STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215183	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayette Health and Rehabilitation Center	1217 West Fayette Street Baltimore, MD 21223

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on observation and interviews, it was determined that the facility staff failed to ensure the dignity of the residents as evidenced by: 1) Nursing staff failed to wear a name tag and 2) Nursing staff use of a personal cell phone during Resident's (#16) care. This was found to be evident for 1 out of 1 Resident for dignity. The findings include: 1) On 3/18/24 at 9:13 AM the surveyor observed Geriatric Nursing Assistant (GNA) #12 on the 3rd floor nursing unit without a name tag. During an interview the surveyors asked GNA #12 what was the facility's expectation for name tags. The GNA advised the surveyors that she was expected to wear a name tag at all times. The GNA #12 then wrote her name on a piece of tape and placed it on her uniform. On 3/20/24 at 6:30 AM the surveyors observed that Registered Nurse (RN) #22 walked out of resident room [ROOM NUMBER] and into the hallway toward the 3rd floor nursing station without a name tag. During an interview the surveyors asked the RN what was the expectation for the name tag. The RN replied that the expectation was for him to have worn a name tag at all times. 2) On 3/19/24 at 8:40 AM the surveyor observed GNA #49 on her personal cell phone while she assisted Resident #16 with their lunch. During an interview, the surveyors observed the GNA's uniform without a name tag. The surveyor asked GNA #49 what was the facility's expectation for name tags and personal phone usage in resident rooms. The GNA stated that she should not use her cell phone inside of the resident room and she should have worn a name tag.

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 44440 Based on interviews and record review it was determined that the facility failed to honor the rights, delegated to a Resident's Representative by informing them of changes to the plan of care. This was found evident of 1 (Resident #77) of 9 residents reviewed for advanced directive during an annual and complaint survey. The finding include: On 3/19/24 at 10:08 AM, the surveyor reviewed Resident #77's medical records. The review revealed that Resident #77 was admitted to the facility in early August 2023. Further review revealed on 9/8/23 and on 9/11/23 two providers evaluated Resident #77 and documented their findings on a form titled, Physician Certification Related to Medical Condition, Substitute Decision Making, and Treatment limitations. Both providers evaluated that Resident #77 was unable to understand and sign admission documentation, unable to understand the nature, extent or probable consequences of the proposed treatment, and unable to make a rational evaluation of the burdens, risks, and benefits of the treatments. Both Providers deemed Resident #77 incapable of making an informed decision regarding the provision of withholding or withdrawing of all medical treatments. The provider on 9/8/23 checked that Resident #77 was unable to appoint a health care representative and the Provider on 9/11/23 checked that Resident #77 was able to appoint a health care representative. On 3/25/24 at 10:52 AM, the surveyor reviewed the social history assessment completed by the Social Worker's Assistant Staff #17. The assessment was completed after Resident #77's was readmitted to the facility in October of 2023. Staff #17 indicated that Resident #77 had decision making-capacity and no name was written in the section Resident's health care proxy or agent. On 3/25/24 at 11:17 AM, the surveyor interviewed the Social Worker Staff #16 and Social Worker Assistant Staff #17. The surveyor showed the social history form to Staff #16. Staff #16 stated Resident #77 came in as his own decision maker but currently his/her ex-significant other is the decision maker. She further stated the Resident #77 was evaluated by his/her provider and is currently unable to make decisions. She further stated that in order to change that decision a new evaluation would have to be completed. The surveyor asked for documentation to validate this information. The surveyor informed Staff #16 that currently the contact information in Resident #77's medical record states Resident #77's Representative as Self/Resident and listed as emergency contact as Resident #77's ex- spouse. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/24 at 11:35 AM, the surveyor reviewed Resident #77's recent change of condition evaluations. On 11/12/23 Resident #77 made an allegation of abuse and was injured. The name of the family/resident representative notified was Resident #77's ex-spouse. The following change of condition was written on that same day, also notified the ex-spouse of Resident #77's non-compliance with treatment of the injury. On 12/12/23 Resident #77 had an increase to his/her methadone (a medication prescribed to treat narcotic drug addiction). In the summary section it stated Nurse Practitioner (NP) notified and the Resident is his/her own Responsible Person (RP). On 2/2/24 the summary of Resident #77's change of condition summarizes that Resident #77's potassium was low, the NP is aware, and Resident is his/her own RP. On 2/6/24 Resident #77's methadone was increased again and in the change of condition summary it stated NP aware, and Resident is his/her own RP. On 3/25/24 at 1:11 PM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #38. During the interview, Staff #38 stated when needing to communicate plan of care changes to the Resident's responsible party, she would look at the face sheet. She further stated the face sheet has an area that indicates who the Resident's Representative is and if they are unable to be reached then the next person listed should be contacted. On 3/25/24 at 12:07 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA stated she was under the impression that Resident #77 was not capable of making medical decisions. She further stated that a surrogate form should be filled out to indicate who is to help make the decision for the resident and the social services staff should have had this filled out.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 14894 Based on resident interview, staff interview, and clinical record review it was determined that the facility staff failed to ensure residents received showers at least twice a week. This was evident for 4 residents (#81, #111, #116, and #28) out of 48 residents who were part of the survey sample. The findings include: 1) This surveyor interviewed Resident #81 on 3/18/24 at 9:19 AM. The resident stated that he/she has not had a shower in three days and needs one. Resident declared that he/she stinks. Resident stated that he/she has requested showers, but the staff say to just go even though the resident cannot physically go on his/her own. A review of Resident #81's clinical record revealed that the Geriatric Nursing Assistants (GNA) documented only providing bed baths for the resident during the months of February and March. This surveyor interviewed the Unit Manager (Staff #50) on 3/28/24 at 9:06 AM. The lack of showers and the resident's right to showers twice a week was discussed. The Unit Manager said he was not surprised that Resident #81 complained and that he would look into it. 2) Resident #111 was interviewed on 3/18/24 at 1:41 PM. Resident stated they have not been receiving showers. A review of Resident #111's clinical record revealed that the facility's Documentation Survey Report form showed the resident only received baths for the months of February and March. Nurse #13 was interviewed on 3/28/24 at 8:46 AM. She was asked about the resident's statement that they have not received any showers. She replied that the resident received a shower on Friday (3/22/24) and is scheduled to receive a shower on every Monday, Wednesday, and Friday. She repeated that the resident got a shower on Friday but refused one yesterday (3/27/24). This surveyor informed the Administrator and the Regional Director of Clinical Operations (Staff #20) on 4/2/24 of the findings. 3) Resident #116 was interviewed on 3/18/24 at 1:25 PM. Resident #116 stated that he/she has not had weekly showers and has had only one shower in the last 30 days. A review of the resident's clinical record on 3/22/24 revealed that the facility's Documentation Survey Report form showed the resident did not receive a shower in either February or March of 2024. This surveyor interviewed Staff #50 on 3/28/24 at 9:06 AM. He informed me that the previous Unit Manager quit recently but he thought that the resident can do things independently and is free to shower on own. Suggested the resident simply chose not to take showers. This surveyor informed him that the clinical record made no mention of the resident refusing to shower. 49815 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 3/17/24 at 12:29 PM the surveyor conducted an interview with Resident #28 who stated that he/she had received 2 showers since being admitted a year ago. Activities of Daily Living (ADL) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet and eating. On 3/29/24 at 8:30 AM the surveyor reviewed the Geriatric Nursing Assistant (GNA) ADL flow sheets for bathing for the period of 12/29/23 through 3/28/24 for Resident #28. There was documentation that the resident received BB which indicated bed bath according to the POC Legend Report for this time period. Further review of the documentation of the ADL flow sheet did not indicate that the resident received a shower during this period. There was documentation of T on the date of 3/18/24 which indicated the resident received a tub bath according to the POC Legend Report. On 4/1/24 at 8:14 AM the surveyor interviewed Resident #28 again and the Resident stated that staff do not offer me showers and that I will take a shower if I get assistance. On 4/1/24 at 8:30 AM the surveyor reviewed the Potomac Hall 7-3 shower list provided by LPN (Licensed Practical Nurse) #6. According to the shower list Resident #28 was scheduled to receive showers on the 7-3 shift every Monday and Thursday. The surveyor interviewed Resident #28's assigned GNA #12 on 4/1/24 at 8:32 AM who confirmed that the resident had not routinely received showers as scheduled. GNA #12 stated that she wanted the residents to get a shower at least monthly. On 4/1/24 at 8:59 AM the surveyor interviewed LPN #6 who conveyed that if a resident refused a shower, the GNA should tell the nurse. Further review on 4/2/24 at 10:10 AM of Resident #28 medical records did not reveal any documentation that the resident refused showers. During an interview conducted on 4/2/24 at 10:23 AM, the Nursing Home Administrator (NHA) and Regional Director of Operations #20 confirmed that the facility expectation is that all residents should receive a shower twice a week. The NHA further stated that the GNAs are expected to document the shower on the ADL flow sheet.