STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215188	A. Building B. Wing	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calvert County Nursing Ctr.	85 Hospital Road Prince Frederick, MD 20678

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and policy review, the facility failed to protect the resident's right to be free from physical abuse by a resident for one of three residents (Resident (R) 58) reviewed for abuse out of 29 sample residents. This had the potential to affect all the residents in the facility who were at risk of abuse. Findings include: Review of R57's Face Sheet, located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included dementia, Alzheimer's, major depressive disorder and restlessness and agitation. Review of R57's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of zero out of 15, which indicated the resident was severely cognitively impaired. Review of R57's Care Plan, dated 10/31/21 and located in the resident's EMR under the Care Plan tab, revealed, The resident wandered into other resident rooms. Interventions in place were I need a sign on my door with my name and something that catches the eye to help me remember where my room is, monitor my location throughout the shift, provide structured activities and staff will redirect me from wandering into other residents' rooms or spaces. Review of R58's Face Sheet, located in resident's EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included dementia and major depressive disorder. Review of R58's quarterly MDS, with an ARD of 10/1805/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a BIMS score of 12 out of 15, which indicated the resident was not cognitively impaired. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a "Nurse's Notes" located in the EMR under the "Notes" tab dated 04/09/2023 at 4:43 PM revealed, resident observed on the floor outside her room. Other Resident observed nearby. Helped up with 2-person assistants. Able to stand alone with cane once assisted up. The resident states He came into my room, and I wanted him to leave then he pushed me. 1/10 pain located back of head. Stable, Verbal, Walking with cane. Residents redirected away from each other and to their separate rooms. Review of the Self-Report Form provided by the facility, dated 04/09/2023 revealed, Following a complete and thorough investigation, including resident and staff interviews, it was determined that R57 wandered into R58's room. She became startled and yelled at him to get out and then because of limited impulse control from his dementia, he shoved her causing her to fall onto her buttocks. R58 remains safe within the facility and without any symptoms of emotional distress from the event. R57 was evaluated by psychiatry on 4-12-23. During an interview on 01/15/25 at 2:47 PM, Licensed Practical Nurse (LPN)7 said when the incident occurred in April 2023, she was unable to remember the specifics, but she knew she was trying to redirect the R57 after he came into R58's room and pushed R58 down. LPN7 said R57 was a wanderer and wandered into other resident rooms and when he wandered into R58's room she became upset and confronted him. During an interview on 01/16/25 at 2:26 PM, LPN2 stated R57 and R58's rooms were next to each other. R57 was a wanderer and would get confused about the rooms. Staff had to redirect him. She said R58 did not like people in her face and would yell. When this occurred, she thinks when R58 yelled R57's response was to push her. Staff witnessed it. After that occurred staff put up a sign so R57 would know which door was his. During an interview on 01/17/25 at 5:41 PM, the DON said she was not the DON at the time this occurred. She was not aware of the incident or what occurred. Review of the facility's policy titled Abuse and Neglect-Clinical Protocol revised July 2017 revealed, our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration will protect our residents from abuse by anyone including other residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and policy review, the facility failed to report an allegation of staff to resident abuse and injuries of an unknown origin for four residents (Resident (R) 342, R295, R296 and R13) reviewed for abuse out of 29 sample residents. This had the potential to affect all the residents in the facility who were at risk of abuse. Findings include: Review of the facility's policy titled Abuse and Neglect-Clinical Protocol revised July 2017 revealed, all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin shall be promptly reported to local, state, and federal agencies. 1. Review of R295's undated Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE], with diagnoses including cellulitis, chronic pain, chronic obstructive pulmonary disease, and hypertension. