and renal failure. Further review of Resident #12's medical record revealed Staff #34's nurse's note on 11/28/24 at 12:04 PM that stated: patient noted as difficult to arouse, lethargic, plan of care ongoing. Further review of Resident #12's medical record revealed Staff #8's nurse's note on 11/28/24 at 12:28 PM that stated: was called to resident room by another staff member to collaborate with another nurse on resident due to change in condition. Resident was cool to touch, difficult to palpate radial pulse, sternal rub-unable to rouse resident. 15 Liter NRB (non-rebreather) mask applied while EMS enroute to facility. EMS arrived and transported resident to the hospital. Interview with Staff #8 on 8/27/25 at 2:35 PM, Staff #8 stated she received a message that Staff #34 wanted her to come up the hall. Staff #8 stated when she arrived on the unit Staff #34 stated since I was the RN (registered nurse) on duty she wanted me to look at the Resident who was unresponsive. Staff #8 stated I asked for the vital signs and Staff #34 had not gotten them, so we got vital signs. The Resident blood pressure was in the 60s over 30s, it was hard to get a oxygen reading and I said the Resident needs to go to the hospital and I put him on 15 Liters NRB mask. During interview with Staff #12 on 8/27/25 at 2:44 PM, Staff #12 stated a GNA (geriatric nursing assistant) asked me to come look at Resident #12 because the GNA couldn't get the Resident to respond, had told Staff #34 and Staff #34 had not checked on the Resident. The GNA thought I might be able to get the Resident to respond. I also couldn't get the Resident to respond to me and Staff #34 was sitting at the desk and I asked her is she knew about the Resident, she said she knew, and I told her if she didn't do something I was going to report her to the State. It was about lunchtime. During interview with Resident #14 (Resident #12's roommate) on 9/3/25 at 10:20 AM, Resident #14 asked if he/she remember the day Resident #12 left the facility in November 2024. Resident #14 stated he/she did remember and the last time the Resident spoke to him/her was the night prior. Resident #14 stated he/she remembered staff bringing in the Resident's breakfast, but the Resident was not talking, and he/she was breathing heavy and fast. The Resident stated it wasn't until after lunch that they did anything. That is when people came in and they put oxygen on him/her and then sent the Resident out. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with Staff #23 on 9/3/25 at 10:31 AM, Staff #23 stated she was working on a different unit and 2 GNAs asked me to come and look at Resident #12. I went to see Resident #12 and shook him/her and tried a sternal rub but he/she was not responding. I went and told Staff #34 and she stated she had been in there and the Resident was okay. I think it was about 11 AM. Review of Staff #34's employee file revealed Staff #34 was a LPN (licensed practical nurse) and on 12/10/24 Staff #34 was terminated with the reason documented due to on 11/28 several staff members reported issues with Resident (#12) immediate action was not taken. Interview with the Assistant Director of Nursing on 9/3/25 at 10:45 AM confirmed Staff #34 did not notify Resident #12's physician timely on 11/28/24 when the Resident had a change in condition. 2.On 8/28/25 at 11:50 AM a review of complaint 295977 alleged there was no communication with the RP when there were medication changes. On 8/28/25 at 11:50 AM a review of Resident (R) #16's medical record was conducted. R #16 was admitted to the facility in August 2023 with diagnoses that included but were not limited to non-rheumatic aortic (valve) stenosis, hyperlipidemia, dementia, hypertension, atrial fibrillation, and heart disease. Review of physician's orders revealed on 3/6/25 the anti-psychotic medication Risperdal was changed from 0. 25 mg every day to twice per day. There was no RP notification found in the medical record. On 3/19/25 there was a new order for the anti-anxiety medication Buspar 5 mg. twice per day. There was no RP notification found in the medical record. On 4/16/25 the Risperdal dose increased to 0.5 mg twice per day. There was no RP notification found in the medical record. On 4/25/25 the Buspar frequency was increased from twice per day to three times per day. There was no RP notification found in the medical record. On 4/30/25 the Risperdal does was increased to 0.75 mg. twice per day. There was no RP notification found in the medical record. On 9/4/25 at 9:48 AM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she thought it was an issue before she started working at the facility but was not currently an issue. The ADON reviewed the medical record and confirmed there was no documentation related to RP notification.