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on medical record review and interview it was determined that the facility failed to ensure the accuracy of the Medical Orders for Life-Sustaining Treatment (MOLST) and to maintain a proper resident's Advance Directive in the resident's medical record. This was found to be evident for 7 (Resident #27, #64, #61 and #111) out of 9 residents reviewed for advance directives. The findings include: Medical Orders for Life-Sustaining Treatment (MOLST) is a medical order form that relays instructions between health professionals about patient care. MOLST certifies orders that were agreed to by a patient or a patient's health care agent as named in the patient's advance directive. MOLST determines resuscitation status and includes other 8 sections of treatment choices. An Advance Directive is a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness. An advance directive may also give a person (such as a spouse, relative, or friend) the authority to make medical decisions. 1) During interview, on 03/19/24 at 04:15 PM, Resident #27's legal contact person/family member (per facility's facesheet) revealed that he/she could not remember that the facility staff had a completed MOLST nor an advance directive on admission but the facility had determined this family member as the legal contact person. Record review, on 3/20/24 at 10:31 AM, of Resident # 27's admission record revealed that the resident was admitted to the facility on [DATE] with diagnoses of schizophrenia, major depression, and dementia. During interview, on 03/20/24 at 02:34 PM, Social Worker Staff #16 revealed that Resident #27's advance directive information was built into the facility's internal face sheet section i.e., the legal contact person. Therefore, she was unsure if there was a MOLST or an advance directive on file from the admitted [DATE]. Requested Staff #16 to provide a copy of the MOLST and Advance Directive from the admission period. Record floor chart review, on 3/20/23 at 3:00 PM, revealed that a MOLST form completed on 9/7/23, it stated that Doctor Staff #61 had had a discussion as Resident #27 as he/she mentally competent and informed consent of the patient which it was a mistake. Not only was this MOLST form an error, but the facility staff also failed to comply with and implement a proper MOLST form and an advance directive on admission to avoid the mistake. During interview, on 3/21/24 at 1:37 PM, Staff #16 stated that MOLST form and Advance Directive had not been obtained during the admission period and that she had sent a blank form out yesterday to the legal contact person. Staff #16 admitted it was an omission on her part. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview, on 3/21/24 at 2:07 PM, the Administrator was notified of the above findings and was made aware that there was a concern. 2) Record review, on 3/20/24 at 10:31 AM, of Resident #64's medical record revealed that the resident had resided at the facility for more than 11 months since 4/28/23. Facility staff identified that the resident needed a representative but no proper documentation of MOLST or Advance Directive were found. Further review of the medical record failed to reveal documentation of advanced directives or that a discussion about advanced directives had occurred with the resident's legal contact person. During interview, on 3/20/24 at 2:34 PM, Social Worker Staff #16 stated that she did not have the MOLST nor the advance directive completed on file because the facility was using their internal face sheet section instead. Record floor chart review, on 3/20/24 at 3:20 PM, unable to find a MOLST nor an advance directive in the medical chart. During interview, on 3/21/24 at 2:07 PM, the Administrator was notified that the facility failed to ensure that copies of the resident's MOLST form and advance directive were in the resident's medical record. After surveyor's interventions, on 3/20/24, facility staff had a MOLST and an affidavit for other relative as surrogate decision maker form completed. 14894 3) A review of Resident #61's clinical record on 3/18/24 revealed that the resident did not have an Advance Directive. Further review showed that the resident and/or their responsible party was not offered an Advance Directive to complete. The Social Work Director (Staff #16) was interviewed on 3/22/24 at 9:20 AM. Staff #16 said that most residents who are their own responsible party (RP) do not have one and that they do not ask them if they want to get one. She added that they have not always documented that in the residents' progress notes. This surveyor informed the Administrator and the Regional Director of Clinical operations (Staff #20) of the findings on 4/2/24 at 10:00 AM. Staff #20 said that the residents often refuse, and he would check to see if it was occurring in this case. 4) A review of Resident #111's clinical record revealed that there wasn't an Advance Directive present nor was there any evidence that facility staff offered to assist the resident with its completion. Further review revealed that on 3/22/24 at 9:03 AM the Social Worker wrote a note Writer spoke with resident about Advance Directive, resident stated [he/she's] well aware of what an Advance Directive is and is not interested in doing one at this time. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This surveyor informed the Administrator and the Regional Director of Clinical operations (Staff #20) of the findings on 4/2/24 at 10:00 AM. Staff #20 said that the residents often refuse, and he would check to see if it was occurring in this case.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49815 Based on observations, interviews and documentation review it was determined the facility failed to ensure that personal property was not lost. This was found to be evident for 1 (Resident #28) out of 1 Resident observed for missing property. The findings include: During the initial tour conducted on the 3rd floor nursing unit on 03/17/24 at 12:25 pm, the surveyors interviewed Resident #28. The Resident informed the surveyors that he/she had missing clothes and that he/she went down to the laundry department often to look for clothes. The Resident further stated that he/she had reported the missing clothes several times to the Nurses, Social Service Director, and the Administrator. On 3/29/24 at 9:05 am the surveyors interviewed the Nursing Home Administrator (NHA) about the process for missing personal property. The NHA conveyed to the surveyors that an inventory list is completed when the Resident is first admitted to the facility. The facility will review the inventory form when Residents have a concern about missing items, a grievance form would be completed and an investigation would be conducted. If the missing item is not located the facility would replace the missing item. The surveyor reviewed the grievance forms that were provided by the NHA on 3/29/24 at 10:30 am. The following grievance forms were reviewed by the surveyor: 12/1/23, 12/4/23, 1/3/24, 1/10/24, 1/16/24, 2/15/24 and 2/22/24. The facility did not have any grievance forms for Resident #28 related to missing personal property (specifically missing clothes). The NHA confirmed that there were not any grievance forms for Resident #28. The surveyors interviewed Resident #28 again on 4/1/24 at 8:14 am, Resident #28 stated that she lost a shirt, pants and coat, but was not aware that he/she needed to include these items on the inventory sheet. On 4/1/24 at approximately 8:45 am the surveyor interviewed Geriatric Nursing Assistant (GNA) #12 and Licensed Practical Nurse (LPN) #6. Both employees conveyed that the personal inventory sheet is kept in the back of the physical chart. On 4/1/24 at 8:50 am the surveyor reviewed Resident #28's physical chart and was unable to locate a personal inventory sheet. The surveyors interviewed Social Service Director #16 at 9:03 am on 4/1/24 about the procedure for missing personal items. The Social Service Director stated that she would check the personal inventory sheet to see if the item is listed on the inventory sheet, the Housekeeping Supervisor #42 would look for any missing clothing items, and if the item could not be located the NHA would replace the missing item. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Social Service Director further indicated that she was aware of Resident #28'ss missing clothing items and that Resident had three bags of clothes when he/she moved-in to the facility. The Social Service Director stated that the Housekeeping Supervisor was now looking for these clothing items. At 9:30 am on 4/1/24 the surveyor asked the NHA if there now was a grievance form completed since Resident #28 had once again expressed his/her concern for the missing clothing items. NHA revealed that she was not aware of missing clothing items for Resident #28 and that she would follow-up with the Social Service Director and Housekeeping Supervisor. On 4/2/24 at 9:35 am the surveyors interviewed Housekeeping Supervisor #42 with the NHA present. The facility is unable to locate Resident #28's personal inventory sheet as conveyed by the NHA. The Housekeeping Supervisor stated that he had met with Resident #28 on 3/29/24 to review his/her missing items and provided the surveyors with a 1 1/2-page list of the missing items. The NHA stated that she will review this list of missing items from Resident #28 and replace items as indicated. The Housekeeping Supervisor further stated that when Resident #28 first came into the facility, he/she had 3 bags of clothing,1 bag to be washed and the other 2 bags to be donated. The Housekeeping Supervisor advised the surveyors that he believed all 3 bags of clothing were donated by mistake because he could not locate the bag of clothes that were labeled to be washed. The NHA provided the surveyor with a grievance form on 4/3/24 at 10:10 am for Resident #28 missing clothing items that included two clothing items listed as an immediate need. This grievance form was dated 3/29/24 as date received from Social Service Director #16 and the NHA signature was signed with a date of 4/2/24.