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/08/25, Brief Interview of Mental Status (BIMS) score was a 15 out of 15, indicating R295 is cognitively intact. R295 was assessed as not exhibiting any behavior during the seven-day look back period. Review of R295's Care Plan located in the EMR under the Care Plan revealed there was no indication resident has been identified as making false allegations of abuse. During an interview with R295 on 01/17/25 at 11:21AM, R295 was questioned concerning R296's incident with the night nurse. R295 stated the Licensed Practical Nurse (LPN)10 was rude and had told R296 to choose what you want to take and tossed the pill cup on R296's bed between the resident's legs. R295 proceeded to state that she had a similar incident with a Geriatric Nursing Assistant (GNA)3, the night before last (01/15/25), being rude to her. R295 stated she had called for help to move in her bed. When the GNA3 responded she told R295 that you can do it yourself. R295 reported the incident to Unit Manager (UM)2. On 01/17/25 at 12:00PM, UM2 was questioned if she had reported the incident with R295 to DON, and she stated maybe in passing as a verbal, telling the Director of Nursing (DON), we have another incident but not officially. When questioned if it should be reported, she stated yes it should have been. 2. Review of R296's undated Admission Record located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE], with diagnoses of psychoactive substance abuse, bipolar disorder, and fracture of lumbar vertebra. Review of R296's admission MDS with a ARD of 01/18/25, located in the EMR under the MDS tab, revealed R296's BIMS score is a 13 out of 15, indicating the resident was cognitively intact. R296 was assessed as not exhibiting any behaviors related to refusing care or making false accusations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the observed medication pass on 01/17/25 at 8:45AM, R296, reported to the Unit Manager (UM)2, that LPN10 from the nightshift threw R296's pills at her, the pills landed on the residents' bed between R296's legs. LPN10 told R296 take what you want and walked out of the room. According to R296, there was valium (benzodiazepine for anxiety) and Dilaudid (opioid used for pain) in the medication cup. This incident was confirmed during an interview with R295, the resident's roommate, that is also cognitively intact. During an interview with R295 on 01/17/25 at 11:21AM, R295's Brief Interview of Mental Status BIMS score is a 13, indicating she is cognitively intact, was questioned concerning R296's incident with the night nurse. R296 stated the LPN9 was rude and had told R295 to choose what you want to take and tossed the pill cup on R296's bed between the resident's legs. During an interview with R296 on 01/17/25 at 11:29AM, R296 stated she had pressed the call button for medication, LPN10 came in her room about 8:30PM, and said this is your valium and suboxone (used to treat opiate addiction). LPN10 proceeded to throw the pill cup at R296, and stated take what you want. R296 stated there were other medications in the cup at the time also. At 7:30AM, LPN10 returned and stated she had tried to give R296's Dilaudid at 6:00 AM, but the resident was asleep. R296 stated LPN10 was disrespectful, rude, and treated her like a child. She felt intimidated and now hesitates to ask for her medications because she doesn't want to deal with the attitude. When questioned if she had informed anyone during the night of LPN10's actions, R296 stated no she had not, not until the UM2 came in this morning. During an interview on 01/17/25 at 11:08AM, the DON was questioned regarding the incident involving R296 and the DON stated, No she had not reported it, because she hadn't realized it rose to that level of investigation. 3. Review of R342's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/06/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated R342 was severely cognitively impaired. Review of R342's Progress Notes located in the EMR under the Notes tab dated 06/20/24 at 9:30 AM revealed, During routine care staff observed a bruise to the residents' left flank. The area is slightly red and warm to touch. Resident showed signs of facial grimacing during the assessment. Tylenol given for discomfort. Review of R342's Physician Progress Note located in the EMR under the Notes tab dated 06/20/24 at 3:06 PM revealed, resident is a .resident with dementia associated with aggressive behavior, cognitive impairment being seen today due to nursing concern. Initially notified by nursing regarding newly found large bruise. Second call received regarding unwitnessed fall which occurred after discovering of ecchymosis. Patient not able to give account of bruising or fall due to cognitive impairment. Nursing unable to account for possible source of left large left flank ecchymosis. During an interview on 01/15/25 at 2:47 PM Licensed Practical Nurse (LPN)Geriatric Nursing Assistant (GNA) reported the bruise to her, and she reported it to her unit manager. They were never able to determine how the bruise occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R432's Progress Note located in the EMR under the Notes tab dated 12/16/2024 at 10:46: am revealed, Change in condition, bruise to right eye socket started on 12/16/2024. The bruise is located where her helmet sits on her head. During an interview on 01/17/25 at 10:16 AM, LPN8 stated she reported the bruise to her Unit Manager. During an interview on 01/17/25 10:35 AM, the Unit Manager (UM)2 stated the bruise to the residents left flank area was reported