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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. Based on review of facility reported incidents, record review, and interview, it was determined the facility failed to report an injury of unknown origin within 2 hours of becoming aware of the injury, to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (#1) 9 residents reviewed for 10 facility reported incidents during a complaint survey. The findings include: On 8/28/25 at 7:53 AM a review of facility reported incident 295995 was conducted and revealed on 4/6/25 at 5:38 PM a staff nurse was made aware of Resident #1 having a swollen, bruised left eye. Review of the facility's investigation revealed the resident had severe cognitive impairment and was unable to say what happened to his/her eye. Review of the email confirmation revealed the initial self-report was sent to OHCQ on 4/7/25 at 7:57 AM, which was not within 2 hours of being informed of a bruised and swollen eye that Resident #1 obtained while residing on the Memory Care Unit.On 9/3/25 at 10:55 AM an interview was conducted with the interim Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON and ADON confirmed the findings as it was initially unknown if the resident was hit, fell, or had some other mechanism of injury.

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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. Based on review of facility reported incidents, documents, and staff interview, it was determined the facility failed to provide documentation that allegations of misappropriation of property were thoroughly investigated. This was evident for 1 (#2) of 9 residents reviewed for facility reported incidents during a complaint survey. The findings include: On 9/2/25 at 11:52 AM a review of facility reported incident 295797 was conducted and revealed Resident #2 alleged that on 12/17/24 between 10:00 AM and 1:00 PM someone entered the resident's room and stole money, a gift card, and 10 gift certificates. Review of the facility's investigation revealed written statements from (3) geriatric nursing assistants (GNA), (1) from the previous Director of Nursing (DON), and (3) other staff in leadership positions. The facility failed to obtain interviews or statements from any of the nurses that were working, staff from previous shifts, housekeeping staff, maintenance staff, or dietary staff that would have had access to the resident's room. On 9/4/25 at 11:08 AM an interview was conducted with the Nursing Home Administrator (NHA) and Assistant Director of Nursing (ADON). They both confirmed that other staff should have been interviewed in the investigation process.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review and interview, it was determined that the facility staff failed to have quarterly care plan meetings for residents (Resident #9). This was evident for 1 of 14 residents reviewed during a complaint survey. The findings include:Once the facility staff completes an in-depth assessment (MDS) of a resident, the interdisciplinary team meet and develop care plans. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assure the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan are accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed. Review of Resident #9's medical record on 8/27/25 revealed the Resident was admitted to the facility in November 2022. Further review of Resident #9's medical record revealed the last quarterly care plan meeting was in December 2024. The facility staff completed quarterly MDS assessments on 3/17/25 and 6/17/25. The facility staff failed to have a quarterly care plan meeting in March and June 2025. Interview with Social Services Assistant on 9/3/25 at 12:25 PM confirmed there is no evidence the facility staff had a quarterly care plan meeting in March and June 2025. Interview with Resident #9 on 9/3/25 at 1:35 PM, Resident #9 stated he/she had not had any care plan meetings this year and has been asking for them. Interview with the Assistant Director of Nursing on 9/3/25 at 2:30 PM confirmed the facility staff failed to have a quarterly care plan meeting for Resident #9 in March and June 2025.