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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. 45733 Based on medical record review and interview, it was determined that the facility failed to ensure that the reporting of reasonable suspicion of an abuse result in serious bodily injury was no later than 2 hours to the State Agency after informing the State Agency of the suspicion of an abuse incident. This was evident for 1 (Resident #64) out of 12 residents reviewed for the facility self-report incidents. The findings include: An incident that involves a reasonable suspicion of abuse of a resident must be reported in an initial facility self-report to the State Agency within 2 hours after the incident was reported. Record review, on 03/28/24 at 1:20 PM, of the facility's self-report file found that an initial self-report (MD00200322) was sent, on 12/6/23 at 5:45 PM, to the State Agency. Further review revealed that within the facility's self-report investigation form, the alleged incident date and time was on 12/4/23 at 10:49 PM. It meant the incident occurred 2 days prior to the initial report date. On page 5 out of 7 of the self-report investigation form Resident #64 complained of right hip pain at that time. On 12/4/23 Nurse Practitioner #52 charted that Resident #64 had, a fall 3 days ago but not documented, which meant that the resident was injured on 12/1/23. On 12/5/23 an x-ray was ordered and confirmed that Resident #64 had a right hip intertrochanteric fracture. The resident was transferred to a community hospital where he/she had urgent surgery on 12/6/23. Hip intertrochanteric fracture- A hip fracture is a break in the upper portion of the femur thighbone. Most hip fractures occur in elderly patients whose bones have become weakened. During a telephone interview, on 4/3/24 at 11:06 AM, nurse (Staff #38) stated that on 12/4/23 at 10:49 PM Resident #64 returned to his/her room in a wheelchair. At that time the resident told Staff #38 about the right hip pain and mentioned that he/she fell 3 days ago but he/she did not tell anyone. Staff #38 added this resident usually was ambulatory upon this date. During an interview, on 4/3/2024 at 11:25 AM, the Administrator confirmed that the facility staff were made aware of this reasonable suspicion of serious bodily injury on 12/4/23 at 10:49 PM, however, the initial self-report was not sent to the State Agency until 12/6/23 at 5:45 PM, 2 days and 7 hours later.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interviews, it was determined the facility failed to: 1) provide written notice with the reason for transfer to a Resident and 2) failed to notify the Ombudsman of residents that transferred. This was found evident of 3 of 6 (Resident #332, #63, and #109) residents reviewed for hospitalization during the survey. The findings included: 1a) On 3/18/24 at 9:49 AM, the surveyor conducted an interview with Resident #332. During the interview Resident #332 stated he/she had recently been hospitalized . On 3/22/24 at 7:56 AM, the surveyor reviewed Resident #332's medical record. The review revealed that in early February 2024 Resident #332 was transferred to the hospital. Further review revealed a change of condition progress note written by Licensed Practical Nurse (LPN) Staff #50 for the hospital transfer. The note stated, the resident was notified of the reason for transfer. However there was no indication that the resident received a written notice for the reason for transfer or that the resident understood or acknowledged the transfer notification. 1b) On 3/27/24 at 9:52 AM, the surveyor requested the notification of transfers and discharges that were given to the Ombudsman for the month of February 2024. On 3/27/24 at 2:01 AM, the surveyor and the Nursing Home Administrator (NHA) reviewed the email sent to the Ombudsman Office regarding February's transfers and discharges. The NHA stated that the Social Worker provided the list. After review, Resident #332 was not on the February 2024 transfer and discharge list. The NHA acknowledged that the transfers for the month were not sent to the Ombudsman, only the discharges. 48393 2) On 03/22/2024 at 08:13 AM, a review of Resident #63's electronic and paper medical record revealed that Resident #63 was transferred to the hospital on 02/17/2024 due to abdominal pain and vomiting. Further review of Resident #63's medical record revealed no documentation that the resident/resident representative was notified in writing of the hospital transfer. On 03/25/24 at 08:35 AM, an interview conducted with Registered Nurse (RN #4) revealed that prior to the transfer, he/she verbally told the resident that they are being transferred to the hospital. RN #4 further stated that he/she does not give a written notice to the resident when they transfer. At the time of exit conference, the facility did not provide any evidence that a written notice of transfer was given to Resident #63 and the resident's representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 03/22/2024 at 08:13 AM, a review of Resident #109's electronic and hospital discharge summary revealed that Resident #109 was admitted to the facility on [DATE] and transferred to the hospital on 1/10/2024 due to the facility not having appropriate respiratory equipment on hand. Further review of Resident #109's medical record revealed no documentation that the resident/resident representative was notified in writing of the hospital transfer. On 03/25/24 at 08:35 AM, an interview conducted with RN #4 revealed that prior to transfer, he/she verbally told the resident that they are being transferred to the hospital. RN #4 further stated that he/she does not give a written notice to the resident when they transfer. At the time of exit conference, the facility did not provide any evidence that a written notice of transfer was given to Resident #109 and the resident's representative.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on interviews and medical record review, it was determined that the facility failed to have an effective system in place to ensure that residents and resident representatives are notified in writing of the bed hold policy upon transfer to the hospital. This was found to be evident for 4 (Residents #16, #63, #109, and #117) out of 6 residents reviewed for hospitalization during the annual survey. The findings include: A Bed Hold is the act of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . It must be provided to all facility residents regardless of payment source. Bed Hold policy should be disclosed in the admission packet during initial admission to the facility and it should be disclosed to resident and, if applicable, resident representatives at the time of transfer; if emergency transfer, within 24 hours. 1) On 3/28/24 at 9:40 am the surveyor conducted a review of Resident #16's medical record. According to the documentation in the medical record Resident #16 called 911 on 3/6/24 to be transferred to the hospital. Resident #16 is his own responsible party and there was no emergency contact listed. Further review of the medical record by the surveyor on 4/1/24 at 8:48 am failed to indicate that the bed hold was offered to Resident #16 upon transfer, and there was no documentation of Resident #16 being offered a bed hold in his/her physical chart on the nursing unit. On 4/1/24 at 8:50 am the surveyor interviewed Licensed Practical Nurse (LPN) #43 in reference to the procedure to offer a bed hold to a Resident upon transfer to the hospital. LPN #43 stated that she completes the information on the etransfer form in the computer and that she has only transferred one Resident to hospital since she has been employed here at facility. LPN #43 stated that she did not offer Resident a bed hold. At 8:54 am on 4/1/24 the surveyor interviewed LPN #6 in reference to the procedure to offer a bed hold to a Resident upon transfer to the hospital. LPN #6 stated that she will document the note in the electronic medical record within 4 hours if the Resident stayed in the hospital or returned to the facility. LPN #6 further stated that she did not offer Residents a bed hold upon transfer to hospital. During an interview conducted by the surveyor with the Nursing Home Administrator (NHA) on 4/2/24 at 9:02 am, the NHA stated that the expectation for staff was to offer and document bed holds to Residents or their responsible parties upon transfer to hospital. The surveyor conveyed to the NHA the response from the two nurses regarding the bed hold process. NHA further stated that she was unable to locate any documentation that staff offered a bed hold to Resident #16 upon transfer to hospital on 3/6/24. 48393 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 03/22/2024 at 08:13 AM, a review of Resident #63's electronic and paper medical record revealed that Resident #63 was transferred to the hospital on 02/17/2023 due to abdominal pain and vomiting. Further review of Resident #63's medical record revealed no documentation that the resident/resident representative was given a copy of the bed hold policy. 03/25/24 08:35 AM, an interview conducted with RN #4 regarding the bed hold policy. RN #4 confirmed that a copy of the bed hold policy for Resident #63 was not in the medical record. RN #4 stated that the social worker reviews the bed hold policy with the resident during the admissions process. RN #4 further stated that he/she verbally lets the resident know that their bed will be held for 24 hours when they transfer and that he/she does not give the resident a copy of the bed hold policy. On 03/25/24 08:40 AM, an interview was conducted with the Director of Nursing (DON) #4. DON #4 confirmed that the social worker reviews the bed hold policy with the resident once, on admission. DON #4 further confirmed that the nursing staff does not provide written notice of the bed hold policy to residents when they transfer out of the facility. On 03/25/2024 at 11:26 AM, an interview was conducted with the Social Worker #16. Social Worker #16 stated, We don't go over bed holds on admission, that is nursing. On 03/25/24 at 11:32 AM, an interview was conducted with the Administrator. The Administrator stated that nursing should offer a written copy of the bed hold policy when the resident goes out to hospital. The Administrator further stated that the Admissions department should be reaching out to the resident within 24 hours of transfer to let him/her know they may not be going back to the same room when they return to the facility. At the time of exit conference, the facility did not provide any evidence that a copy of the bed hold policy was given to Resident #63 and the resident'ss representative. 3) On 03/22/2024 at 08:13 AM, a review of Resident #109 's electronic and paper medical record revealed that Resident #109 was admitted to the facility on [DATE] and transferred to the hospital on 1/10/2024 due to the facility not having appropriate respiratory equipment on hand. Further review of Resident #109's medical record revealed no documentation that the resident/resident representative was given a copy of the bed hold policy. 03/25/24 08:35 AM, an interview conducted with RN #4 regarding the bed hold policy. RN #4 confirmed that a copy of the bed hold policy for Resident #63 was not in the medical record. RN #4 stated that the social worker reviews the bed hold policy with the resident during the admissions process. RN #4 further stated that he/she verbally lets the resident know that their bed will be held for 24 hours when they transfer and that he/she does not give the resident a copy of the bed hold policy. On 03/25/24 08:40 AM, an interview was conducted with the Director of Nursing (DON) #4. DON #4 confirmed that the social worker reviews the bed hold policy with the resident once, on admission. DON #4 further confirmed that the nursing staff does not provide written notice of the bed hold policy to residents when they transfer out of the facility. On 03/25/2024 at 11:26 AM, an interview was conducted with the Social Worker #16. Social Worker #16 stated, We don't go over bed holds on admission, that is nursing. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/24 at 11:32 AM, an interview was conducted with the Administrator. The Administrator stated that nursing should offer a written copy of the bed hold policy when the resident goes out to hospital. The Administrator further stated that the Admissions department should be reaching out to the resident within 24 hours of transfer to let him/her know they may not be going back to the same room when they return to the facility. At the time of exit conference, the facility did not provide any evidence that a copy of the bed hold policy was given to Resident #109 and the resident's representative. 14894 4) A review of Resident #117's clinical record on 3/21/24 revealed that the resident was sent to the hospital on 3/9/24. There was no documentation that the resident was provided with a copy of the facility bed hold policy at the time of being sent out or having the policy sent to the hospital at a later time. The Administrator and Regional Clinical Director was interviewed on 4/2/24 at 11:00 AM. Informed them of the concern as well as the need to inform the residents and reminded the Administrator that I had requested the bed hold notice days earlier. They did not dispute the findings or provide any evidence that the resident was notified.