to her, and she reported it to the prior DON, and it was discussed during their clinical at-risk meetings. She said she did not report the bruised eye socket immediately because she didn't think it was so severe that it needed to be reported immediately. But they did discuss it during the clinical at-risk meetings. Review of Customer at Risk document, provided by the facility, dated 06/27/24 revealed discoloration to flank. Further review of this document revealed a note dated 12/19/24 bruise (yellow) right eyebrow-wears soft helmet-remove at bedtime. During an interview on 01/17/25 at 10:51 AM, the DON stated she was not the DON at the time the bruise was found on R342 on 06/20/24. She did say the bruise to R342 right eye was reported but she could not remember if she reported it to the Administrator. The DON stated any suspicious bruise, or mark should be reported to the DON or Administrator as soon as staff become aware. During an interview on 01/17/25 at 11:24 AM, the Administrator said injuries of unknown origin must be reported to a supervisor immediately if the nurse does not know how the injury occurred. The Administrator said they determined that the bruise to R342's right eye was the result sleeping with the helmet on. The Administrator confirmed this was not reported to the state and she was not sure if she had documentation of how and when they determined it was the result of sleeping with the helmet on, but she would provide that if she was able to do it. The Administrator did not provide the documentation prior to survey exit. 4. Review of R13's undated Face Sheet located under the Profile tab in the EMR revealed R13 was admitted to the facility on [DATE]. Review of R13's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 12/13/24 revealed the facility assessed R13 to have a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R13's Nursing Progress Note located under the Progress Note tab in the EMR revealed a note dated 11/30/24 at 6:53 PM which stated, While giving resident scheduled medications, Resident kicked blanket down and exposed right thigh. Swelling and bruising noted to the right inner thigh. Resident 6 out of 10 on non-verbal pain scale. On call [name of APN (advanced practice nurse)], informed of situation at 1710 [5:10 PM] .Daughter [name of daughter] informed of situation at 1730 [5:30 PM]. Supervisor notified of situation. Review of R13's Skin Assessment, dated 11/30/24 and located under the Assessment tab in the EMR revealed R13 had bruising to the Right thigh (front). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the list of Self-Reports 2024, provided by the facility, revealed no documented evidence R13's injuries to her inner thigh was reported to the State Survey Agency (SSA) as possible abuse. During an interview on 01/15/25 at 2:30 PM, the Director of Nursing (DON) stated, I saw her [R13], and it was discolored and hard to touch but not like a knot and it went down her leg. It did not look like a bruise from you hitting something. I saw her [R13] on the day she went to the hospital (12/02/24) because a supervisor or I have to assess anyone that the doctor is wanting to send to the hospital to see if we could take care of this issue here instead of going to the hospital. When the DON was asked if there was a documented assessment on R13, the DON stated, I don't know if I actually did a note. I don't remember. When the [NAME] was asked if she had knowledge of the bruise on R13's inner thigh before 12/02/24, the DON stated, I really don't remember. During an interview on 01/16/25 at 6:00 PM, Licensed Practical Nurse (LPN) 11 stated, I don't remember the specifics on this, but I remember she [R13] had a bruise on her inner thigh. I reported this to the Supervisor . During an interview on 01/17/25 at 8:49 AM, Registered Nurse (RN) 1 stated, The nurse [LPN 11] reported this to me. I told her to fill out a Change in Condition, call the MD [medical doctor] and call the [resident's] family. She [LPN 11] also put in a progress note. There were no reports of this from the off-going shift. I put this in the Supervisor's report and then at the end of my shift, I faxed it to the DON. I think this was an injury of unknown origin because no one knows how it got there. When RN 1 was asked what the time frame was to report an injury of unknown origin to the state agency, RN1 replied I have 24 hours to report this. During an interview on 01/17/25 at 9:04 AM, the DON was asked what the Supervisor's reports were used for. The DON stated, It is used so the Supervisors can let us know what is going on in there shift. For example, call outs and any issues out of the ordinary. When asked what the time frame was to report an injury of unknown origin to the SSA after it was identified, the DON stated, From the time you see it, or it is reported, that person is supposed to notify the Administrator and myself, and this has to be reported to the state agency within two hours. When asked if R13's bruising/injury of unknown origin was reported to the state agency, the DON stated, I don't know. During an interview on 01/17/25 at 11:24 AM, the Administrator stated, If we are not here, the Supervisors are to call me and the DON to report suspicious bruising. The nurses will attempt to find out how. For example, how the bruising occurred and if they cannot find the etiology of the bruise, then I will do a Self-Report. When the Administrator was asked what the time frame was for reporting this to the SSA, the Administrator stated, They have to investigate this immediately so I can report this within two hours. The Administrator was notified of the nursing note dated 11/30/24 and the Administrator stated, Should have been the same thing. I should have been notified so that it could have been reported within two hours if they did not know the cause of the bruise. When the Administrator was asked if the bruise was reported to the SSA, the Administrator stated, I don't believe so.