STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215160	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellicott City Healthcare Center	3000 North Ridge Road Ellicott City, MD 21043

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48259 Based on record review, observations, and interviews, it was determined that the facility failed to maintain residents' dignity by staff standing over residents while assisting them to eat. This was evident for 2 (#48, #140) of 2 residents reviewed for dignity. The findings include: 1) A medical record review for Resident #48 on 9/3/24 at 9:50 AM showed that the Resident was admitted to the facility in July 2024 with diagnoses including dementia. Continued review noted that he/she required staff assistance with eating. During a meal observation on 9/4/24 at 8:09 AM, staff #41 was noted feeding Resident #48 while standing. An interview with staff #41 on 9/4/24 at 8:37 AM revealed that she was unaware that feeding a resident while standing was a dignity concern. In an interview on 9/4/24 at 9:41 AM, staff #33, a unit manager, reported that staff was expected to sit at eye level when assisting residents to eat and not to stand because of dignity concerns. 2) A meal observation on the Dogwood unit on 9/4/24 at 8:27 AM showed staff #40, a geriatric nurse aid (GNA), standing over Resident #140, who was lying in bed while assisting him/her in eating breakfast. Staff #40 was questioned then and stated that she was unaware that she had to sit down while assisting in feeding a resident. A medical record review for Resident #140 on 9/4/24 at 8:34 AM showed that the Resident had been living in the facility since December 2023, was confused, and required assistance with his/her care needs. In an interview on 9/4/24 at 11:52 AM, the DON said that staff was expected to sit while feeding residents because of their dignity. The DON also added that staff would be educated.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 37296 Based on observation and interview, it was determined that the facility staff failed to display the results of the annual recertification survey and plan of correction in a place readily accessible to residents, family members, and legal representatives. This was evident in the 1 of 1 survey results book posted in the facility. The findings include: Surveyor observation of the lobby from 8/27/24 through 9/9/24 revealed no evidence of the State inspection results in an open and readily accessible area for residents, staff, and visitors to review. A Sign was not posted telling residents where the state survey results were located. On 9/9/24 at 9:30 AM, an interview with the Nursing Home Administrator confirmed the facility staff failed to place the results of survey inspections in a place easily accessible to any persons to be reviewed.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 30428 Based on medical record review secondary to a complaint, interview with representatives and facility staff, it was determined that the facility failed to notify the correct resident representative when there was a documented change in condition. This was evident during the review of 1 of 4 residents reviewed with pressure ulcers. The findings include: Interview on 8/27/24 at 12:30 PM with the representative for Resident #463 revealed multiple concerns including that s/he was power of attorney (POA) for Resident #463 and was not notified of the changes that occurred with him/her. The concern was that there was a decline and Resident #463 eventually passed away 6/4/24. The POA verbalized that they were not included in the changes and care with Resident #463. Review on 8/28/24 at 10:53 AM of the medical record for Resident # 463 revealed diagnosis including multiple sclerosis (a chronic disease of the central nervous system, resulting nerve damage disrupts communication between the brain and the body) with contractures. This review revealed that there were 17 changes in condition 'eInteract' forms completed for Resident #463 between 10/10/23 and 3/14/24 where there was consistency that the POA was not notified of the changes in condition. Of these 6 of 11 of these changes in condition that required notification to the resident's representative did not occur. The changes in conditions documented the resident was notified as 'self rp (representative)' not the medical power of attorney that was identified in Resident #463's Advanced Directives from 2/17/16, available in the electronic medical record. This was reviewed with the Regional Nurse on 9/6/24 when the eInteract documentation was requested. This concern was reviewed with the facility throughout the survey and again on 9/6/24 at 1:05 PM with the Regional nurse and the Nursing Home Administrator.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48259 Based on record review and interviews, it was determined that the facility failed to ensure that Beneficiary Protection Notifications were issued to 1) a resident who was discharged from Medicare-covered Part A stay with benefit days remaining and was discharged from the facility to his/her home and 2) Residents who were discharged from Medicare Part A services but had benefit days remaining and intended to remain at the nursing facility receiving non-skilled care. This was evident for 3 (#514, #147, #65) of 3 residents reviewed for Skilled Nursing Facility Beneficiary Protection Notification. The findings include: Residents with Medicare Part A have certain rights and protections related to financial liability and appeals. The financial liability, appeal rights, and protections are communicated to beneficiaries through notices given by providers to residents who are being discharged from Medicare services but have Medicare benefit days remaining. The notices include: Notice of Medicare Non-Coverage (NOMNC): This must be issued at least two calendar days before the last day of Medicare coverage. The NOMNC informs the beneficiary of his/her right to an expedited review of services termination. The resident and/or their representative must receive a copy of the notice in enough time to appeal the decision to terminate the paid coverage. The facility must indicate that the notice was sent/and/or given within the specified time. Skilled Nursing Facility Advance Beneficiary Notice (SNFABN): This notice must be issued far enough before delivering potentially noncovered services to allow sufficient time for the beneficiary to consider all available options. 1) A review was completed on 9/5/24 at 8:49 AM of Resident #514's Beneficiary Notification checklist completed by the facility. The review showed that the facility started the resident's Medicare Part A services on 5/8/24 and ended on 7/16/24. Continued review noted that the facility initiated Resident #514's discharge from Medicare Part A services when benefit days were not exhausted. However, the review failed to show that a NOMNC was issued to the resident or his/her representative. In an interview on 9/5/24 at 1:24 PM, staff #15, the social services director, confirmed that there was no proof of documentation showing that a NOMNC was issued to Resident #514 when Medicare A services ended on 7/16/24. 2) Record review on 9/5/24 at approximately 9:20 AM, of the Beneficiary Notification checklist completed and provided by the facility to the survey team showed that Residents #147 and #65 remained in the facility after the last day of their Medicare coverage. However, the review did not show that Residents #147 and #65 were issued SNFABNs. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SNFABNs should have been provided to Residents #147 and #65 when their skilled services ended. This would have allowed them a choice as to whether to continue non covered items or services. The notice would have estimated the cost of the services and listed the reasons Medicare may not pay. In an interview on 9/5/24 at 9:51 AM, staff #15 reported that the social services team was in transition and was unaware that SNFABNs were a requirement. Staff #15 was unable to provide evidence that SNFABNs were issued to Residents #147 and #65 when their Medicare A services ended with benefit days remaining, and they continued to stay in the facility.