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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** 49815 Based on staff interview and medical record review, it was determined that the facility failed to accurately document resident assessment on the MDS (Minimum Data Set) as evidenced by the inaccurate coding for residents. This was found to be evident for 4 out of 6 Residents (#13, #16, #24, & #28) reviewed for accuracy of MDS assessments. The findings include: The MDS (Minimum Data Set) is a health status screening and assessment tool used for all residents of long-term care nursing facilities. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. Hemodialysis is a process of filtering the blood of a person whose kidneys are not working normally and is a treatment to filter wastes and water from the blood, as the kidneys did when they were healthy. Hemodialysis helps control blood pressure and balance important minerals, including potassium, sodium, and calcium in the blood. 1) On 03/18/24 at 9:59 AM, the surveyor conducted medical record review for Resident #16. The medical record revealed that Resident #16 had a medical diagnosis of ESRD (End Stage Renal Disease) and was dependent on dialysis as documented in the Medical Diagnosis tab of the electronic medical record. Further review of the medical record on 3/25/24 at 11:40 AM, revealed that Resident #16 had a quarterly MDS assessment dated [DATE]. Section I of the MDS had a diagnosis of Dependence on Renal Dialysis listed, but Section O of the MDS had dialysis not checked. On 4/3/24 at 12:50 PM the surveyor reviewed Resident #16's MDS assessment dated [DATE] with the NHA (Nursing Home Administrator) and explained that Section I of the MDS assessment had a diagnosis of Dependence on Renal Dialysis, but Section O of the MDS did not indicate that the resident received dialysis. The NHA confirmed that Resident #16 did not receive dialysis. 2) On 3/27/24 at 7:15 AM a review of Resident #28's medical record by the surveyor revealed an annual MDS assessment dated [DATE]. Section J had documented that the resident's Health Condition for Current Tobacco Use is checked as, no. Further review of the medical record revealed that the resident had Smoking Assessments completed on the following dates 11/7/22, 11/29/22, 10/18/23, and 2/17/24 which indicated that the resident uses nicotine. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/24 at 11:20 AM the surveyor reviewed Resident #28's MDS assessment dated [DATE] with the Lead MDS Coordinator (Staff #46) via telephone interview and in the presence of the NHA. The surveyor explained that, no, was checked on the MDS for Tobacco use, and that the four smoking assessments indicated that the resident uses nicotine. The Lead MDS Coordinator (#46) stated that she was not aware that the resident is a smoker. 3) On 4/1/24 review of the Resident #24's medical record by the surveyor revealed that the resident had a medical diagnosis of Depression and Anxiety disorder, unspecified as documented on the encounter progress note dated 1/20/24 by the psychiatric Nurse Practitioner (NP #51) from Brighter Days Recovery Center. The quarterly MDS assessment dated [DATE] Section I did not have Anxiety Disorder or Depression checked as active diagnoses, but Section N did have antianxiety and antidepressant medication checked as being used by the resident. On 4/3/24 at 11:20 AM the surveyor reviewed Resident #24's MDS assessment dated [DATE] with Lead MDS Coordinator (#46) via telephone interview and in the presence of the NHA. The surveyor explained that Section I of the MDS assessment did not indicate that the resident has an active diagnosis of depression and anxiety disorder, and Section N of the MDS indicated that the resident does receive antianxiety and antidepressant medications. The Lead MDS Coordinator (#46) stated, I see that, error on our part, can we do a modification. 45733 4) During observation and interview, on 03/18/24 at 10:06 AM, Resident #13 was in a sitting upright position with visible two above-the-knee stumps. The resident reported he/she had bilateral above knee amputations several years ago but could not remenber what year. Record review, on 3/26/24 at 3:11 PM, of Resident #13's MDS assessment found that the resident had the following diagnoses: bilateral above knee amputations, mood disturbance and anxiety. Resident #13's two MDS assessments contained the following documentation: Dated 9/26/23 by MDS Staff #34 under GG section -H putting on/off footwear was coded maximal assistance. Dated 12/26/23 by MDS Staff #23 under GG section -H putting on/off footwear was coded maximal assistance. However, Resident #13 had bilateral above knee amputation years ago and did not have protheses. During an interview, on 3/27/24 at 11:50 AM, the MDS Coordinator (Staff #23) stated that she oversaw the putting on/off footwear section and miscoded the level of assistance was maximal. During interview, on 3/27/24 at 12:50 AM, the Administrator stated that she was not aware of the MDS incorrect coding under the GG section, letter H and agreed that it was an MDS coding error.

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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 44440 Based on interview and record review it was determined that the facility failed to develop and provide the baseline care plan to a newly admitted resident. This was found to be evident for 1(Resident #125 and #109) of 6 residents reviewed for care planning during the survey. The finding include: On 3/21/24 at 8:51 AM the surveyor reviewed Resident #125's medical record. The review revealed that Resident #125 was admitted to the facility in late January 2024. Further review revealed no baseline care plan note. A nursing evaluation was completed on 1/24/24, however in the evaluation there was no indication that any care planning was discussed with the resident or that the resident received a summary. The evaluation did not document the therapy services the facility planned to provide, the resident's goals to be obtained or a summary of the resident's medications with dietary instructions. On 3/21/24 at 12:54 PM, the surveyor requested the baseline care plan for Resident #125 from the Nursing Home Administrator (NHA). On 3/21/24 at 1:41 PM, the NHA returned stating that nursing does the baseline care planning in their initial assessment. The surveyor reviewed the concerns that there was no indication that the care plan was discussed with the resident and that the services that the facility was planning on providing was not part of the evaluation. The NHA stated that she would investigate the concern. At the time of exit no additional information was given to the surveyor regarding baseline care planning.

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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** 49815 Based on observation, interviews and record review it was determined that the facility failed to develop a care plan for smoking. This was found to be evident for 3 (Resident #28, #125, and #111) out of 6 residents reviewed for care plans. The findings include: On the initial tour of the facility on 3/17/24 at 12:10 PM the surveyors smelled smoke in Resident #28's room as they entered the room. Resident #28 was the only resident residing in the room at that time. The surveyors immediately interviewed the resident with the Unit Manager #50. The resident conveyed that he/she does not smoke. The surveyors and Unit Manager #50 observed 3 cigarette butts in water in a plastic cup and an empty pack of [NAME] cigarettes on the dresser in the rsident's room. Resident #28 denied the use of these cigarette butts. Review of the care plan for Resident #28 conducted by the surveyor on 3/17/24 at 1:00 PM revealed that the resident did not have a care plan for smoking. The surveyors interviewed the Nursing Home Administrator (NHA) at 1:20 PM on 3/17/24 and told the NHA that there was a smell of smoke in Resident #28's room along with cigarette butts and an empty pack of cigarettes. The NHA confirmed that Resident #28 had a smoking contract. A review of the facility's smoking list was conducted on 3/19/24 at 11:45 AM by the surveyors. The smoking list identified Resident #28 as a smoker. During an interview with the Activities Assistant (Staff #35) on 3/19/24 at 11:48 AM, Activities Assistant #35 stated that Resident #28 comes outside to smoke two times a month without his/her oxygen tank. The Activities Assistant further stated that the resident stopped off at the therapy department to drop off his/her oxygen tank prior to going outside to smoke. Once the resident had finished smoking outside Resident #28 would return to the therapy department to retrieve his/her oxygen tank. Review of the medical record by the surveyor on 3/27/24 at 7:15 AM revealed that Resident #28 had smoking assessments completed on the following dates: 11/7/22, 11/29/22, 10/18/23 & 2/17/24 which indicated cigarettes as the type of nicotine used. Further review of the medical record revealed a Notice of Violation of Guidelines or Resident Behavior form signed by Resident #28 on 1/2/24 that indicated that the resident had been observed, and documented that he/she had smoked with oxygen in the room. Also, Resident #28 signed the Smoking Acknowledgement Form (smoking contract) on the following dates: 1/2/24 and 3/12/24. Upon review of Resident #28's care plan on 3/27/24 at 9:45 AM the surveyor noted that a care plan was not added for Resident #28 related to the use of nicotine products until 3/18/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44440 2) On 3/19/24 at 9:43 AM, the surveyor interviewed Resident #125. During this interview Resident #125 stated that he/she had just been discharged from physical therapy and was waiting on someone to help him/her with discharge planning. On 3/21/24 at 8:51 AM the surveyor reviewed Resident #125's medical record. The review revealed that Resident #125 was admitted to the facility in late January 2024. Further review revealed on Resident #125's admission Minimum Data Set (MDS) assessment that Resident #125 indicated his/her discharge goal was to be discharged to the community. The assessment stated no, to the question; Is active discharge planning already occurring for the resident to return to the community? The surveyor next reviewed Resident #125's care plan. No care plan was initiated for anticipating the resident's discharge needs. On 3/21/24 at 1:41 PM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the NHA confirmed that there was no discharge care plan initiated and there should have been one. 14894 3) A review of Resident #111's clinical record on 3/18/24 revealed that the resident has incontinence and that staff use incontinence briefs on him/her. The resident was not on a toileting program to correct the incontinence. The resident's care plan noted that the resident was independent with bathroom Activities of Daily Living (ADL). A resident who is independent with bathroom ADL's is usually able to use a commode or toilet, and does not need to use an incontinence brief. The Administrator was interviewed on 4/2/24. She was informed of the findings and asked why the nursing was using the incontinence briefs on the resident. She acknowledged the findings, said it was a concern to her, and she would look into it.

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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. 44440 Based on record review, and interviews, it was determined that the facility failed to hold care plan meetings with an interdisciplinary team for residents at the time of the Minimum Data Set (MDS) assessment. This was found evident for 3 (#97, #33, and #81) of 6 residents reviewed for care planning. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team. 1) On 3/19/24 at 9:05 AM, the surveyor interviewed Resident #97. During the interview Resident #97 stated he/she was never invited to a care plan meeting. On 3/22/24 at 9:36 AM, the surveyor conducted an interview with Social Worker Staff #16. During the interview Staff #16 stated that Resident #97 was a long term care resident and her Social Work Assistant, Staff #17, would be more familiar with Resident #97's care plan meetings. Staff #16 however, stated that Resident #97's sister had recently called and she spoke with her and gave her an update on Resident #97. On 3/22/24 at 9:54 AM, the surveyor interviewed Social Worker Assistant Staff #17. In the interview Staff #17 stated she plans her care plan meeting following the Minimum Data Set (MDS) assessment calendar. She further stated that a week before the meeting she sends an invitation letter stating a care plan meeting is going to be held. She stated that residents are always invited to the meetings even if they have a Resident Representative helping them make decisions. Staff #17 stated a call is made to update the Resident Representative/Responsible Party (RP) if needed. After the care plan meeting, Staff #17 stated she records the care plan meeting in the Resident's progress notes and documents the topics that were discussed and everyone that was in attendance. When asked if Resident #97 was ever invited a to a care plan meeting Staff #17 stated she couldn't remember having a care plan meeting with him/her. She further stated she is not up-to-date on conducting care plan meetings for her residents. The surveyor requested any progress notes from a care plan meetings for Resident #97. On 3/22/24 at 10:06 AM, the surveyor interviewed Staff #16. Staff #16 confirmed she was responsible for overseeing Staff #17's work. She stated she was unaware that Staff #17 was behind on the care plan meeting but would work on getting the meetings up to date. At the time of exit no care plan meeting notes were provided to the surveyor for Resident #97. 45733 2) During interview, on 3/19/24 at 2:25 PM, Resident #33 reported that he/she did not remember that he/she had a care plan meeting in the past. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review, on 3/21/24 at 10:10 AM, of Resident #33's record, from January 1, 2022 to March 21, 2024, for social worker care plan notifications and meetings documentation, revealed that there was none. During interview, on 3/22/24 at 11:11 AM, Social Worker Staff #16 stated that on or about 9/3/23 there should have been an annual care plan meeting, Staff #16 stated the last annual care plan meeting was 2020. However, Staff #16 confirmed that the last care plan meeting was on 1/29/20 and no other care plan meetings were conducted after that date. On 3/22/24 at 11:23 AM, the Administrator was made aware that the last care plan meeting was 2020 and it was a concern that facility staff had failed to not properly notify and conduct the care plan meetings. 14894 3) This surveyor interviewed Resident #81 on 3/18/24 at 9:23 AM. Resident stated that he/she has not had a care plan meeting and has not seen the Social Worker since admission. This surveyor requested the care plan attendance sheets on 3/26/24 at 10:30 AM from the Administrator. The sheets had not been provided prior to the exit conference.