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and policy review, the facility failed to investigate an injury of an unknown origin for two residents (Resident (R) 342, and R13) reviewed for abuse out of 29 sample residents. This had the potential to affect all the residents in the facility who were at risk of abuse. Findings include: Review of the facility's policy titled Abuse and Neglect-Clinical Protocol revised July 2017 revealed, all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. 1. Review of R13's undated Face Sheet located under the Profile tab in the EMR revealed R13 was admitted to the facility on [DATE]. Review of R13's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 12/13/24 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated the resident was severely cognitively impaired. Review of R13's Nursing Progress Note, dated 11/30/24 and located under the Progress Note tab in the EMR revealed While giving resident scheduled medications, Resident kicked blanket down and exposed right thigh. Swelling and bruising noted to the right inner thigh. Resident 6 out of 10 on non-verbal pain scale. On call [name of APN (advanced practice nurse)], informed of situation at 1710 [5:10 PM] .Daughter [name of daughter] informed of situation at 1730 [5:30 PM]. Supervisor notified of situation. During an interview on 01/17/25 at 9:04 AM, the Director of Nursing (DON) was asked if the bruising to R14's right inner thigh was investigated to find out what caused the bruise and the DON stated, I don't believe so. When the DON was asked if the bruising to R13's right inner thigh should have been investigated, the DON stated, Looking back, yes this should have been investigated. During an interview on 01/17/25 at 11:24 AM, the Administrator was asked if the bruise to R13's right inner thigh was investigated and the Administrator stated, I don't believe so. When the Administrator was asked if the bruise should have been investigated, the Administrator stated, Yes. 2. Review of R342's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/06/24 and located in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated no cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R342's Progress Notes located in the EMR under the Notes tab dated 06/20/24 at 9:30 AM revealed, During routine care staff observed a bruise to the residents' left flank. The area is slightly red and warm to touch. Resident showed signs of facial grimacing during the assessment. Tylenol given for discomfort. Review of physician Progress Notes located in the EMR under the Notes tab dated 06/20/24 at 3:06 PM revealed, Resident with dementia associated with aggressive behavior, cognitive impairment being seen today due to nursing concern. Initially notified by nursing regarding newly found large bruise. Second call received regarding unwitnessed fall which occurred after discovering of ecchymosis. Patient not able to give account of bruising or fall due to cognitive impairment. Nursing unable to account for possible source of left large left flank ecchymosis. During an interview on 01/15/25 at 2:47 PM, Licensed Practical Nurse (LPN)7 said a Geriatric Nursing Assistant (GNA) reported the bruise to her, and she reported it to her unit manager. They were never able to determine how the bruise occurred. Review of Progress Notes located in the EMR under the Notes tab dated 12/16/2024 at 10:46 AM revealed, Change in condition, bruise to right eye socket started on 12/16/2024. The bruise is located where her helmet sits on her head. During an interview on 01/17/25 at 10:16 AM, LPN8 stated she reported the bruise to her unit manager. During an interview on 01/17/25 at 10:35 AM, the Unit Manager (UM)2 stated the bruise to the residents left flank area was reported to her, and she reported it to the prior DON, and it was discussed during their clinical at-risk meetings. UM2 said she did not report the bruised eye socket immediately because she didn't think it was so severe that it needed to be reported immediately. Review of of a document entitled Customer at risk, provided by the facility, dated 06/27/24 revealed discoloration to flank. This document further revealed meeting notes dated 12/19/24 bruise (yellow) right eyebrow-wears soft helmet-remove at bedtime. During an interview on 01/17/25 at 10:51 AM, the DON stated she was not the DON at the time the bruise was found on R342 on 06/20/24. The DON stated she did not