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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. 31145 Based on review of a facility reported incident with investigation, medical record review, and interviews, it was determined the facility staff failed to protect a resident from verbal abuse from facility staff. This was evident for 2 (#47, #54) of 8 residents reviewed for abuse during an annual and complaint survey. The findings include: 1) On 9/4/24 at 11:30 AM a review of Resident #47's medical record revealed Resident #47 had resided at the facility for the past 8 years. Resident #47 had diagnoses that included post-traumatic stress disorder, schizoaffective disorder-bipolar type, anxiety disorder, and major depressive disorder that was recurrent and moderate. On 9/4/24 at 11:30 AM a review of facility reported incident MD00196514 was conducted and revealed on 9/3/23 at approximately 8:00 AM Resident #47 alleged that Housekeeping Staff #37 screamed and yelled at the resident. Review of Staff #38's written statement documented that Resident #47 was out of the room receiving morning medication. When Resident #47 went back to his/her room and walked into the bathroom, Staff #37 started yelling that Resident #47 could not go in the bathroom because Staff #37 had just sprayed. The statement documented that Resident #47 and Staff #37 started arguing and Resident #47 felt threatened. Resident #47 told Staff #38, I feel threatened as I sit here. I do not know what she is going to do to me. I feel like she has an anger issue. Resident #47 stated, In the midst of the argument she picked up a white trash can and threw it on the ground, all the trash fell out all over the floor. Then she left. Staff #38 documented, this writer provided resident with emotional support. Resident felt calm after reporting the situation. [He/she] stated, I do not want her to clean my room any longer. I do not wish to be near her. Review of Staff #39's written statement documented that she met with Resident #47 on 9/4/23 and asked what happened and Resident #47 stated that the resident was getting ready doing morning routine and went to get his/her morning meds. When Resident #47 came back Staff #37 yelled, no, no, no, you can't go in there. I just sprayed. The resident responded, I've asked you not to come in here until I'm finished getting ready. Staff #37 replied, I can come in here any time I want. The resident stated that was when Staff #37 picked up the trashcan and threw it down and all the trash came out and she then walked out of the room. Review of a witness statement from Resident #47's roommate documented, the housekeeper was upset because my roommate went into the bathroom after she mopped the floor. They had words. Staff #38 asked the roommate if the housekeep was yelling and the roommate stated, she yells at everybody. Yes. On 9/5/24 at 7:32 AM an interview was conducted with housekeeping staff #19. Staff #19 was asked about housekeeper #37 who was involved in this case, and she stated, yes, she would yell and could be nasty. Everybody here knew she always had an attitude around the residents being disrespectful. The nurses would report that she was rude to some of the residents. She was written up and terminated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's conclusion to the investigation documented, based on resident interviews, the facility is substantiating this allegation. Other residents stated they heard the altercation between this staff and the resident and resident's roommate stated that the associate yells. Recommendations made to [name of housekeeping group] that this facility is requesting that this staff no longer provide any services to the residents in this facility to avoid exposing other residents to the same behavior pattern. Review of the Employee Corrective Action (ECA) form for Staff #37, dated 9/7/23, documented the performance background as; 10/5/21 poor performance/rule violation/insubordination - documented counseling; 5/4/22 poor performance/rule violation - workplace violence - final written ECA; and 3/15/23 poor performance/rule violation - written warning. Staff #37 was terminated for failure to follow workplace rules, patient/resident abuse/neglect per page 17 of the employee handbook, violation of patient's/resident's rights per page 18 of the employee handbook, and failure to follow the company's principal business practices per page 2 of the employee handbook. On 9/10/24 at 9:45 AM the case was discussed with the Director of Nursing (DON). The DON was not employed at the facility at the time of the incident. 37586 2. Record review on 8/29/24 at 1:22 PM revealed the facility's investigation related to facility reported incident #MD0000205524 and complaint # MD00207282. Facility investigation revealed the facility substantiated through witnesses (staff # 9) and (staff #10 and staff # 11) that Resident # 54 was verbally abusive and used inappropriate language while outside in the courtyard smoking with other residents. Resident # 54 used inappropriate language towards Resident # 37, calling resident # 37 a B***h and N***a. Resident # 37 asked resident 54 to stop and not call others names. Resident # 54 continued to call resident # 37 a b***h. Resident # 37 stood up and hit resident 54 on the side of the face and knocked Resident #54 out of the wheelchair to the ground and continued to hit the resident while on the ground. Resident # 54 received an abrasion to the knee and face. Staff were able to break up the residents. The police were called and resident # 54 went to the hospital for an X-ray of the head. Resident returned to the facility the following day. Resident # 54 had no fractures or major injuries except for lacerations to the head. No stitches were required. Psych. followed up with both residents and responsible parties were notified. An interview with staff # 9 and staff # 11 conducted on 8/29/24 around 2 PM confirmed the incident that occurred between the two residents.

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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. 31145 Based on reviews of facility reported incidents with documentation and interview, it was determined the facility failed to report allegations of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 3 (#165, #47, #42) of 8 residents reviewed during the annual and complaint survey. The findings include: 1) On 9/3/24 at 11:45 AM a review of facility reported incident MD00199871 was conducted and revealed a written statement from RN #12 that documented around 4:00 AM on 11/25/23 RN #12 received a call from LPN #1 to come to Resident #165's room to check on the resident. RN #12 documented that she immediately went to the resident's room to find out what happened, and the resident stated, the black big guy raped me with his hand and some equipment. It was around 5:30 PM yesterday. Review of the Facility Reported Incident Initial Report Form documented the initial report was sent to OHCQ on 11/25/23 at 8:30 PM, which was not within 2 hours of an alleged sexual abuse. There were no email confirmations provided to the surveyor to corroborate the exact time the report was submitted to OHCQ. On 9/3/24 at 2:00 PM the Director of Nursing (DON) confirmed that it was not sent in within 2 hours. On 9/5/24 at 10:47 AM an interview was conducted with Staff 35 (Regional Nurse) who stated, they told us when we started the new way of reporting that we would need the email confirmations. 2) On 9/4/24 at 11:30 AM a review of facility reported incident MD00196514 was conducted and revealed on 9/3/23 at approximately 8:00 AM Resident #47 alleged that Housekeeping Staff #37 screamed and yelled at the resident. Review of the written statement from Staff #38, Staff #38 wrote that she was informed on 9/4/23, however there was no time on the statement. There were no email confirmations that were produced to confirm the date and time the initial report was sent to OHCQ. The date in the upper left-hand corner of the Comprehensive and Extended Care Facilities Self-Report Form documented, 4 September 2023 with a time of 1529 (3:29 PM). However, the final self-report also had the time as 1529. On 9/4/24 at 12:30 PM an interview was conducted with the NHA who stated he would look for email confirmations, but he couldn't find any previous email confirmations for any of the other self-reports and that was before his time in the facility. On 9/5/24 at 10:47 AM an interview was conducted with Staff 35 (Regional Nurse) who stated, they told us when we started the new way of reporting that we would need the email confirmations. On 9/9/24 at 11:33 AM an interview was conducted with the NHA who stated that they only keep 30 days' worth of emails and if they don't have an email then it wasn't done. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 9/9/24 at 10:22 AM a review of facility reported incident MD00204472 documented a report was received from the hotline and Ombudsman that Resident ##42 stated he/she was neglected due to not receiving showers as scheduled on 3/26/24 and 3/30/24. Review of the investigative packet that was given to the surveyor revealed the date the incident was first reported to OHCQ was on 4/1/24 at 2:30 PM. However, a corporate incident management document revealed corporate became aware on 3/30/24 at 7:31 PM via the corporate hotline. It was a red alert, and the case number was 7388. There were 21 people listed on the case access list. The DON did not become aware until 4/1/24 at 12:30 PM according to the facility reported incident. There were no email confirmations to validate when the initial report was sent to OHCQ. On 9/9/24 at 11:33 AM an interview was conducted with the NHA who stated that they only keep 30 days' worth of emails and if they don't have an email then it wasn't done.