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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. 14894 Based on resident interview, staff interview, and observation it was determined that the facility staff failed to ensure that residents toenails were cut. This was evident for 1 (#183) out of 48 residents in the survey sample. The findings are: This surveyor observed Resident #183 on 3/18/24 at 9:59 AM and witnessed that the right foot had a long toenail on the big toe that measured about one inch above the toe. This surveyor interviewed Resident #183 on 3/18/24 at 10:02 AM. The resident stated that no one has cut the toenails even after the dressings on the feet were changed. The resident's toenail was observed on 3/22/24 at 1:13 PM to still be long. The Regional Clinical Director (Staff # 20) was interviewed on 4/2/24 at 11:40 AM. He confirmed that the resident had a podiatry appointment last week and said the facility will complete an 100% audit of all residents to ensure nails would be cut.

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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. 44440 Based on interviews and record review it was determined that the facility failed to have an activities program designed to meet the interests and needs of residents based on the resident's comprehensive assessment and care plan. This was found evident of 2 (Resident #7 and #79) of 5 residents reviewed for activity during the survey. The findings include: 1) On 3/18/24 at 10:33 AM, and on 3/19/24 at 10:21 AM, the surveyor observed Resident #7 lying in bed with the covers pulled over his/her head. On 3/21/24 at 6:43 AM, the surveyor reviewed Resident #7's medical record. The review revealed that Resident #7 was admitted to the facility in early 2020 with a medical diagnosis, of, but not limited to, paranoid schizophrenia, major depressive disorder, adjustment insomnia, and mild cognitive impairment. Further review revealed a Minimum Data Set (MDS) assessment was conducted on 1/15/24 for Resident #7 and indicated his/her preferences in section F of the assessment. Resident #7 indicated it was very important to do things in group activities, keep up with the news, go outside, participate in religious practices and to do his/her favorite activities. Resident #7 also indicated it was somewhat important to listen to music and be around animals. Next the care plan was reviewed and Resident #7 had two care plans for activities. The first care plan was initiated in October of 2021 and the stated focus was for Resident #7 to engage in self-directed activities. The second care plan was developed in February of 2024 and the focus stated, Resident #7's activities to be self-directed and for activities in and out of the room daily. It further stated Resident #7 was dependent on staff for activities, cognitive simulation, or social interaction due to the disease process of paranoid schizophrenia. Interventions listed were, encourage attendance to entertainment programs, large and small group activities, volunteer demonstrations and religious activities. On 3/25/24 at 1:08 PM, the surveyor again observed Resident #7 lying in bed. The lunch tray was at the bedside table and the juice container was empty. On 3/27/24 at 6:58 AM, the surveyor reviewed a progress note written on 2/27/23 Activities Assistant Staff #50. In the progress note Staff # 50 described that the Activities Director Staff #28 followed up with Resident #7 about an altercation Resident #7 had with another Resident. The plan described Resident #7 will be receiving 1:1 programs. The plan further states the activities staff would visit 1-2 times per day and provide 1:1 in and out room diversionary activities and materials of interest for the resident. The notes stated an infant doll was provided and the Resident was pleased with the plan. On 3/27/24 at 12:25 PM, the surveyor interviewed the Activities Director Staff #28. During the interview Staff #28 stated she had completed the last preference assessment on Resident #7. She further stated she could provide the attendance log for the activities that were provided to Resident #7. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/29/24 at 9:25 AM, the surveyor reviewed the one-on-one visit logs provided by the activities staff. The documented activities are as follows: On 2/15/24, a notation that activities staff delivered a snack to Resident #7, on 2/17/24 tea and coffee was delivered with music stimulation. In March of 2024 on 3/4/24 and 3/24/24 a snack was delivered with music playing during distribution, on 3/8/24 a light conversation was offered, and 3/25/24 a crossword and snack was delivered and on 3/27/24 a snack and a conversation was offered. In the two months reviewed no activities were offered that Resident #7 had expressed were very important in the MDS preferences assessment or the 1-2 time a day interaction as written in the activities progress note. 14894 2) This surveyor interviewed Resident #79 on 3/17/24 at 11:42 AM. Resident #79 was asked about the facility's activity program and he/she replied that the activities were limited to being provided a snack such as fruit or pizza, listening to music or talking with each other. This surveyor requested activity logs from the Administrator on 3/21/24. The logs were for 2/9/24, 2/11/24, and 2/23/24. The activities were coloring material dropped off (3/21), supplies delivery (2/11), and nails and conforsation. This surveyor interviewed the Administrator and the Regional Clinical Director (Staff #20) on 4/2/24 at 10:15 AM. They were shown the sheets, and the lack of activities was shared with them including supplies delivery being used as an activity. They saw the sheets and did not disagree that the activities were lacking.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44440 Based on interviews, record review, and observation it was determined that the facility failed to provide wound care treatments according to professional standards. This was found evident of 4 (Resident #101, #21, #332, and #74) of 6 Residents reviewed for skin and wound care. The findings include: 1) On 3/22/24 at 11:54 AM, the surveyor interviewed Resident #101 along with his/her significant other. During the interview Resident #101 stated his/her significant other was performing the wound care and that he/she was content with this arrangement. Resident #101's significant other stated he/she had no problem with providing the wound care. He/she further stated that until recently the facility's wound nurse would watch and evaluate the wounds while they were being changed; however, the wound nurse had not been in for several weeks and since then no other staff had watched the wound dressing change. On 3/26/24 at 9:53 AM, the surveyor reviewed Resident #101's care plan. On 2/14/24 a care plan was initiated that stated Resident #101 had his/her wound care treatment preference. On 7/27/23 an intervention was initiated that stated; evaluate existing wound daily for changes (redness, edema, drainage, pain and foul odor). On 3/26/24 at 1:35 PM, the surveyor reviewed the progress notes for Resident #101. On 2/13/24 at 4:19 PM, Wound Nurse Staff #39, wrote a progress note and documented the size, skin characteristic and drainage of all 5 of Resident #101's wounds. She wrote treatment for the resident's right foot wound would change and ended her note by writing, nursing to continue with the current plan of treatment for the rest of the wounds. On 2/20/24 a progress note written by Wound Nurse Practitioner Staff # 40 documented an assessment on all 5 of Resident #101's wounds. The assessment included size, skin characteristics and drainage. The assessment documented that Resident #101's right toe wound status was resolved and the other 4 were either stable or stalled. On 3/22/24 at 11:22 AM the surveyor reviewed a progress note written by Staff # 40. In this progress note Staff #40 wrote; the wound was not seen. If further stated; patient was unable to be evaluated by the skin and wound team today; patient refused care today. The notes next stated, Staff reports [significant other] has been completing wound dressing changes. On 3/6/24 at 10:38 AM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #45. During the interview staff #45 stated the facility used to have a wound nurse who would perform the wound care but a few weeks ago she left. He further stated the nurses are now doing their Resident's wound cares. Staff #45 stated the wound Nurse Practitioner still comes once a week and does wound care evaluations and is responsible for measurements of the wounds to keep consistent documentation. He further stated the nurse should assess the wound each dressing change and notify the provider if there are any changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #101's medical record revealed wound care signed off on the Resident #101's Treatments Administration Record (TAR) however, no size, skin characteristic or drainage was noted since the 2/20/24 progress note written by NP Staff #40. On 3/28/24 at 9:23 AM, the surveyor interviewed the Nursing Home Administrator (NHA) along with Resident #101's Nurse Practitioner Staff # 41 about the lack of wound documentation. During this interview the NHA confirmed that on 2/27/24 the facility's wound nurse no longer worked at the facility and that the nurses are expected to provide their Resident's wound care Staff #41 stated that Resident #101 should have had his/her wounds assessed and documentation of that assessment should be in the medical record. On 4/1/24 at 7:30 AM, the surveyor reviewed the facility's Skin Care and Wound Treatment policy the NHA provided when asked for skin and wound policy. The policy was specific to a skin tear wound (a laceration of the epidermis (superficial layer of the skin)). In the policy it states that documentation of the wounds measurements and characteristics should be completed no less than weekly. At the time of exit no additional assessments were provided with wound care assessments. 2) On 3/25/24 at 7:59 AM, the surveyor reviewed Resident #21's medical record. The review revealed in March the Wound Nurse Practitioner (NP) Staff #40 evaluated Resident #21's left ankle wound on 3/5/24, 3/12/24 and attempted to 3/22/24 but was unable to due to Resident #21 not present in the facility at the time of the visit. On further review no documentation of Resident #21's wounds measurements were found after the 3/12/24 visit from the wound NP. On 3/25/24 at 1:20 PM, the surveyor interviewed Resident #21. During the interview Resident #21 stated that during the night he/she had to remove his/her sock because the left leg started to hurt. He/she told the night nurse and she changed the dressing on his/her left leg wound. Resident #21 further stated that the Nurse Practitioner Staff #41 was in to see the wound and told him/her she would be starting antibiotics due to the leg wound infection. The surveyor observed Resident #21's left leg. The leg appeared red, swollen and Resident #21 reported it be hot to touch. On 3/25/24 at 1:26PM, the surveyor reviewed the orders. Resident #21 had an order placed on 3/25/24 for clindamycin (antibiotic) described for cellulitis (skin infection). On 3/26/24 at 9:23 AM, the surveyor reviewed Resident #21's March Treatment Administration Record (TAR). The TAR had a chart to document daily assessment of the left ankle wound. Drainage, dressing, infection, necrotic (dead) tissue present, odor, surrounding skin, and pain at wounds site were to be assessed. Instructions were Y=yes, N=No and specifically for surrounding skin, N=normal A=abnormal and level of pain. On further review NA was documented in all the assessment boxes on three of the days in March. On three additional days the boxes were left blank and on 3/14/24 0 was in all of the assessment boxes. On 3/25/24 and 3/26/24 the assessment for infection was documented no and the assessment for surrounding skin was normal even as the Resident was on antibiotics for the infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/28/24 at 9:28 AM, the surveyor conducted an interview with the Regional Director of Clinical Operations Staff #20. During the interview the concern of lack of and inaccurate wound documentation was discussed. Staff #20 stated he would look into the documentation and return with the rationale the documentation. At the time of exit not additional information was provided. 