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on a review of a complaint, medical record review, facility documentation review, and staff interviews, it was determined the facility failed to keep a dependent resident free from injury while transferring the resident from the bed to the chair via a Hoyer lift, which resulted in actual harm to Resident (R) #11. The failure of facility staff to follow the plan of care while transferring a resident resulted in bilateral sacral fractures and a L2 fracture. This was evident for 1 (#11) of 3 residents reviewed for falls. The findings include:A Hoyer lift is a mechanical device that uses a sling to safely lift and move a resident who is unable to transfer themselves between surfaces like a bed, wheelchair, or toilet. The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.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 care.On 8/27/25 at 10:35 AM complaint 295983 was reviewed and alleged that an aide put Resident #11, who was an amputee and paralyzed, in a Hoyer lift and dropped the resident onto the floor which resulted in Resident #11 being transferred to the hospital.A review of Resident #11's medical record was conducted and revealed Resident #11 was admitted to the facility in June 2024 with diagnoses that included, but were not limited to quadriplegia, anxiety, and acquired absence of left leg above the knee.Review of a 12/16/24 at 15:00 (3:00 PM) nurse's note documented, GNA (geriatric nursing assistant) came to get me stating resident fell. Resident states that [his/her] back is hurting mostly on the left side. The note stated, is requesting to go to hospital.A 12/17/24 at 8:55 AM Nurse Practitioner (NP) progress note documented, patient returned from hospital s/p fall with bilateral sacral fractures and L2 compression fracture. Patient with complaints of pain. Patient is alert and responsive but does not appear at full baseline at this time, frequently falling asleep. However, patient spent the night in the ER and has not slept. The assessment was, bilateral fractures to bilateral sacrum and L2 compression.A 12/17/24 at 10:12 AM IDT (interdisciplinary team) note documented, IDT met today to discuss resident's witnessed fall on 12/16/24. Intervention initiated is staff re-education on Hoyer transfers.A 12/18/24 physician's note documented, is being evaluated following a fall while in a harness, landing on the buttock region. [He/she] was sent to the emergency department, where a CT scan revealed a bilateral sacral fracture and a mild L2 compression fraction. The patient reports experiencing mild pain with movement, which occurs even with assistance, as [he/she] is quadriplegic and requires help for mobility. The note documented the resident had quadriplegia after acute trauma after an MVA (motor vehicle accident) in 2009. The plan documented that a neurosurgery consult was placed. Tylenol was ordered every 6 hours for pain relief as the resident preferred not to take Oxycodone, but had it ordered if needed.Review of GNA #16's witness statement documented that Resident #11 wanted to get up. I grabbed one of the two slings placed in [his/her] chair. I placed the smallest sling under [him/her] while crossing the bottom of it. As I lifted [him/her] and proceeded to move [him/her] from the bed to chair. I hit the end of the bed with the wheel of the Hoyer, and [he/she] slipped through the sling and fell to the floor, bottom first. The GNA documented that she placed pillows under the resident and went to get the nurse.Review of Resident #11's 10/14/24 MDS assessment documented in Section GG0115 that the resident had impairment on both sides, upper and lower; dependent for all ADLs (activities of daily living.)Review of R #11's care plan, has an ADL self-care performance deficit r/t paralysis, that was initiated on 1/25/24, had the intervention, the resident requires Hoyer Lift with 2 staff assistance for transfers with a date initiated of 4/30/24.Review of the actual nursing schedule for 12/16/24 documented that there was 1 nurse (LPN #15) and 2 GNAs (GNA #16, and another GNA) for the 300 unit, the