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 48259 Based on interviews and medical record review, it was determined that the facility failed to notify residents and/or their representatives in writing of the facility's bed hold policy upon transfer to an acute care facility. This was evident for 2 (#126, #39) of 7 residents reviewed for hospitalization . The findings include: 1) An interview with Resident #126's representative on 8/29/24 at 1:59 PM revealed that Resident #126 had been hospitalized recently. The representative stated that the facility staff discussed the bed hold policy with her via the phone and not in writing. A medical record review for Resident #126 on 9/6/24 at 7:53 AM showed that the Resident was admitted to the facility in February 2023. Continued review revealed that Resident #126 was having difficulty breathing on 7/31/24. The attending provider was notified and ordered Resident #126 to be transferred to the hospital for evaluation. However, the review failed to show that a copy of the facility's bed hold policy was mailed to the Resident's representative. In an interview on 9/6/24 at 9:52 AM, the assistant director of nursing (ADON) reported that Resident #126's representative was made aware of the acute transfer to the hospital; however, the bed hold policy was not mailed. The ADON also added that the facility was working on improving the process. 2) A medical record review for Resident #39 on 9/4/24 at 1:00 PM contained a nurse's note dated 8/30/24 that stated that the Resident had a change in condition and was transferred to the emergency room for evaluation. The review showed that the Resident's representative was notified of the transfer. However, continued review failed to show that Resident #39's representative was notified in writing of the facility's bed hold policy. In an interview on 9/4/24 at 1:50 PM, staff #20, a licensed practical nurse, reported that the bed hold policy was typically discussed with the Resident's representative via phone and then printed out for the social services department, which mailed it to the Resident's representative. During an interview with the social services director on 9/4/24 at 2:01 PM, he said that he did not receive documentation for Resident #39's bed hold policy so he did not mail one to the representative upon the Resident's transfer to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on medical record review, interviews and observation, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for 2 (#27, #75) of 6 residents reviewed for unnecessary medications, 1 (#92) of 6 residents reviewed for limited range of motion (ROM), 1 (#563) of 7 residents reviewed for accidents, and 1 (#20) of 1 resident reviewed for dental. The findings include: The Minimum Data Set (MDS) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and modify the care plan based on the resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need. 1) A record review on 8/29/24 at 11:24 AM showed that Resident #27 was admitted to the facility in August 2019. Continued review found an MDS assessment dated [DATE] for Resident #27. The MDS had recorded antiplatelet use in section N. A continued review of Resident #27's medical record showed a medication administration record for June 2024 with no documentation of antiplatelet use for the observation period of the MDS assessment. Further review of the record failed to show an attending provider's order for antiplatelet use during the look-back period for the MDS assessment. An interview on 9/6/24 at 11:51 AM with staff #7 confirmed that Resident # 27's MDS assessment dated [DATE] was documented with antiplatelet. Staff #7 was asked to provide supporting documentation. In a subsequent interview later the same day, staff #7 stated that there was no documentation to support the documentation of antiplatelet on Resident #27's MDS of 6/26/24 and that it was recorded in error. 2) Observation of Resident #92 on 8/30/24 at 1:35 PM noted that he/she was lying in bed in a fetal position (lying on the side with knees up to the chest, and arms curled). Staff #36, a geriatric nurse aide was present and asked the resident to stretch out. Resident #92 was able to stretch out all upper and lower extremities. A record review on 8/30/24 at 2:35 PM for Resident #92 showed that he/she had been residing in the facility since November 2020. The review contained an MDS assessment dated [DATE]. The MDS had recorded in section GG that Resident# 92 had no functional limitations in ROM. However, further review noted documentation in another MDS assessment dated [DATE] that Resident #92 had impairment in ROM to both sides of his/her upper and lower extremities. An interview on 9/5/24 at 11:37 AM with staff #7, MDS coordinator, with staff #35, regional nurse present, showed that Resident #92 had no limitation in ROM to all sides of his/her extremities and that the MDS assessment dated [DATE] was coded in error. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31145 3. On 9/3/24 at 9:17 AM Resident #563's medical record was reviewed and revealed a nurse's note written on 3/3/24 that documented, patient was found by staff sitting on the floor in front of [his/her] wheelchair beside [his/her] bed. Review of the MDS with an assessment reference date of 3/15/24 documented in section J1800, Falls since admission/entry or reentry or prior assessment, no. The MDS failed to capture the fall of 3/3/24. Review of Section J0100, received scheduled pain medication regimen documented, no. Review of Resident #563's March 2024 Medication Administration Record (MAR) documented that Resident #563 received Gabapentin 300 mg. at bedtime for neuropathic pain every evening. The MDS failed to capture the use of Gabapentin for pain relief. Further review of the March 2024 MAR documented the resident received Mirtazapine, an antidepressant, Lasix which is a diuretic, Plavix which is an antiplatelet medication and Aspirin which is an antiplatelet medication. Review of Section N, Medications, of the 3/15/24 MDS failed to capture the use of antidepressants, diuretics, and antiplatelet medications. On 9/3/24 at 12:45 PM the fall and medications were reviewed with the MDS Coordinator. On 9/3/24 at 1:46 PM the MDS Coordinator confirmed the errors to the surveyor. 30428 4. During initial interview on 8/29/24 at 8:44 AM with Resident #20, it was revealed that s/he had some visible missing teeth on the upper and lower jaw. S/he verbalized at that time that s/he has been to a dentist recently and there were recommendations, but s/he does not think that there has been any follow up. Resident #20 then showed this surveyor a loose tooth in the front bottom right of his/her mouth. There was no pain reported but some discomfort. S/he reported that they were just waiting for it to fall out. A review of the medical record on 8/29/24 at 9:04 AM for Resident #20 revealed a dentist visit on 8/14/24 with recommendations for Peridex to improve oral health. The consult noted that nursing staff is to provide Peridex-a prescription oral mouthwash for gum disease and gingivitis, to be administered on a swab twice a day. A review of Residents medical record on 9/3/24 at 11:21 AM failed to reveal any order for the Peridex solution. The DON was interviewed on 9/3/24 at 11:20 AM. She followed up with the surveyor at 12:43 PM and reported that the consult recommendations were not added to the physician orders and medication administration record. A review of the 12/7/23 significant change MDS under section L dental for z0200- documented 'no' for dental issues and failed to identify that there were any broken or loose natural teeth. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS coordinator was interviewed on 9/3/24 at 12:43 PM. The concern was reviewed regarding the coding of Resident #20's teeth on the significant change MDS. She had visited with the resident prior and confirmed with the surveyor the dental findings. 5. Review of the medical record on 9/5/24 at 8:56 for Resident #75 revealed multiple comorbidities including the presence of a tracheostomy, chronic pain, diabetes mellitus, atrial fibrillation and insomnia. A review on 9/5/24 of the admission MDS for section 'O' special treatments and programs, failed to identify that Resident #75 was receiving oxygen on admission. A review of the ordered medication for Resident #75 revealed that s/he was receiving an antidepressant, anticoagulant, insulin and a diuretic. These medications are monitored and coded on the MDS. A review of the 8/14/24 quarterly MDS revealed that the insulin was inaccurately coded. During the 7 days look back period for the medication administration of the insulin, it was coded as administered 5 times when it was given 4. These concerns were presented to the MDS coordinator on 9/6/24 for review. Follow up on 9/6/24 at approximately 12:58 PM revealed concurrence to the surveyor's findings.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on record review and interview it was determined that the facility failed to have a process in place to ensure that a baseline care plan was provided to the resident and resident representative within 48 hours of admission to the facility (Resident #159 and #75). This was evident for 2 of 14 residents reviewed for baseline care plans during an annual survey. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. 