3) On 3/22/24 at 7:41 AM, the surveyor reviewed Resident #332's medical record. The record revealed that in late February Resident #332 was discharged from a hospital and readmitted to the facility. On further review Resident #332 was seen by the Wound Nurse Practitioner (NP) Staff # 40 on 3/1/24. Staff #40 evaluated Resident #332's wounds. Resident #332's right hand and right ischium (back/hip) wound had measurement and treatment recommendation and his/her left heel wound was assessed as resolved. On 3/26/24 at 10:46 AM, the surveyor observed Resident #332 in the hallway. Resident #332's right hand had a dressing covering his/her hand and forearm. The dressing was dated 3/22/24 to indicate when it was last changed. On 3/27/24 at 11:39 AM, the surveyor reviewed additional wound notes written by Staff NP #40. The note written on 3/22/24 stated Resident #332's skin and wound was not seen. It further stated; patient was unable to be evaluated by skin and wound team today; primary nurse reported he already completed wound dressing. The note written on 3/26/24 stated skin and wound was not seen again and that Resident was in the hallway and when asked to return to his room for the dressing change did not comply. After returning to attempt dressing change again Resident #332 was not available. No documentation of wound measurements or skin characteristics were found between these missed dressing changes. On 3/27/24 at 11:45 AM, the surveyor reviewed the wound care orders for Resident #332. No wound care order was found for Resident #332's right hand wound. No documentation was found on the Treatment Administration Record (TAR) for Resident #332's right hand wound. On 3/28/24 at 9:19 AM, the surveyor conducted and interview with Nurse Practitioner Staff #41 and the Nursing Home Administrator (NHA). During the interview Staff #41 stated that the wound Nurse Practitioner will write recommendations for dressing changes in her note and sometimes the wound nurse working with her will write the orders. Staff #41 confirmed if a wound care needs to be done there should be an order for it in the medical record. The NHA stated currently the facility does not have a dedicated wound nurse. She reported the wound nurse they had left on February 27th. On 3/29/24 at 1:55 PM, the surveyor conducted an interview with the wound Nurse Practitioner Staff #40. During the interview the surveyor asked Staff #40 how wound care orders get placed. Staff #40 confirmed that the nurse she works with writes verbal orders for the wound treatment. Staff #40 was not aware Resident #332 did not have right arm treatment orders. 47758 4) During an interview with a complainant on 3/18/24 at 8:27 AM the surveyor was informed that the facility had to be reminded to perform bandage changes on Resident #74 or they were not completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review by the surveyor on 3/21/24 at 7:10 AM, revealed that Resident #74 had 12 out of 60 wound care dressing changes for September of 2023 that were not documented as completed on the Treatment Administration Record. During an interview on 3/21/2024 at 8:55 AM, the Director of Nursing (DON) was informed of the concern that 12 out of 60 dressing changes were not documented as complete on Resident #74 in September of 2023. She stated 12 missing doses out of 60 was a lot and she would look for documentation in the record and that it may have been documented by the wound nurse. The DON returned on 03/21/2024 at 10:33 AM and stated that she found notes related to two of the dressing changes for Resident #74, but I would have expected to find notes for all wound cares that were not completed. She further stated that staff would be educated on documentation and wound care requirements.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42783 Based on observations, record reviews and interviews it was determined that the facility failed to ensure the medication error rate of 5% or less. This was found to be evident for the medication administration observation during the re-certification survey. The findings include: During an observation of medication administration conducted on 3/20/24 at 8:38 AM for Resident #113, the surveyor observed Certified Medication Aide (CMA) #14 check off Vitamin D 25 mEq (milliequivalent) 2 tablets in the resident's electronic health record as administered. The surveyor observed the CMA retrieve and place all medications ordered for 8:00 AM except for Vitamin D in a medication cup. The CMA entered the resident's room, handed the resident the medication cup and stated here are your morning medications. During the continued observation of the medication administration conducted on 03/20/24 at 9:08 AM, CMA #14 and the surveyor reviewed Resident #72's electronic health record for medications. The resident had an order for Levothyroxine 50 mcg (1 millionth of a gram) to be administered before breakfast. The surveyor observed CMA administer 1 tablet of Levothyroxine 50 mcg to Resident #72. During the observation the surveyor observed a breakfast tray that appeared to have been eaten. The surveyor asked the resident had he/she eaten breakfast; the resident replied yes. On 03/20/24 at 9:14 AM the surveyor conducted an interview with CMA #14. During the interview the CMA confirmed that she failed to administer the Vitamin D tablet for Resident #113 and stated she did not realize that Resident #72's order for Levothyroxine was to be administered before breakfast. During an interview conducted on 03/20/24 at 10:25 AM, the surveyor advised the Nursing Home Administrator (NHA) and Director of Nursing (DON) that the medication administration observation resulted in an error rate of 8%.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on observations and staff interviews it was determined that the facility failed to maintain a safe and effective system for securing medication and treatments in designated carts on the nursing units. This was found to be evident for 1 out of 7 medication carts and 2 out of 5 treatment carts observed during random tours of the facility. The findings include: During a random tour of the 1st floor nursing station conducted on 03/18/24 at 6:30 AM, the surveyor observed a medication cart unlocked. This surveyor was able to open each drawer of the cart and observe medications that were labeled with the resident's name and room number, as well as, house medications. On 03/18/24 at 6:33 AM an interview was conducted with the Licensed Practical Nurse (LPN) #18. During the interview the LPN confirmed that the unlocked medication cart was assigned to him and that he was responsible for the cart being unlocked. The LPN further stated the facility's expectation was for the medication cart to be always locked when unattended. During an interview with the Nursing Home Administrator (NHA) conducted on 03/18/24 at 7:00 AM, the NHA stated that she had been made aware of the unlocked cart and would educate LPN #18. She further stated that she had begun to conduct an in-service for unlocked medication carts. During a random tour of the 1st floor nursing station conducted on 03/19/24 at 7:58 AM, the Surveyor observed an unlocked treatment cart labeled treatment 1st floor. The Surveyors observed LPN #13 leave the nursing station and go into the service room located on the 1st floor nursing unit. This surveyor was able to open each of the drawers and observe a suture removal kit, scissors, creams, ointments, bandages, and dressings. On 03/19/24 at 8:03 AM an interview was conducted with LPN #13. During the interview LPN stated, she was aware the cart was unlocked, and it had been unlocked prior to her taking possession. When asked what the facility's expectations were for unlocked carts the LPN replied that the facility's expectation was that the treatment cart always remained locked when unattended. During an interview conducted on 03/19/24 at 8:04 AM, the Director of Nursing (DON), stated the facility's expectation was that once the Nurse or Certified Medication Aide (CMA) took possession of the cart, they were responsible for ensuring the cart is locked at all times when unattended. During a random tour of the 3rd floor nursing unit conducted on 03/20/24 at 6:30 AM, the surveyor observed a treatment cart unlocked and unattended. This surveyor as able to open each drawer of the cart and observe scissors, ointments, bandages, and dressing. Further in the observations the surveyor observed Registered Nurse (RN) #22 exit resident room [ROOM NUMBER] and return to the 3rd floor nursing station on 03/20/24 at 6:34 AM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 03/20/24 at 6:34 AM, RN #22 stated the treatment cart was his responsibility and confirmed the cart should have been locked. During an interview conducted on 03/20/24 at 7:15 AM, the surveyor notified the NHA of the observation of the unlocked cart. The NHA stated that she had an in-service conducted for unlocked carts. The surveyor inquired how were new and agency night shift employees provided the education and in-service. The NHA replied that new hires work during the day shifts during orientation and are provided impromptu education and in-services. The NHA further stated that agency staff assigned to work the night shift should receive the education and in-services by the night supervisor.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 45733 Based on observation, interview and medical record review it was determined that the facility staff failed to assist the resident as necessary to make appointments for dental care or treatment. This was found to be evident for 1 (Resident # 13) out of 3 residents reviewed for dental treatments during an annual survey. The findings include: During observation and interview, on 03/18/24 at 10:06 AM, Resident #13 showed that he/she only had 3 teeth left and reported some of the gum areas were hurting. Record review, on 3/26/24 at 2:43 PM, of Resident #13's record revealed that the admitted was 6/11/2015 with the diagnoses of tobacco use, bilateral above knee amputations, dementia and anxiety. Further review of a dental on-site visit on 4/3/23, signed by Dentist Staff #58 for dental cleaning, found that Resident #13 had dormant retained roots and the dentist recommended extractions. However, during the following two on-site visits on 6/23/23 and 7/5/23 teeth were not extracted. And no further dental appointment was made. During interview, on 3/27/24 at 12:07 AM, the Administrator was notified that Resident #13's teeth were not extracted during on-site visit on 6/23 or 7/5/23. Additionally, no documentation was found that identified the Resident's specific teeth needed to be extracted. The Administrator agreed that the facility staff- failed to assist Resident #13 to obtain the necessary dental care/treatments.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. 