unit where R #11 resided. It was noted that GNA #16 was assigned to unit 300 and unit 400, therefore GNA #16 had a split assignment.On 8/28/25 at 8:10 AM an interview was conducted with LPN #15 who stated, I remember them coming to get me that [he/she] fell out of the Hoyer lift. I called the doctor and 911 and had [him/her] sent to the hospital. LPN #15 stated that they told her GNA #16 was transferring the resident by herself. I think we were short staffed that day. We worked short a lot. It happened at the end of day shift. I thought it was a lot taking care of people for the GNAs when short staffed. When I went in there the resident was on the floor. I can't remember if [he/she] was in pain. It was so busy, crazy that day and I was the only nurse on those 2 hallways.On 8/28/25 at 9:25 AM an interview was conducted with Staff #17, the previous Director of

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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. Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to follow physician ordered blood pressure and heart rate parameters for administering a blood pressure medication. This was evident for 1 (#6) of 13 residents reviewed during a complaint survey. The findings include: On 8/28/25 at 11:50 AM a review of Resident (R) #6's medical record was conducted. R #6 was admitted to the facility in August 2023 with diagnoses that included but were not limited to non-rheumatic aortic (valve) stenosis, hyperlipidemia, dementia, hypertension, atrial fibrillation, and heart disease. Review of R #6's physician's orders revealed the order for Metoprolol Tartrate 100 mg. two times per day related to hypertension (high blood pressure) and atrial fibrillation. Atrial fibrillation (AFib) is a heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly. The physician's order stated to hold for b/p (blood pressure) less than 110/65 and HR (heart rate) less than 65.Review of R #6's May 2025 Medication Administration Record (MAR) documented on 5/15/25 in the PM that the HR was 60. The medication was given. On 5/30/25 in the AM the b/p was 105/71 and the medication was given. Review of R #6's June 2025 MAR documented on 6/16/25 in the AM the HR was 62, 6/17/25 in AM the b/p was 109/64, and on 6/27/25 in the AM the HR was 59. The medication was given each time.Review of R #6's July 2025 MAR documented on 7/14/25 in the PM the HR was 62. The medication was given. Review of R #6's August 2025 MAR documented on 8/12/25 in the AM the HR was 61, on 8/13/25 in the AM the HR was 62, and on 8/23/25 in the PM the HR was 62. The medication was given. Review of R #6's September 2025 MAR documented on 9/2/25 in the AM the HR was 60. The medication was given. On 9/4/25 at 8:12 AM an interview was conducted with Staff #30. The surveyor reviewed the physician's order with her for the Metoprolol. Staff #30 stated that she would hold if one or the other was below parameters, either the blood pressure or heart rate. When the surveyor read the order to her with the word and she said, it should be or. Staff #30 stated, if there is a question about whether to hold or not hold the medication, I would call the physician.On 9/4/25 at 8:18 AM an interview was conducted with Physician #31. The surveyor read the order to him and asked if staff should hold only if both the b/p and the HR were outside of parameters as the order read. Physician #31 stated, no, if the HR is below 65 the med should be held or if the b/p was below 110/65 the med should be held. Physician #31 agreed that the order should have read OR so he changed it at that time. Physician #31 was informed of the times when the medication was given when it was outside of the physician ordered parameters. Physician #31 stated he would expect a phone call if there was a question about whether to hold or give the medication. On 9/4/25 at 9:33 AM the issue was discussed with the Assistant Director of Nursing (ADON), Nursing Home Administrator (NHA) and Staff #32. They all agreed the order should have said OR and not and. They were informed of the days that the medication was given when outside of physician ordered parameters.