1. During interview with Resident #159 on 8/29/24 at 10:27 AM, Resident #159 stated he/she was never given a baseline care plan or had a meeting with the facility staff to discuss. Review of Resident #159's medical record on 9/3/24 revealed the Resident was admitted to the facility on [DATE] and there was no evidence in the medical record of a baseline care plan that was reviewed and given to Resident #159. During interview with the Social Worker on 9/4/24 at 9:00 AM, the Social Worker stated different members of the Interdisciplinary team (IDT) meet with a resident after admission but was unsure who creates the baseline care plan that is given and reviewed with the resident. The medical record review failed to reveal evidence that the facility offered the Resident and their representative a summary of the baseline care plan that included initial goals, physician orders, therapy services, dietary services, and social services within 48 hours of the resident's admission to the facility. During interview with the Director of Nursing (DON) on 9/3/24 at 9:11 am, the DON stated the facility's process for the baseline care plan is it completed within 48 hours by the IDT and the Resident is supposed to get a copy and this should be documented by the Social Worker in the medical record. Interview with the Regional Nurse on 9/9/24 at 9:19 AM confirmed the facility staff failed to provide a summary of the baseline care plan to Resident #159 and their representative within 48 hours of the resident's admission to the facility. 30428 2a. Review of the medical record on 9/5/24 at 8:56 for Resident #75 revealed multiple comorbidities including the presence of a tracheostomy, chronic pain, diabetes mellites, atrial fibrillation and insomnia. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review on 9/5/24 of the admission MDS for section 'O' special treatments and programs, failed to identify that Resident #75 was receiving oxygen on admission. Although the MDS noted Resident #75 had a tracheostomy and required suctioning and supplemental care, and this was triggered on the Care Area Assessment (CAA), which guides care plans, a care plan related to the presence of a tracheostomy and oxygen use was not initiated. Therefore, not only was there not a care plan initiated within 48 hours of admission by the nursing staff addressing the resident's tracheostomy status and need for care related to that, but it was also not picked up and care planned after the admission assessment was completed by the MDS staff. There was also no documentation in the electronic health record that the base line care plan that was initiated was provided to Resident #75 on admission. Interview with the facility social worker on 9/4/24 revealed that he was new to the facility and was not aware of the process and timing of meeting and giving the residents the baseline care plans. b. Continued review of the medical record for Resident #75 failed to reveal that a baseline care plan was not developed related to the usage of MDS identified high risk medications, anticoagulants, antianxiety, antidepressants and insulin medications. The nursing admission assessment for #7 Medications documented (a.) currently takes none of these medications. A care plan related to the administration of these medications was not initiated until 8/16/24. Interview with the MDS coordinator and the Unit Manager, staff #4 on 9/9/24 at 9:30 AM, regarding the process of care plans revealed that the admitting nurse is supposed to initiate the concerns that would be in the baseline care plan, activities of daily living and fall concerns for example. There was, however, no set way for staff to determined who was responsible for getting the other concerns identified in the hospital discharge and the CAA onto the care plan or who was ensuring that any changes or that key diagnoses made it to the care plan. The 2 employees, UM and MDS coordinator both confirmed at that time that there was no process in place to ensure that care plans are created with the residents personalized needs and care concerns. The concerns identified for Resident #20 were reviewed with the facility DON who then reviewed how the process is supposed to go. This surveyor stated that, that is not what was verbalized at the time of the interview and staff may not be aware or implementing what is expected of the administrative staff as evident by the surveyors' findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on medical record review, observation and interview, it was determined the facility staff failed to develop comprehensive care plans for residents (Resident #20 and #75). This was evident for 2 of 31 residents reviewed during an annual survey. The findings include: 1. During initial interview on 8/29/24 at 8:44 AM with Resident #20, it was revealed that s/he had some visible missing teeth on the upper and lower jaw. S/he verbalized at that time that s/he has been to a dentist recently and there were recommendations, but s/he does not think that there has been any follow up. Resident #20 then showed this surveyor a loose tooth in the front bottom right of his/her mouth. There was no pain reported but some discomfort. S/he reported that they were just waiting for it to fall out. A review of the medical record on 8/29/24 at 9:04 AM for Resident #20 revealed a dentist visit on 8/14/24 with recommendations for Peridex to improve oral health. The consult noted that nursing staff is to provide Peridex-a prescription oral mouthwash for gum disease and gingivitis, to be administered on a swab twice a day. A review of the care plans, failed to reveal any initiation of a dental care plan. There was no triggering of dental concerns from the MDS staff related to dental concern for the CAA and even though Resident #75 was given interventions and recommendations from the dental visit completed on 8/20/24 there was no care plan initiated related to his/her needs. This was reviewed with the MDS coordinator and the DON on 9/3/34 at 12:43 PM. 2. Review of the medical record for Resident #75 failed to reveal care plan was developed related to the usage of MDS identified high risk medications; anticoagulants, antianxiety, antidepressants and insulin medications. The nursing admission assessment for #7 Medications documented (a.) currently takes none of these medications. A care plan related to the administration of these medications was not initiated until 8/16/24, although Resident #85 was initially admitted on the evening of 7/25/24 and readmitted on [DATE] with the same high-risk medications. Interview with the MDS coordinator and the Unit Manager, staff #4 on 9/9/24 at 9:30 AM, regarding the process of care plans revealed that the admitting nurse is supposed to initiate the concerns that would be in the baseline care plan, activities of daily living and fall concerns for example. There was, however, no set way for staff to determined who was responsible for getting the other concerns identified in the hospital discharge and the CAA onto the care plan or who was ensuring that any changes or that key diagnoses made it to the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2 employees, UM and MDS coordinator both confirmed at that time that there was no process in place to ensure that care plans are created with the residents personalized needs and care concerns. The concerns identified for Resident #20 were reviewed with the facility DON on 9/9/24 at 9:50 who then reviewed how the process is supposed to go. This surveyor stated that, that is not what was verbalized at the time of the interview and staff may not be aware or implementing what is expected of the administrative staff as evident by the surveyors' findings. cross reference F641, F656

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to have quarterly care plan meetings for residents (#101 and #27) and failed to revise a resident's care plan (Resident #6 and #16). This was evident for 3 of 31 residents reviewed during an annual survey. The findings include: Once the facility staff completes an in-depth assessment (MDS) of the 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 is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed. 1. The facility staff failed to have quarterly care plan meetings for Resident #101. Interview of Resident #101 on 8/29/24 at 9:40 AM, Resident #101 states he/she hasn't had a care plan meeting in a while. Review of Resident #101's medical record on 9/4/24 revealed the Resident was admitted to the facility to 1/10/23. Further review of Resident #101's medical record revealed for care plan meetings revealed the facility staff failed to have a quarterly care plan meeting in [DATE] and August 2024. During interview with the Social Worker on 9/4/24 at 9:00 AM, the Social Worker stated he began working at the facility in June 2024 and is unsure why the facility failed to have a care plan meeting in August 2024. Interview with the Regional Nurse on 9/9/24 at 9:19 AM confirmed the facility staff failed to have a quarterly care plan for Resident #101 in October 2023 and August 2024. 42886 2. The facility failed to update the resident's care plan after the resident attempted to elope from the facility in July 2024 (Resident # 6). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #6's medical records on 8/29/24 at 9:52 am revealed the resident attempted an unauthorized exit (elope) from the facility in 7/4/24. Review of the resident's care plan revealed no changes to the resident's interventions for elopement since 7/2/24. Further review of resident #6's medical record on 9/3/24 at 8:30 am revealed the resident attempted to elope from the facility several times on 7/2/24. The facility assessed the resident and an order for a wanderguard (patient tracking device) was obtained on 7/2/24. The Wanderguard was placed on the resident's left wrist on 7/2/24. On 7/4/24, the resident was able to leave the facility with the wanderguard on the resident's wrist. Facility staff was able to locate the resident and redirect him/her back to the building. The wanderguard was found to be malfunctioning when staff assessed the resident. The wanderguard was replaced and no other elopement attempts were made after the 7/4/24 incident. Interview with the Director of Nursing (DON) on 9/3/24 at 9:11 am revealed that the resident was newly admitted to the facility at the time of the elopement on 7/4/24. The elopement investigation revealed that the resident wanted soda from a local store and left the facility to obtain the beverage. The DON stated the facility supplies resident #6 with soda and there have been no other elopement attempts since 7/4/24. The surveyor asked the DON if the resident's care plan was updated to include the intervention of the facility supplying sodas to the resident to deter future elopement attempts. The DON checked the resident #6's care plan and found no new interventions since 7/2/24. 