44440 Based on interviews and employee file review it was determined that the facility failed to employ a Licensed Practical Nurse in accordance with Maryland State laws. This was found evident in 1 (Staff #13) out of 11 employees reviewed during the survey. The findings include: On 3/20/24 at 1:37 PM, the surveyor reviewed Staff # 13's employee file. In the review it was noted that Staff #13 had an active Virginia Practical Nurse License, however the employee file was not complete. No education transcripts, hire application, evaluations or disciplinary actions were in the file. The surveyor requested the entire employee file from the Nursing Home Administrator (NHA). On 2/21/24 at 9:59 AM the NHA provided additional documents as part of Staff #13's employment file. The surveyor reviewed the additional paperwork. Staff #13 was hired in May of 2022. However, no up-to-date human resources documents were in the file. On 3/22/24 at 11:09 AM, the surveyor interviewed the Corporate Human Resources Business Partner Staff # 30. During the interview Staff #30 confirmed that Staff #13 was hired while residing in Virginia however on her current I-9 or Employment Eligibility Verification form Staff #13 reported her residence in Maryland. On 3/25/23 at 11:13 AM, the surveyor conducted a follow-up interview with the NHA. The NHA confirmed she was aware that in Maryland a nurse is required to have an active license in the State of their primary residence. The NHA further stated she has been in contact with Staff #13 and Staff #13 has been informed she needs to apply for her license with the Maryland State Board of Nursing.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on observation, interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by: 1) safeguarding resident identifiable information from the public and 2) keeping accurate documentation. This was found evident in 4 of 45 (Resident #73, #101, #332, and #533) residents reviewed during the survey. The findings include: 1) On 3/19/24 at 9:25 AM, the surveyor observed an unattended medication cart on the third floor with a computer on top of the cart. The computer screen was facing out into the hallway. On further observations, the computer screen had Resident #73's medication profile displayed and the surveyor could see a list of medications. On 3/19/24 at 9:26 AM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #25 who had walked up to the medication cart. During the interview Staff #25 closed out the computer screen and confirmed that the computer screen should not have been displaying the resident's health care information. She further stated she has been having technology issues all morning and the screen has been cutting out and not displaying anything. She further stated it was not displaying anything before she left. She stated that her Unit Manager was aware and was working on the issue. On 3/19/24 at 9:30 AM, the surveyor interviewed the Unit Manager Staff #50. During the interview Staff #50 stated he was aware that staff were having issues with the computers this morning and that Staff #25 told him about the screen displaying resident health information. When asked if the screen could have been closed to prevent the information from being displaced when Staff #25 walked away, Staff #50 stated that the screens could be closed. 2a) On 3/26/24 at 9:50 AM, the surveyor reviewed Resident #101's medical record. The review reviewed that Resident #101 was admitted to the facility in July of 2023. Further review of the medical record revealed a note written on 3/13/24 by Licensed Practical Nurse (LPN) Staff #54 that stated, the patient was escorted to dialysis. On 3/27/24 at 1:04 PM, the surveyor interviewed the interim Director of Nursing (DON) and when asked about the progress notes she stated it was an error because Resident #101 does not go to dialysis. 2b) On 4/1/24 at 10:30 AM, the surveyor reviewed Resident #101's Treatment Administration Record (TAR). The review revealed that the current day time dressing change for a toe wound was documented as completed for 4/1/24. On 4/1/24 at 10:42 AM, the surveyor interviewed LPN Staff #43. During the interview Staff #43 stated she was the nurse assigned to Resident 101 but had not completed the dressing change yet. She further stated that LPN Staff 38's initials signed off on the dressing change. She stated that maybe Staff #38 was completing the dressing changes today but was not informed it was completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/24 at 11:06 AM, the surveyor interviewed LPN Staff #38. During the interview Staff #38 stated she was assigned to work on the 4th floor and did not change Resident 101's dressing today. She further stated she did not know how her name got put on to Resident #101's TAR. On 4/1/24 at 11:20 AM, the surveyor interviewed the Unit Manager Staff #50. During the interview Staff #50 stated that nobody should have had the ability to sign off using another person's access. He stated he could not understand how the documentation happened. Staff #50 agreed it was a concern to have incorrect documentation but also a concern that the dressing change for Resident 101 may have been missed if signed off after not being completed. On 4/1/24 at 11:21 AM, the surveyor interviewed Resident #101. During the interview Resident #101 stated the toe dressing was not completed this morning and that he doesn't have a toe wound anymore. On 4/1/24 at 11:31 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the NHA stated she did not understand how the dressing change was being documented as completed by a nurse that doesn't have the resident and would look into the issue. At the time of exit no additional information was given as to why inaccurate documentation was being recorded. 2c) On 2/22/24 at 7:41 AM, the surveyor reviewed Resident #332's medical record. The review revealed that Resident #322 had a past medical history of acute renal failure, weakness, open wounds and substance abuse disorder. On 3/27/24 at 9:52 AM, the surveyor reviewed Resident #332's progress notes. A note written on 3/23/24 at 1:30 PM, by Registered Nurse Staff #53, listed skilled services for Resident #332 and documented urostomy (a surgical opening that re-director urine away from the bladder), and nephrostomy (a tube placed in surgery that drains urine from the kidney). On 3/29/24 at 9:03 AM, the surveyor interviewed Staff #6. During the interview Staff #6 was asked about documenting that Resident #332 had an ostomy and/or foley/suprapubic catheter. Staff #6 stated Resident #332 does not have any of those devices. She further stated it was an error. She stated the skilled service notes are done by clicking checkboxes and she must have checked those boxes in error. Further review of the progress notes revealed a note was written by Licensed Practical Nurse (LPN) Staff #6 on 3/24/24 at 11:04 AM and 6:03 PM, both documenting skilled services being provided as; general maintenance of ostomy (a surgical opening that allows waste to pass through a stoma in the abdomen into a pouch) and maintenance of foley/suprapubic catheter (tube that drains urine from the bladder through the abdomen). Additionally a monthly progress note written by Nurse Practitioner Staff #41 written on 3/25/24 included Gabapentin (nerve pain medication and Buprenorphine HCL-Naloxone HCL (prescribed to help with substance use disorders) as medications Resident #332 was currently taking. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/28/24 at 8:51 AM, the surveyor interviewed Staff #41. During the interview staff #41 stated in the monthly review she would review the medications a resident is currently on. She further stated that the medications list that is reviewed in the note is automatically pulled over from Point Click Care (PCC) (the software the facility uses for electronic medical records) into the platform she used for documenting her medical notes. The surveyor asked Staff #41 if the resident was currently taking Gabapentin and Buprenorphine HCL-Naloxone. After reviewing her notes in her computer, Staff #41 stated that the resident was not currently taking those medications and the medications were pulled over in error. She further stated after refreshing her credentials in her software the correct medications were pulled from PCC. 49815 3) On 3/19/24 at 8:10 AM the surveyors observed LPN (Licensed Practical Nurse) #13 administer medications to Resident #533. During the medication administration observation the LPN did not administer the following four medications: Diclofenac Sodium 1% gel, Jardiance 10 mg tablet, Enoxaparin 40 mg/0.4 ml syringe and Senokot 8.6 mg capsule because these medications were not available in the medication cart. The LPN stated that the resident was admitted to the facility on [DATE] and the pharmacy had not delivered those medications yet. The LPN further stated she would follow up with the pharmacy to determine the status of the medication. During medical record review by the surveyors on 3/19/24 at 11:00 AM it was revealed that LPN #13 had documented on the Medication Administration Record (MAR) that Resident #13 was given the four medications that the LPN stated were not available. During an interview conducted on 03/19/24 at 11:15 AM, the surveyors asked LPN #13 if she was able to obtain any of the four missing medications, the LPN #13 stated no. During an interview conducted on 03/19/24 at 12:00 PM with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), the surveyors reviewed Resident #533's MAR. The surveyors advised the NHA and DON that LPN #13 had not administered the four missing medications during the medication administration observation however she documented that the medications were administered. The surveyors also advised the NHA and DON of the interview with LPN #13 where the LPN stated she had not obtained the resident's four missing medications. On 03/20/24 at 9:30 AM the DON notified the surveyors that the resident had now received all the missing medications. The DON stated that LPN #13 located the bag of medications at the back door of the facility in the evening of 03/19/24 and had administered the medications at that time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42783 Based on observations and interviews it was determined that the facility failed to ensure staff sanitized medical equipment between residents and failed to ensure gowns were available for staff use as posted on the Enhanced Barrier Precaution signage at the door. This was found to be evident for 1 out of 3 staff observed for infection control and for 4 rooms (#300, #336, #338, and #340) out of 10 rooms observed for Personal Protective Equipment (PPE)availability. The findings include: 1) During an observation of the medication administration conducted on 3/20/24 at 8:38 AM for Resident #113, the surveyor observed Certified Medication Aide (CMA) #14 obtain the resident's blood pressure reading with a blood pressure monitor that had a wrist blood pressure cuff. The CMA returned to the medication cart and placed the blood pressure monitor on top of the medication cart. The CMA did not sanitize the blood pressure monitor and cuff. On 03/20/24 at 9:08 AM, the surveyor observed the CMA retrieve the blood pressure monitor with the wrist blood pressure cuff off the top of the medication cart. The CMA did not sanitize the monitor or cuff. The surveyor then observed the CMA obtain Resident #72's blood pressure reading. The CMA returned to the medication cart and placed the blood pressure monitor back on top of the medication cart. The CMA again did not sanitize the blood pressure monitor and cuff. During an interview conducted with CMA (#14) on 03/20/24 at 9:14 AM, the CMA acknowledged that she had not sanitized the blood pressure monitor and cuff between residents. The CMA further stated that the facility's expectations were to sanitize all shared medical equipment after each use and between each resident. During an interview conducted on 03/20/24 at 9:45 AM, the Director of Nursing (DON) advised the surveyors that it is expected of all nursing staff to sanitize all medical equipment between the use of each resident with sanitizing wipes. 