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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. 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 #5). This was evident for 1 of 14 residents reviewed during a complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. Review of Resident #5's medical record on 8/27/25 revealed the Resident was admitted to the facility in 2018 with a diagnosis to include cerebral infarction (stroke) and hemiplegia affecting left nondominant side. Hemiplegia is the total paralysis or severe loss of strength on one side of the body, affecting the arm, leg, and sometimes the face. It results from damage to the brain, often caused by stroke, brain tumors, or trauma. Review of Complaint 295996 on 8/27/25 revealed Resident #5 had lost his/her nursing home level of care, and the facility was looking into discharge options. During interview with the Social Services Assistant (SSA) on 8/27/25 at 11:49 AM, the SSA was asked about the Resident's loss of nursing home level of care. SSA stated he/she received notice the Resident had lost his/her level of care, our Regional MDS (Minimum Data Set) Coordinator appealed the findings in July 2025 and the Resident was again denied his/her level of care. SSA stated he/she had discussed the findings with Resident #5 and his/her representative. The Surveyor at that time asked for the paperwork submitted for nursing home level of care. Review of Resident #5's facility documentation provided to appeal the nursing home level of care revealed the documented diagnosis was personal history TIA (Transient Ischemic Attack) and Cereb Infarct (Stroke) no residual deficit. Further review of the facility documentation of electronic medical records submitted revealed it did include all of the Resident's diagnosis, including hemiplegia affecting left dominant side but this diagnosis was not included on the Resident's information sheet. Further review of Resident #5's medical record on 9/3/25 revealed no care plan meeting after April 2025 and no evidence of a discussion of loss of level of care in the Resident's medical record. On 9/3/25 at 11:50 AM, Social Services Assistant was asked for evidence of a care plan meeting since April 2025. On 9/3/25 at 12:25 PM the Social Services Assistant brought in evidence of a care plan meeting was held on 7/1/25 for Resident #5 on paper. During interview with Social Services on 9/3/25 at 12:25 PM, Social Services Assistant stated she keeps evidence of care plan meetings in her office, and the former Director of Nursing would upload the care plan meeting notes in the medical record but was unsure who was doing that now. During interview with the Regional MDS Coordinator (Staff #26) on 9/3/25 at 12:50 PM, Staff #26 stated she would change the diagnosis to include Resident #5's hemiplegia. During interview with the Assistant Director of Nursing (ADON) on 9/3/25 at 1:40 PM confirmed the facility staff failed to include Resident #5's July 2025 care plan meeting, and discussions with Resident and representative regarding loss of level of care in the medical record. The ADON also confirmed the diagnosis of no residual deficit was documented instead of left side hemiplegia. At that time the ADON stated the facility would be resubmitting paperwork for the Resident #5's nursing home level of care.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and staff interviews, it was determined that the facility failed to correct and monitor quality deficiencies identified on the previous survey. This was evident for 3 out of 19 deficiencies reviewed in the revisit survey. The findings include: On 11/13/2025 at 2:30 PM, A review of the survey teams findings revealed that the facility did not follow their plan of correction for 3 deficiencies (F610, F842, and S1320). Of these 3 deficiencies, S1320 was found to still be in noncompliance.On 11/14/2025 at 8:06 AM, the Director of Nursing (DON) stated that the facility's Quality Assurance (QA) contact person was the Administrator.On 11/14/2025 at 8:45 AM, an interview with Administrator was conducted. When asked how often they hold QA meetings, the administrator stated every month. When asked if there was a QA meeting after the facility received the deficiencies from the Office of Health Care Quality, they stated that they did meet. When asked if the QA team/committee discussed the citations and progress of the plan of correction, the administrator stated not really because they have been working on correcting the deficiencies since the survey. This surveyor expressed concern that all the tags in the Plan of Correction stated that the QAPI team will review all of the audits. This surveyor made the administrator aware that the plan of correction was not followed for 3 deficiencies (F610, F842, and S1320), and the on going concern related to a qualified social worker.