48259 3. In an interview on 8/29/24 at 10:58 AM, Resident #27 was asked if he/she participated in his/her care plan meeting and responded, I don't know of any meeting. A medical record review on 9/5/24 at 1:53 PM showed that Resident #27 was admitted to the facility in August 2019. Further review found that Resident #27 was alert, oriented, and cognitively intact per an MDS assessment dated [DATE]. A continued review of the MDS assessment showed that it was completed on 6/6/24. However, the review failed to show that a care plan meeting occurred following the completion of the Resident's MDS assessment. Further review also found that a subsequent MDS assessment dated [DATE] was completed on 7/5/24. However, the review failed to show that a care plan meeting occurred following that. An interview with staff #15, social services director, on 9/5/24 at 2:15 PM showed that care plan meetings were held within 7 days after the Residents' MDS due dates. In an interview on 9/5/24 at 2:55 PM with staff #7, an MDS coordinator, she reported that the social service department was provided with a list of all MDS assessments due dates for the month, and care plan meetings were scheduled based on those dates. However, the interview failed to show that care plan meetings occurred following the completion of Resident #27's MDS assessments dated 5/31/24 and 6/26/24. In an interview with staff #15 on 9/5/24 at 2:57 PM, he confirmed that there was no documentation to show that care conference meetings were conducted following Resident #27's MDS assessments dated 5/31/24 and 6/26/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48259 Based on observations, medical record review, and interviews, it was determined that the facility failed to 1) provide a resident with the amount of assistance needed during meals, 2) ensure that a resident who was unable to carry out activities of daily living (ADL) fingernails were trimmed. This was evident for 2 (#48, #92) out of 4 residents who were reviewed for activities of daily living (ADL). The findings include: 1) An Observation on 8/29/24 at 8:10 AM showed Resident #48 lying in bed, and a signage reading RN/GNAs-1:1 feed was noted above the head of the resident's bed. Continued observation noted Resident #48 trying to feed him/herself breakfast. The Resident's gown was soiled with food particles in the chest area. Further observation of the staff assignment board later that day showed a statement Assisted diners which included Resident #48's room number. Staff #33 was questioned about it, and she reported that it meant Resident #48 needed assistance eating all his/her meals. A subsequent observation on 8/30/24 at 1:19 PM noted Resident #48 feeding himself/herself lunch. The Resident's gown was soiled with food particles, a juice container was sitting under the bedside table, and juice was poured on the floor. A medical record review on 9/3/24 at 9:50 AM showed that Resident #48 was admitted to the facility in July 2024 with diagnoses including dementia. The continued review contained an attending provider's order for Resident #48 for one-on-one assistance with feeding due to impulsive PO intake (PO- by mouth). In an interview on 9/4/24 at 9:41 AM, staff #33 stated that staff needs to be available at Resident #48's bedside during meals to cue and assist with eating. However, earlier observations failed to show staff assisting Resident #48 during mealtime to assist him/her with eating. 2) An observation made on 8/29/24 at approximately 8:20 AM showed Resident #92 lying in bed with long nails. Subsequent observation on 8/30/24 at 1:17 PM showed Resident #92 in bed and continued to have long nails. During a continued observation on 8/30/24 at 1:35 PM, staff #36, a certified nurse aide, was present in Resident #92's room and stated, Yes, the nails are pretty long; I didn't cut them today. A review of Resident #92's medical record on 9/3/24 at 10:47 AM showed that the Resident had been residing in the facility since November 2020. The review also contained a care plan for Resident #92 initiated on 2/8/24, which documented that the Resident had an ADL self care performance deficit and required staff to perform all his/her personal hygiene needs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review found a minimum data set (MDS-an assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives Resident care planning decisions) dated 4/26/24 that recorded that Resident #92 had severely impaired cognition and depended on staff for all self-care needs. On 9/3/24 at approximately 10:57 AM, staff #33, a unit manager, was asked to come to Resident #92's room. During an interview, Staff #33 confirmed that the resident's nails continued to be long, then said, They should have been taken care of by the GNAs [geriatric nurse aides] because they can dig into [his/her] skin and cause a wound. In an interview on 9/4/24 at 9:41 AM, staff #33 reported that Resident #92's nails were trimmed after the surveyor's intervention.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 48259 Based on observations, medical record reviews, and staff interviews, it was determined that the facility failed to provide activities to meet the residents' needs and preferences. This was evident for 1 (#48) of 4 residents reviewed for Activity. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure each resident receives the necessary care. Observations on 8/29/24 at approximately 12:14 PM and 8/30/24 at approximately 1:17 PM showed Resident #48 lying in bed and not involved in any activity. A record review for Resident #48 on 9/3/24 at 9:50 AM showed that the resident was admitted to the facility in July 2024 with diagnoses including Dementia. The review also noted an Admission Minimum Data Set (MDS) assessment for Resident #48 dated 7/26/24, which had documented that the resident had severely impaired cognition. Further review of the MDS assessment noted that the resident was interviewed about Preferences for customary routine and Activities (Section F) by staff #16, activity director. The Activity preferences recorded revealed that it was very important to Resident #48 to listen to music s/he likes, to keep up with the news, to be around animals such as pets, go outside to get fresh air when the weather is good, to participate in religious services or practices. A review of activity logs for Resident #48 for August 1- August 31, 2024 was completed. The review showed 1:1/Conversation/Social time/Family visits on 8/15/24, 8/28/24, 8/29/24, 8/30/24, 8/31/24 and 9/1/24. However, the logs failed to show that Resident #48 was involved in activities that included music s/he likes, keeping up with the news, being around animals such as pets, going outside to get fresh air when the weather was good, and participating in religious services or practices previously documented as his/her activity preferences during the admission activity assessment. In an interview with staff #16 on 9/4/24 at 2:59 PM, she reported that 1:1/Conversation/Social time/Family visits meant that one of her staff visited Resident #48 in his/her room and had conversations with him/her. In a subsequent interview with staff #16 later the same day, she said she understood the concern that the activities provided did not meet Resident #48's activity preferences.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of complaint, medical record review, and staff interview, it was determined the facility failed to provide care to meet the needs of a resident's physical, mental, and psychosocial health. This was evident for 1 (#166) of 4 residents reviewed for quality of care. The findings include: On 9/4/24 at 9:42 AM a review of complaint MD00205771 alleged that Resident #166 was a quadriplegic and in need of assistance. The complaint alleged that the resident felt the facility was not helping the resident and for that reason, had not had a bowel movement in 6 to 7 days because he/she was afraid they wouldn't be cared for correctly. Resident #166 called 911 and was transported to the hospital on 5/13/24. On 9/4/24 at 9:42 AM a review of Resident #166's medical record was conducted and revealed Resident #166 was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included a fracture of the left mandible, traumatic subarachnoid hemorrhage, quadriplegia, pressure ulcers of the sacral region and right hip, and constipation. Review of Resident #166's bowel movement (BM) documentation revealed there were no recorded bowel movements on Sunday, 5/12/24 during day and evening shift. There was documentation that Resident #166 did not have a BM on 5/11/24, 5/12/24, and 5/13/24. Review of Geriatric Nursing Assistant (GNA) documentation on Sunday, 5/12/24 was blank for day and evening shift for oral hygiene, personal hygiene, bowel movement documentation, dressing, and bed mobility. Review of Resident #166's Treatment Administration Record (TAR) for May 2024 failed to document that dressing changes to a wound on the right lateral rib, right scapula, right shin and the sacrum were done on Saturday, 5/11/24 and Sunday, 5/12/24. Review of the staffing schedule for Sunday, 5/12/24 documented that the Dogwood Unit, the unit that Resident #166 was on, had a census of 55 residents on the unit. According to the actual worked schedule that was given to the surveyor, the unit had 3 GNAs for 55 residents during day shift, which was a 1 to 18 ratio for GNA to resident. On the evening shift there were 2 GNAs on the unit which was a 1 to 28 ratio for GNA to resident. On 9/6/24 at 7:40 AM the Assistant Director of Nursing (ADON) reviewed Resident #166's shower/bath schedule with the surveyor. The ADON confirmed that the resident was not documented as having a bed bath or shower on 5/12/24 on any shift. Reviewed the personal hygiene and other ADLs (activities of daily living) with the ADON and the ADON stated, if it was not documented it wasn't done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/6/24 at 9:47 AM the ADON reviewed the May 2024 TAR that showed that the pressure ulcer treatment was blank which indicated it was not done. The ADON agreed if it was not documented it was not done. The surveyor asked could they have been short staffed those 2 days in May. The ADON stated, if it was the weekend, yes, we are short a lot on the weekends. The ADON was informed of the concern with the short staffing for Sunday, 5/12/24 along with the census and the lack of documentation from nurses and GNAs. The ADON stated that they are doing much better now with staffing, and she confirmed the numbers that she supplied the surveyor were correct.