47758 2) According to the Center for Disease Control and Prevention, Enhanced Barrier Precautions (EBP) involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multi drug resistant organism (MDRO) as well as those at increased risk of MDRO acquisition. On 03/19/24 at 08:25 AM, the surveyor observed that Enhanced Barrier Precaution signs were posted on rooms #300, #336, #338, and #340, however there were no gowns stocked in the wall caddies or on a cart outside the room for staff use. During an interview on 03/19/24 at 08:31 AM, LPN #6 was asked where the PPE is kept for EBP we don't keep gowns on the wall caddies, we call Central Supply Staff #21 to bring up the cart to get gowns. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/19/24 at 08:34 AM, GNA #12 was asked what PPE she was supposed to wear for EBP. She stated those EBP signs were just put up there, the signs weren't there yesterday but I would ask my nurse for the day what precautions I need to use. On 03/19/24 at 08:36 AM, the 3rd floor Unit Manager asked the surveyor to be shown the concern of the rooms with no gowns available. The Unit Manager and the Regional Director of Clinical Operations were shown rooms with no gowns available for staff to use. The Infection Control Nurse joined the group and supplies were obtained from the Central Supply Room in the basement and the wall caddies were stocked. The Infection Control Nurse was interviewed on 03/20/24 at 08:15 AM and asked what the expectation was for staff to wear when a resident is on EBP. He replied staff are expected to wear gloves and gowns for direct resident care. He further stated that the facility will work on training and keeping supplies stocked. The Director of Nursing was interviewed on 3/21/24 at 10:39 AM and stated that she was aware of the concern with gowns being available for use at the bedside and the Infection Control Nurse was educating staff and working with Central Supply to keep the gowns available for use.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 44440 Based on observations and interviews it was determined that the facility failed to ensure that a resident's bed mattress was properly secured to the bed frame. This was found evident of 2 residents (Resident #85, & #97) on 4 different observations. The findings include: 1a) On 3/19/24 at 9:17 AM, the surveyor observed Resident #97's mattress slid over and approximately 4 inches of the bed frame exposed while Resident 97 was laying in his/her bed. The surveyor asked Resident #97 why the mattress was slid over and Resident # 97 stated the mattress always slides over when he/she gets into bed. On 3/25/24 at 1:25 PM, the surveyor again observed Resident # 97's mattress slid over approximately 4 inches exposing the bed frame. On 3/27/24 the surveyor reviewed Resident #97's medical record. The review revealed on admission, Resident #97 had a history of falling and on the February 6, 2024 Minimum Data Set (MDS) assessment Resident #97 required supervision or touching assistance while moving from sitting to lying flat in bed. On 3/28/24 at 8:56 AM, the surveyor conducted an interview with the Maintenance Director Staff #37. During the interview Staff #37 stated he does room and bed inspections when they are prompted, and the report is generated monthly. He further stated throughout the year, all rooms and beds are inspected as prompted. The surveyor showed the picture the surveyor had taken of Resident #97's mattress and the exposed bed frame. Staff #37 agreed it was a safety concern and it should not look like that. He stated he would look at the bed and mattress. On 3/29/24 at 8:58 AM, the surveyor observed Resident #97's mattress slid over exposing the bed frame again even after Staff #37 stated he would look at the bed. On 3/29/24 at 1:28 PM, the surveyor conducted and interview with the Nursing Home Administrator (NHA) and reported the 3rd observation of Resident #97's mattress slid over with the bed frame being exposed. The NHA stated she would talk to the Maintenance Director. On 3/29/24 at 1:38 PM, the surveyor conducted a follow-up interview with Staff #37. During the interview Staff #37 was able to provide the last scheduled bed inspection reports for Resident #97's room number. The inspection was completed in May of 2023. Staff #37 stated he would re-look at the mattress because the bed frame should not be exposed. No update on corrections that were done were reported back to the surveyor at the time of exit. 1b) On 3/22/24 at 11:48 AM, the surveyor observed Resident # 85's mattress slid down exposing the top right corner of the bed frame. Resident # 85 stated that due to his/her bilateral amputation he/she needed to use the bed frame to help him/her move around. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/28/24 at 8:01 AM, the surveyor reviewed Resident #85's medical record the review revealed that Resident # 85's MDS assessment completed February 12, 2024 that documented, Resident #85 needed supervision or touching assistance with the ability to transfer from bed to wheelchair and set up assistance from sitting to lying flat in bed. On 3/28/24 at 8:56 AM, the surveyor conducted and interview with the Maintenance Director Staff #37. During the interview Staff #37 stated he does room and bed inspections when they are prompted, and the report is generated monthly. He further stated, throughout the year all rooms and beds are inspected as prompted. The surveyor showed the picture of Resident #85's mattress and bed frame exposed and the safety concern. Staff #37 stated he would look at the bed because it shouldn't be like that and it was a safety concern. On 3/29/24 at 8:59 AM, the surveyor observed Resident #85's room and noted a new bed and mattress. On 3/29/24 at 1:28 AM, the surveyor conducted an interview with the NHA. During the interview the NHA stated that Staff #37 changed the beds for Resident #85. On 3/29/24 at 1:38 PM, the surveyor conducted an interview with Staff #38. During the interview staff #37 provided the last bed inspection for Resident #85's room. The report was dated 5/31/23 stated that the bed was compliant, however the bed was changed due to concerns brought to the attention of the facility.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 42783 Based on observation and interview it was determined that the facility failed to maintain an effective pest control program as evidenced by the presence of insects. This was found to be evident for 1 out of 1 resident's (#77) room observed for pest control. The findings include: During a medication administration observation conducted on 03/21/24 at 7:11 AM, this surveyor observed multiple gnats swarming around the inside of the resident's room. The surveyor left the room to asked the Director of Nursing (DON) who was at the 3rd floor nursing station to come to the resident's room for the concern of gnat infestation. Both the surveyor and DON observed a privacy curtain covered in gnats from the top of the curtain to the bottom of the curtain. The DON took a picture of the infestation and stated she would report the observation to the Nursing Home Administrator (NHA). During an interview conducted on 03/21/24 at 11:25 AM, the surveyor asked the NHA what the facility's plan was to address the gnat infestation in Resident #77's room. The NHA stated she was not aware of the infestation and stated she would investigate the situation. The surveyor advised the NHA that the DON had taken pictures of the infestation. During a follow-up interview conducted on 03/21/24 at 12:45 PM, the NHA stated that all residents had been moved out the room and the room was scheduled to be fumigated. A review of the pest logs conducted on 03/21/24 at 1:00 PM revealed the facility had received extermination treatments for gnats.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 44440 Based on employee record review and interviews it was determined that the facility failed to monitor staff to ensure required in-service training for nurse aide staff was completed. This was found evident in 1 out of 5 Geriatric Nursing Assistants (GNA# 48) reviewed. The finding include: On 3/20/24 at 1:17 PM, the surveyor reviewed the employee file for Geriatric Nursing Assistant (GNA) Staff #49. During the review of the employee's file the surveyor noted the facility completed a criminal background check, a sex offender registry check and a licensure check. The application and hire date for Staff #48 was 10/16/2023. No other documentation was in the employee file. 3/21/24 at 09:59 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor informed the NHA that Staff #48 had no records of education in his employee file. The NHA stated she would look to see if there were more documents. On 3/22/24 at 8:18 AM, the surveyor conducted an interview with the facility's staff educator, Staff #3. During the interview, Staff #3 stated she had been in the job position of staff educator for 2 months. She further stated it was her responsibility to keep track of in-service and education that was provided for nursing staff. She stated that new hires are required to do in-service training depending on their hired positions. Staff #3 stated the facility also utilizes Relias, a computer based training program as well. Staff #3 reported that when a staff is due for required education an email is sent out as a reminder. She also reported using On Shift a messaging system that can send out general information to the staff. On 3/22/24 at 11:04 AM, the surveyor interviewed the Human Resources Director, Staff #29. During the interview Staff #29 stated that on the first day of hire the Human Resources department along with the Social Services department conduct abuse training with all staff. She further stated she would provide a list of required training. On 3/22/24 at 11:09 AM, the surveyor conducted and interview with the Corporate Human Resource Business Partner, Staff #30. During the interview Staff #30 confirmed that all completed education should be a part of the employee's file. And would look into getting training records. On 3/22/24 at 1:16 PM, Staff #29 delivered the required hire training completed on Relias. 30 different training modules were required and to be completed by the 60th day from hire. On 3/25/24 at 11:13 AM, the Nursing Home Administration (NHA) brought in additional training documentation for Staff #48. On review the surveyor asked the NHA why did the Staff (#48) complete only one training in 2024. All other completed training modules were recorded in 2019 & 2020. The NHA stated that Staff #48 was hired in a different position in October of 2023 and he had worked in a different position in 2019. She stated she would look for additional education. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215183	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayette Health and Rehabilitation Center	1217 West Fayette Street Baltimore, MD 21223

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/24 at 6:55 AM, the surveyor conducted a follow-up interview with the NHA. During this interview the NHA confirmed that there are no additional education records for Staff #48.