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	09/04/2025

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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 0921 Level of Harm - Actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0921 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility documentation and interview, it was determined the facility failed to provide a safe and functional environment resulting in psychosocial and physical harm to a resident (Resident #9). This was evident for 1 of 79 residents in the facility on 1/24/25 and reviewed during the complaint survey.The findings include:Review of facility documentation provided by the Administrator on 8/27/25 revealed the Office of Health Care Quality (OHCQ) conducted a Life Safety Code complaint survey on 1/29/25 and found the facility was cited for not maintaining temperature in the attic to prevent pipes from freezing causing the pipes to rupture. During interview with the Director of Maintenance (DM) on 9/2/25 at 11:05 AM, The DM stated the pipes were not insulated and the broken pipes caused the ceiling to collapse on Resident #9 who was in room [ROOM NUMBER] on 1/24/25. The DM stated no other residents were affected. The DM stated the facility has implemented their plan of correction, the pipes have been insulated, and he is doing temperature checks in the attic regularly.Review of Resident #9's medical record on 8/27/25 revealed the Resident was admitted to the facility in November 2022 with a diagnosis to include quadriplegia. Quadriplegia is a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso. The facility staff assessed the Resident on 12/15/24 to have a BIMS (Brief Interview for Mental Status) out of 15 which indicates the Resident has a fully intact cognitive function.Further review of Resident #9's medical record revealed a Change of Condition Assessment on 1/24/25 that stated: Pipe burst above resident room causing ceiling to collapse on top of resident and resident to be covered in water, insulation and drywall.During interview with Resident #9 on 8/27/25 at 10:45 AM, the Resident stated on 1/24/25 he/she heard water sounds and then saw water dripping from the ceiling by his/her feet and he/she called the front desk to get help. Resident #9 stated staff did come in, but it was too late, and the ceiling crashed on me and water was pouring on me. He/she stated I felt like I was drowning and was coughing. I couldn't move myself and it took them a few minutes to get me out of the room. The resident also stated that every time it rains; he/she is afraid it is going to happen again. Further review of the Resident's medical record revealed the Resident was sent to the emergency room on 1/24/25 and the triage note stated: Patient arrives after a piece of dry wall fell on him/her. A pipe burst in the ceiling and water was pouring on him/her for approximately 5 minutes until staff arrived to move him/her to another bed. The Resident received a CT scan of the head which showed no acute intracranial hemorrhage. The discharge instructions included lots of fluids, Tylenol or Motrin for pain and fever, follow-up with your primary care and the Resident was sent back to the facility on 1/24/25.Further review of Resident #9's medical record revealed the Resident was seen by the Physician (Staff #31) on 1/27/25 who diagnosed the Resident with cervical spine and lumbar strain. The Physician documented that the Resident was complaining of neck and back pain. The patient reports that baclofen, Tylenol, a short course of Flexeril, and ibuprofen (Motrin) as needed have not alleviated his/her symptoms. At that time the Physician ordered Oxycodone 5 mg every 6 hours as needed for pain for 14 days for the Resident.Review of Resident's Medication Administration Records (MAR) for January, February, March, April and May 2025 revealed the Resident was administered Oxycodone 5 mg twice a day from 1/27 through 1/31/25; at least once a day from 2/2 through 2/28/25; at least once a day in March 2025 except 3/9 and 3/22/25; at least once a day in April 2025 except 4/9, 4/15, 4/20, 4/29 and 4/30/25; and in May 2025 received Oxycodone 5mg on the following days: 5/1, 5/2, 5/6, 5/7, 5/11, 5/12, 5/15, 5/16, 5/17, 5/18, 5/19 and 5/21/25.Review of the Neurologist consultation on 5/16/25 revealed the Neurologist documented patient reports lower back pain since an incident on 1/24/25 when a ceiling fell on him/her. An MRI conducted on 5/6/25 showed a mild disc bulge at L5-S1. Mild disc bulge may be due to injury. The Resident is scheduled for a follow up Neurologist appointment 9/16/25. At that time the Neurologist recommended to continue physical therapy and may increase Oxycodone for better pain control.Review of Resident #9's physician orders revealed the Oxycodone 5 mg was discontinued on 5/22/25 and the Resident was ordered Suboxone film 4-1 mg every 24 hours as needed for pain. Further review of Resident #9's pain medication orders on 9/2/25 revealed the Resident is currently ordered Buprenorphine-Naloxone 2-0.5 mg 3 tablets every 24 hours as needed for pain with the last dose received on 9/2/25. Review of a psychiatric evaluation and consultation note dated 1/30/25 revealed it stated: seen for psych follow-up per facility request following a flood on the 300 unit. The patient is currently relocated to a new room. He/she reports the roof fell on him/her, and this has worsened his/her PTSD (Post Traumatic Stress Disorder) Review of a psychological services progress