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #263). This is evident for 1 of 4 residents reviewed for pressure ulcers during an annual survey. The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). A deep tissue injury (DTI) is a unique form of pressure ulcer. The National Pressure Ulcer Advisory Panel defines a deep tissue injury as A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise. The findings include: Review of Resident #263's medical record on 9/9/24 revealed the Resident was admitted to the facility on [DATE]. On admission the Resident was assessed to have bruising to his/her left heel with no measurements. Further review of Resident #263's Wound Assessment Report on 4/4/24 revealed the Resident was assessed to have left heel, right heel and right great toe DTIs with measurements that were present on admission. Review of Resident #263's April 2024 Treatment Administration Record revealed the facility staff failed to put any treatment in place for the Resident's DTIs until 4/4/24, 5 days after admission. Review of Resident #263's weekly Wound Assessment Reports and electronic medical records revealed the facility staff failed to conduct a weekly skin assessment with measurements on 4/18/24. Interview with the Regional Nurse on 9/9/24 at 10:00 AM confirmed the facility staff failed to assess Resident #263's pressure ulcers with measurements on admission, failed to put treatment in place until 4/4/24 and failed to conduct a weekly wound assessment on 4/18/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 30428 Based on interview and observation, it was determined that the facility failed to change the oxygen tubing for a resident dependent on Oxygen per facility policy. This was evident during the observations of 1 of 3 (#20) residents dependent on oxygen. The findings include: During an initial observation and interview on 8/29/24 at 8:49 AM with Resident #20, this surveyor was observing the environment when the Resident was asked if the oxygen equipment could be reviewed. The tubing was labeled with the date 7/18/24. A note was made, and the surveyor asked Resident #20 if the staff change the oxygen equipment. S/he stated they do but, they were not sure when the last time was, and they had concerns about the noise the oxygen regulator was making. Interview with that unit manager, staff #4 on the process of changing oxygen tubing at 8/29/24 at 11:02 AM, revealed that the process is every 7 days. This surveyor reported that the tubing for Resident #20 was dated 7/18/24. He immediately took care of the oxygen tubing. A review of Resident #20's physician orders revealed that there was an order in place for the oxygen tubing to be changed every 7 days and the medication administration record (MAR) also showed that the order was signed off every week for July and August as being completed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37296 Based on a review of medical records, Controlled Medication Utilization Record sheets, Medication Administration Record (MAR), and interviews with staff, it was determined that the facility failed to consistently document the administration of an as-needed (PRN) pain medication on the electronic MAR and further monitor the resident's pain level and efficacy of the medication. This was evident for 3 of 3 residents (#151, #81 and #169) reviewed during an annual survey. The findings include: 1. On 9/8//24 at 12 PM a review of Resident #151's clinical record revealed that the resident's primary physician on 8/10/2024, ordered Dilaudid (Hydromorphone) Oral Tablet 2 MG, give 1 tablet by mouth every 4 hours as needed for Pain. This medication is used to help relieve moderate to severe pain. Dilaudid (Hydromorphone) belongs to a class of drugs known as opioid analgesics. A review of the August 2024, Control Medication Utilization Record revealed Dilaudid (Hydromorphone) on the following days and times was removed from the controlled lock box on 8/28/24 at 10 AM, and 2:30 PM, 8/29 at 9 AM, and 7 PM, 8/30 with no time recorded and 8/30 at 8 PM and 9/12 at 12 PM. Further review of the resident's clinical records revealed that the resident's August 2024 Medication Administration Record (EMAR) revealed that the Dilaudid (Hydromorphone) medication on the stated date was not documented as given to the Resident and the resident's pain level and efficacy of the medication was not monitor. The facility staff failed to administered pain medication as ordered by the physician. 2. On 08/29/24 10:28 AM, a review of Resident #81's clinical record revealed that the resident's primary physician on 7/10/2024, ordered oxyCODONE HCl 5 MG Tablet, 1 tablet by mouth every 4 hours as needed for pain. Oxycodone is a semisynthetic opioid used for acute or chronic management of pain. A review of the August 2024, Control Medication Utilization Record revealed oxyCODONE HCl 5 MG Tablet on the following days and times was removed from the controlled lock box on 8/11 with no time recorded, 8/11 at PM, 8/12 at 10:54 AM, 8/18 at 9 AM and 8/24 at 8 PM Further review of the resident's #81 clinical records revealed that the August 2024 Medication Administration Record (EMAR) revealed that the Oxycodone medication on the stated date was not documented as given to the Resident and the resident's pain level and efficacy of the medication was not monitor. Interview with the Director of Nursing on 8/30/24 @ 12:30 PM confirmed the facility staff failed to ensure Resident #81, was administered pain medication as ordered by the physician. 31145 3). On 9/5/24 at 10:33 AM a review of complaint MD00186126 revealed an allegation that pain medication had not been given to Resident #169 since the resident was discharged from the hospital. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #169's medical record revealed the resident was admitted to the facility on [DATE] at 1:04 AM from an acute care facility following surgery due to a fall. Review of nursing notes revealed a 7:34 AM note that documented, Pt. chief complaint: L hip pain s/p fall, s/p L hip hemiarthroplasty and full-thickness tear repair of gluteus minimus. It was noted that the surgery took place on 11/22/22. Hemiarthroplasty is also known as a partial hip replacement which is a surgical procedure that replaces the thigh side of the hip joint while leaving the socket intact. A gluteus minimus is a tear in one of the gluteal muscles in the buttocks that can cause pain, weakness, and instability in the hip. Review of nursing notes dated 11/24/22 at 7:34 AM revealed a note that documented, Pt. chief complaint: L hip pain s/p fall, s/p L hip hemiarthroplasty and full-thickness tear repair of gluteus minimus. It was noted that the surgery took place on 11/22/22. Review of a physician's history and physical dated 11/24/22 at 8:40 AM documented, Complains of chronic lower back pain and requesting for [his/her] morphine. The physician documented the plan, mechanical fall, left femoral neck fracture s/p left hip hemiarthroplasty, WBAT (weight bearing as tolerated), anterior hip precautions, continue PT/OT, c/w (continue with) pain management. Review of November 2022 physician's orders for Resident #169 documented the order Morphine Sulfate 15 mg three times a day at 9:00 AM, 2:00 PM, and 8:00 PM and a prn (when needed) Morphine Sulfate 15 mg, give 0.5 tablet every 4 hours as needed for pain. There was also an order for Tylenol 325 mg (2) tablets every 4 hours as needed for pain. Additionally, there was an order to monitor for pain every shift. Review of Resident #169's November 2022 Medication Administration Record (MAR) revealed that Tylenol and Morphine were not administered at anytime on 11/24/22. The MAR had a check mark that pain was monitored but there was no pain assessment found. There was no documentation if the resident was having verbal or non-verbal signs and symptoms of pain. There were no pain assessments found in Resident #169's medical record from the time of admission until the time of discharge. Review of the complaint documented that Resident #169 complained of pain, however the facility stated that they did not have the medication but was working on it. Review of a 11/24/22 at 11:52 change in condition note documented, patient C2 form for pain meds was faxed to pharmacy. Writer called pharmacy to get morphine in the Omnicell. The note continued that the spouse stated he/she could not wait and was calling 911 to take his/her spouse back to the hospital. Omnicell is the facility's medication dispensing system for extra medications that may be needed in an emergency or if the resident is prescribed a medication that has not been delivered by the pharmacy yet. Review of the facility's Omnicell list of medications on hand documented that Morphine 15 mg. was available. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/24 at 2:29 PM an interview was conducted with LPN #21. LPN #21 stated, If they just came from the hospital, we have to call the doctor for the doctor to call the pharmacy to give an electronic signing and pharmacy would give us a code and we would need 2 people to get the medicine out of the Omnicell. Depends on what time at night. When I get report from the hospital, I will ask them to medicate the resident before sending them here, so I have time to get the medication authorization from the pharmacy. On 9/9/24 at 9:30 AM an interview was conducted with Staff #35 (regional nurse) who confirmed there were no written pain assessments. Staff #35 pointed out under the vital sign section of the electronic medical record that there were 2 pain assessments: one at 10:51 AM on 11/24/22 and one at 14:31 on 11/24/22 with a pain level of zero. Staff #35 was asked how the resident could have a pain assessment at 14:31 if the resident was discharged to the hospital at 11:52 AM and never came back. Staff #35 agreed that there were no pain assessments, and that the resident never received any pain medication while at the facility. Staff #35 stated she became aware of the problem and showed the surveyor the audit she had done along with her plan because she found it had been an issue.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 30428 Based on observation and interview with consultants and facility staff, it was determined that the facility consultants failed to appropriately assess a resident and their need for psychiatric services, this was evident during the review of 1 of 5 (#107) residents reviewed for outside consultant services. The findings include: Resident #107 was observed in bed asleep during initial tours and observation on 8/29/24 at 8:54 AM Record review on 08/29/24 12:37 PM revealed diagnosis including encephalopathy (a group of conditions that cause brain dysfunction), aphasia (a disorder that affects how you communicate) post cerebrovascular accident and dysphagia (a language disorder that affects the ability to understand and produce spoken language). Again on 8/30/24 at 10:10 AM this surveyor attempted to interact with Resident #107, and s/he was in the middle of physical therapy. S/he was sitting on the side of the bed with the physical therapist but was not verbally interactive noted from the observation and the physical therapist who also confirmed, though s/he could look around with his/her eyes. On 9/6/24 the admission psychiatric assessments were reviewed; one was completed on 7/1/24 and another on 7/2/24. The assessment completed on 7/1/24, noted that Resident # 107 was 'sleepy and nonverbal .history of stroke, dysphagia, anxiety and aphasia .' However, the assessment proceeded to document 'speech: regular rate and rhythm, thought process: organized, thought content; appropriate and organized, not suicidal or homicidal. The Psychiatric Mental Health NP Staff #32 was interviewed on 9/9/24 at 11:33 AM regarding the note and assessment she completed on 7/2/24 for Resident #107. She stated that it must have been a transcription issue and would look into it. The assessment completed on 7/2/24, noted that Resident #107 would be followed 'routinely related to [his/her] mental health issues.' The assessment continued to note 'speech: regular rate and rhythm, gait: normal, thought process: organized, thought content: appropriate and goal-directed, perceptions: no hallucinations.' Additionally, the assessment noted that the resident was counseled on 'sleep hygiene, and coping mechanisms such as practicing self-care, grounding, mindfulness and meditating. ' The DNP staff #31 was interviewed on 9/9/24 at 11:27 AM. His note was reviewed in addition to Resident #107's active diagnosis. He stated that 100% it was wrong, his error, a typo and he would have to fix it. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These concerns were reviewed with the DON on 9/9/24.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48259 Based on observations, medical record reviews, and interviews, it was determined the facility failed to maintain a medication error rate of less than 5%. This was found to be evident based on 9 errors identified out of 26 opportunities for error. The findings include: 1) During observation of medication administration on 8/30/24 at 8:52 AM, the surveyor observed that Staff #30, a licensed practical nurse (LPN), had already prepared medications for Residents #76 and #134. The nurse prepared a total of 2 medications for Resident #76 and 4 medications for Resident #134. Staff #30 went into Resident #76's room to administer his/her medications and took Resident #134's medications along with her. Staff #30 was questioned and stated, I know I'm not supposed to pull medications for 2 residents at a time, but you already caught me. A review of the facility's medication Administration policies and standard procedures on 8/30/24 at 12:41 PM noted a statement to prepare one resident's medication at a time. However, staff #30 prepared medications for 2 residents at a time. 2) On 8/30/24 at approximately 9:20 AM, the surveyor observed staff #42 prepare and administer 7 medications to Resident #7. Following the medication administration, a review of Resident #7's August 2024 medication administration record (MAR)was done. The review showed an attending provider's order for a Muro 128 eye drop to both eyes two times daily which was recorded as given for the morning dose, however, the surveyor did not observe the eye drop being administered to the resident on 8/30/24. In an interview with staff 42, on 8/30/24 at 2:45 PM, she confirmed that she did not give the eye drop. Staff #42 added that she signed the medication before she realized it was finished. So, she went ahead and reordered it from the facility's pharmacy. 3) On 8/30/24 at 9:40 AM, the surveyor observed staff #43 prepare medications to be administered to Resident #48. Staff #43 signed for the medications, then put a total of 3 medications into a medicine cup consisting of one tablet of an antidepressant, one tablet of vitamin D, and one tablet of an anticonvulsant. Resident #48 refused to take the medications, staff went for apple sauce in a medicine cup, dropped the 3 tablets into it, and began to feed it to Resident #48. The resident continued to refuse to take the medications, spat them out to the floor, and stated, I told you I don't want it. Staff #43 said to the surveyor that she already signed the medications as given but she would go back and cancel. Following the medication administration, a review of Resident #48's August 2024 MAR was completed. The review showed an attending provider's order for an antihypertensive medication to be given in the morning to Resident #48. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The continued review found that Staff#43 had signed off the antihypertensive medication as given to Resident #48 on 8/30/24 at 09:38. However, the surveyor did not observe Staff #43 giving this medication to the resident. In an interview with staff #43 on 9/6/24 at 11:01 AM, she was asked if she documented everything that happened with Resident #48's refusal of medications on 8/30/24 and she stated, The system will not allow me to go back. Staff #43 added that she went back with an ensure drink and the resident took all her medications. In an interview on 9/9/24 at 2:22 PM, the director of nursing was made aware of the facility's medication error rate. The DON stated she would continue to provide training to the staff.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48259 Based on observations and interviews, it was determined that the facility failed to properly store medications, as evidenced by not labeling multi-dose medications when they were opened. This was evident for 2 of 2 medication rooms and 2 of 4 medication carts observed during the survey. The findings include: 1) Observation on 9/3/24 at 9:12 AM of the Dogwood unit medication room with Staff #33, a unit manager, showed an antidiabetic injection pen in the refrigerator for Resident #27. The medication had one dose remaining and was not labeled with the opening date. Staff #33 reported that staff was supposed to date it upon opening it. Continued observation noted a multi-dose vial of purified protein derivative (PPD) injection which had been opened but not labeled with the date it was opened. Staff #33 confirmed that it was not labeled with the opening date. 2) Observation on 9/3/24 at 9:17 AM of the Cedar unit medication room refrigerator with staff #33 showed a multi-use vial of PPD which was opened and not labeled with the date it was opened. Staff #33 confirmed it was not dated and should have been dated at the time of opening. 3) Observation on 9/3/24 at 9:22 AM of the cherry unit medication cart with staff #33 present, found a multi-use container of Tylenol 500mg tablets that had been opened and not labeled with the date it was opened. Staff #33 stated that it was a house stock and used for multiple residents so the expectation was to label it with the date it was opened. 4) Observation on 9/3/24 at 10:48 AM of the Magnolia unit long hallway medication cart with staff #34, a registered nurse, showed multi-use containers of Calcium Carbonate 500mg and Vitamin D supplement. Both medications were opened, however, the observation failed to show that they were labeled with the dates they were opened. Staff #34 confirmed that both medicines were not labeled with the opening dates. In an interview on 9/3/24 at 12:56 PM, the director of nursing stated that her expectation of the nurses was to label all the multi-use medications with the date of opening at the time they were opened.