think this was investigated. The DON stated any suspicious bruise, or mark should be reported to the DON or Administrator as soon as staff become aware and investigated. During an interview on 01/17/25 at 11:24 AM, the Administrator said injuries of unknown origin must be reported to a supervisor immediately if the nurse does not know how the injury occurred. She said they determined that the bruise to R342's right was the result sleeping with the helmet on. She confirmed this was not investigated and she was not sure if she had documentation of how and when they determined it was the result of sleeping with the helmet on, but she would provide that if she was able to do it. (This information was not provided prior to the end of the survey. The Administrator stated that any incident where a resident has an injury of unknown origin should be investigated to try and figure out how the injury occurred.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37296 Based on medical record review, observation and interview, it was determined the facility staff failed to transfer Resident #417 using a sit to stand transfer device that resulted in the resident sustaining a fracture to their right arm. This was identified a G of past non-compliance for facility reported incident MD00210322 for F689. This was true for 1 out of the 29 residents reviewed during this survey. The findings include: 1) Based on reviews of medical records, administrative records, and staff interviews, it was determined the facility staff failed to provide a resident with a safe environment, during a transfer from the bed to the wheelchair. Review of Resident #417's fall prevention care plan initiated on 8/11/2024 revealed Resident #417 was at high risk for falls. A review of Resident #417's Minimum Data Set (MDS) Assessment, with an Assessment Reference Date of 4/20/24 Quarterly, was conducted. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provides the appropriate care and services to the resident and to modify the care plan based on the resident's status. MDS Section GG: Functional Abilities is coded to reflect that Resident #417 depends on staff for transfers (how the resident moved between surfaces including to or from the bed, chair and wheelchair and required the support of two or more individuals to transfer. Review of the facility reported incident MD00210322 on 8/23/24 at 9:59 AM, the date of the incident, revealed that the resident reported to the Director of Nursing that the Aide did not transfer her correctly. The resident explained that the GNA2 bear hugged her/him, and the arms were around the GNA2 neck when he/she lifted her. On 1/15/25 at 9:30AM, an interview with the resident revealed that the resident was getting ready to attend an activity and her Geriatric Nursing Assistant (GNA) was helping another resident. GNA 2 and GNA 3 came into the room to help her transfer from the side of the bed to the wheelchair. GNA 2 said they could lift the resident to the wheelchair, the resident and GNA 3 said that the resident was to be transferred via a sit to stand. A sit-to-stand device is meant to replace the manual stand-and-pivot transfer that's performed frequently by caregivers when transferring a weight-bearing resident/patient from a seated posture to a standing posture or different seated surface. The resident stated that's she felt the pain in her arm and heard the snap when she lifted her arms around the GNA's neck. (continued on next page)

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Calvert County Nursing Ctr.	85 Hospital Road Prince Frederick, MD 20678

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/15/25 at 11AM, GNA 3 revealed the resident was a sit-to-stand transfer and offered to get the resident the sit-to-stand device but, GNA 2 was in a hurry and lifted the resident. They said that they did hear the snap of the resident's arm. I immediately got the RN and then stayed with the resident to comfort them On 1/15/25 at 12 PM, an interview with the Director of Nursing revealed that resident had a sit-to-stand lift transfer initiated on 2/4/22 and it was continued to this day. GNA 2 did not follow the GNA transferring Kardex. The resident was sent to the emergency room for treatment of the right fractured arm. Education to staff on the protocol for safe lifting and movement of resident requiring a sit-to stand lift transferwas completed on 9/27/24. On 1/15/25 at 2:30PM, an interview with the Director of Nursing stated the delay in education was that the resident failed to inform staff at the time of the incident that the sit-to-stand device was not used in the transfer. On 1/16/25 at 8:55 AM, an interview with the Administrator revealed a Quality Assurance Performance Improvement (QAPI) action plan, completed 9/27/24, that identified what occurred i.e. full house education including agency staff and the suspension of GNA2. GNA2 was not allowed to return to the facility. There have been no new agency staff since this occurred. If new agency staff are to start work in the facility, they are educated on the transfer procedures for the residents. The plan of correction to address the facility's failure to be in compliance was completed by 9/27/24 and training is ongoing as needed for agency staff