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. 18819 Based on reviews of a facility reported incident and medical record and facility staff interview, it was determined that the facility failed to obtain a urinalysis and urine culture, and sensitivity as ordered by Resident #106's physician. This was evident in 1 of 86 resident complaints reviewed during an annual recertification survey. The findings include: The State Survey Agency (SA) received complainant allegations (Intake #MD00205948) indicating that Resident #106 was physically aggressive towards a staff member on 05/22/24. The facility intake MD00205948 indicated that Resident #106 was going to be assessed by his/her attending physician, was to be evaluated by the facility psychiatric services, and was to have blood and urine samples obtained. Resident #106 was assessed by his/her physician on 05/22/24 at 2 PM who wrote orders instructing the nursing staff to obtain a psychiatric consult for Resident #106 and obtain lab specimens that included a CBC/CMP/urinalysis/urine culture and sensitivity due to abnormal behavior. Further review of Resident #106's medical record on 08/28/24 at 9 AM, failed to reveal a urinalysis and urine culture and sensitivity results from 05/22/24. In an interview with Nursing Unit Manager, staff member #8, on 08/28/24 at 2:45 PM, the nursing unit manager indicated that the order for Resident #106's 05/22/24 urinalysis and urine C&S was placed into the electronic medical record system (PCC) on 05/22/24. The order was not placed in the lab system, AHA labs, orders. It was not scheduled. Staff did not see the order. The nursing unit manager stated that Resident #106's urine and urine C&S specimen was not obtained by the nursing staff. This concern was reviewed with the DON on 08/30/24 at 3:30.

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	215160	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellicott City Healthcare Center	3000 North Ridge Road Ellicott City, MD 21043

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37296 Based on medical record review and interview, it was determined the facility staff failed to ensure a resident went to scheduled out of the facility physician visits in a timely manner. This was evident for 3 (#81, #20 and #159) of 31 residents reviewed during a complaint survey. The findings include: 1. The facility staff failed to ensure Resident #81 went to a urology appointment in a timely manner. Review of Resident #81's medical record on 9/3/24 revealed the Resident had a schedule Urology appointment on June 13, 2024, at 10:15 AM. Further review of Resident #81's medical record revealed no documentation of a urology follow up on June 13, 2024. On 9/3/24 at 9:30 AM, the Unit Manager #4 was unaware of the missed Urology appointment for Resident #81 and rescheduled the appointment for 9/25/24 at 1:45 PM. Interview with Director of Nursing on 9/9/24 at 10 AM confirmed the facility staff failed to schedule transportation for Resident #81's urology follow up. 30428 2. During initial interview on 8/29/24 at 8:44 AM with Resident #20, it was revealed that s/he had some visible missing teeth on the upper and lower jaw. S/he verbalized at that time that s/he has been to a dentist recently and there were recommendations, but s/he does not think that there has been any follow up. Resident #20 then showed this surveyor a loose tooth in the front bottom right of his/her mouth. There was no pain reported but some discomfort. S/he reported that they were just waiting for it to fall out. A review of the medical record on 8/29/24 at 9:04 AM for Resident #20 revealed a dentist visit on 8/14/24 with recommendations for Peridex to improve oral health. The consult noted that nursing staff is to provide Peridex-a prescription oral mouthwash for gum disease and gingivitis, to be administered on a swab twice a day. A review of Residents medical record on 9/3/24 at 11:21 AM failed to reveal any order for the Peridex solution. The DON was interviewed on 9/3/24 at 11:20 AM. She followed up with the surveyor at 12:43 PM and reported that the consult recommendations were not added to the physician orders and medication administration record, and she was in the process of taking care of it. 34484 (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility staff failed to schedule follow up appointments with consultant physicians for Resident #159. Review of Resident #159's medical record on 9/3/24 revealed the Resident was admitted to the facility on [DATE] from the hospital. Review of Resident #159's hospital discharge summary dated 8/13/24 revealed the Resident is to see the following consultants: a. Follow up in 1-2 weeks with urology about renal mass noted on CT scan. b. Follow up in 1-2 weeks for surveillance of left 2nd toe c. Follow up in 2 weeks with GI (gastroenterology) Further review of Resident #159's medical record revealed the Resident has not seen any of the consultant physicians or have they been scheduled. Interview with the Regional Nurse on 9/9/24 at 9:19 AM confirmed the facility staff failed to schedule follow up appointments with consultant physicians for Resident #159.

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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. 31145 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. This was evident for 2 (#169, #166) of 93 residents reviewed during an annual and 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. 1) On 9/5/24 at 10:33 AM a review of complaint MD00186126 revealed an allegation that pain medication was not given since Resident #169 was discharged from the hospital. Review of a physician's history and physical documented that Resident #169 was receiving Morphine 50 mg. three times a day, when documentation indicated the resident received Morphine 15 mg. three times a day. The dosages did not match. Additionally, the nurse documented a pain assessment in the resident's vital section of the electronic medical record on 11/24/22 at 14:31 (2:30 PM), however the resident had been discharged from the facility on 11/24/22 in the morning at 11:00 AM. On 9/9/24 at 9:30 AM an interview was conducted with Staff #35 (regional nurse). Staff #35 was asked how the resident could have a pain assessment at 14:31 if the resident was discharged to the hospital at 11:52 AM and never came back. Staff #35 confirmed the finding. Staff #35 also reviewed the dosage of Morphine with the surveyor and stated that it was an error. 2) On 9/4/24 at 9:42 AM Resident #166's medical record was reviewed and revealed Resident #166 was discharged from the facility on 5/13/24. Review of a 5/16/24 nurse practitioner follow-up note revealed the date of service that the resident was seen was 5/16/24. The nurse practitioner signed the note on 5/16/24 at 1:56 PM. On 9/4/24 at 10:06 AM an interview was conducted with Nurse Practitioner (NP) #18. NP #18 was asked when the last time she saw Resident #166. NP #18 looked in the electronic medical record and stated, the last time I saw [him/her] was on 5/16/24. The surveyor asked, how could you see the patient on 5/16/24 when the resident was discharged from the facility on 5/13/24. NP #18 continued to look through the computer and stated she saw the resident on 5/13/24. It was a mistake. I did not report a late entry. We cannot chart on the patient when we see them. When you see a patient, you chart 48 hrs. or 3 days after. I did advanced care plan on 5/13 and then I did my other visit note 3 days later. NP #18 stated, That is the policy for [corporate name]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/24 at 11:21 AM the Nursing Home Administrator (NHA) was asked if he had a policy for physician documentation. On 9/4/24 at 11:30 AM the NHA stated he spoke to the medical director and said they did not have a written policy, but preferably within 48 hours of seeing a resident. The NHA was informed of the NP's documentation at that time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42886 Based on observations and interviews, it was determined that the facility failed to supply a staff restroom with soap for staff to wash their hands after use. The lack of soap in a staff restroom is an important step in the implementation of appropriate standard and transmission-based precautions to help prevent the spread of infections. This deficient practice has the potential to affect all residents, staff, and visitors in the facility. The findings include: On 8/30/24 at approximately 11:00 am, the surveyor observed that the staff restroom by the Magnolia Unit nurses' station did not contain soap for staff use due to a malfunctioning automatic soap dispenser. At 11:10 am, the surveyor interviewed Magnolia Unit Manager #4 at the Magnolia nurses' station regarding the lack of soap in the staff restroom and the malfunctioning automatic soap dispenser. Magnolia Unit Manager #4 stated that he/she was unaware of the lack of soap in the staff restroom and the malfunctioning automatic soap dispenser. While the surveyor was interviewing Magnolia Unit Manager #4, the Maintenance Director visited the Magnolia nurses' station to repair the Magnolia staff breakroom door. The surveyor informed the Maintenance Director of the malfunctioning automatic soap dispenser in the Magnolia nurses' station staff restroom. The Maintenance Director inspected the automatic soap dispenser and found that the unit needed batteries. The surveyor expressed concern to the Executive Director on 8/30/24 at 12:500mg that the Magnolia Unit staff restroom did not have any soap for staff use and the automatic soap dispenser was malfunctioning. On 8/31/24 at 10:30 am, the surveyor checked the Magnolia Unit nurses' station restroom for repairs on the automatic soap dispenser. The restroom's automatic soap dispenser was not repaired but a container of liquid soap was available for staff use in the staff restroom.