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review and interview, the facility failed to ensure residents' medications were on hand at the facility to be administered per the physician's order for one of 29 sampled residents (Resident (R) 245). This failure placed the resident at risk of not receiving therapeutic pharmacological interventions for ordered medication's indication of use. Findings include: Review of R245's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R245 was admitted to the facility on [DATE] with the diagnosis of complete intestinal obstruction, encounter for surgical aftercare following surgery on the digestive system, and hypertension. Review of R245's admission Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/04/24 revealed the facility that the resident assessed to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Review of R245's Physician Orders located under the Orders tab in the EMR revealed orders dated 10/30/24 for Pramipexole Dihydrochloride ER (extended release) 24 hour 0.375 mg (milligram), Give one tablet by mouth at bedtime for restless leg syndrome, and carvedilol 12.5 mg, Give 12.5 mg two times a day for HTN (hypertension) Hold for SBP (systolic blood pressure) less than 110 and HR (heart rate) less than 60. Review of R245's Medication Administration Record (MAR) located under the Orders tab in the EMR and dated October 2024 and November 2024, revealed on 10/30/24, 10/31/24, 11/01/24, and 11/02/24 at 9:00 PM, it was documented Pramipexole Dihydrochloride ER was coded as being on Hold as represented as a 5 documented for these dates and time. Carvedilol was documented as on Hold on 10/31/24 at 9:00 PM as represented as a 5 documented for this date and time for this mediation. During an interview on 01/17/25 at 5:15 PM, Licensed Practical Nurse (LPN) 12 stated, I don't know why I have documented this except that the medication possibly wasn't here from the pharmacy yet. Review of the documentation that LPN12 documented in the progress notes for these dates, and it stated, Awaiting from Pharmacy. Asked if LPN12 checked the stock of medications that were available to be used for residents in the event that this happens, LPN12 stated, I don't believe that I checked that. During an interview on 01/17/25 at 5:25 PM, the Director of Nursing stated, I can't confirm that he [LPN12] gave the medications. If they were not here from pharmacy, then the nurse should call the MD [medical doctor] and make them aware of this.

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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. 29015 Based on observations, interviews, and policy review the facility failed to ensure that one of seven medication carts were kept locked, and medications were kept secured during medication pass. Specifically, medication was left on top of the medication cart, and the medication cart was left unlocked and unattended while the nurse went into the resident's bathroom out of site of the medication cart. This has the potential for other residents or visitors to have access to the medications in the cart. Findings include: Review of the facility's policy titled Security of Medication Cart revised 04/07, revealed The nurse must secure the medication cart during the medication pass to prevent unauthorized entry .Medication carts must be securely locked at all times when out of the nurse's view. Review of the facility's policy titled Storage of Medications revised 04/07 revealed The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. During an observation on 01/16/25 at 11:03 AM, Registered Nurse (RN)4 went into Resident (R)38's room to conduct his blood sugar check. RN4 left the medication cart outside of R38's room door, the medication cart was facing inside of R38's room. RN4 left the medication cart unlocked, with an insulin pen on top of the medication cart. After conducting the blood sugar check, RN4 went into R38's bathroom to wash her hands. The medication, and medication cart were out of RN4's sight while she was in the bathroom. During an interview with RN4 on 01/16/25 at 11:08AM, RN4 confirmed she had left the medication cart unlocked with the insulin pen on top of the cart. RN4 stated she should have put the insulin pen in the cart and locked it while she was in the room. During an interview with the Director of Nursing (DON) on 01/17/25 at 11:08 AM, the DON stated she expected that medications are securely stored, and the medication carts to be locked when the staff are not within sight of the cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46592 Based upon observation and interview, the facility failed to ensure the ice machine in the kitchen and on the Southern Shore unit remained clean. This failure has the potential for food-borne illness affecting 97 of 98 residents in the facility. Findings include: During an observation on 01/13/25 at 9:40 AM, the kitchen ice machine, located in the food service area inside the double doors leading to the dining room, clear and brownish colored smears with debris on the top, sides, and front of the ice machine. The interior front portion of the ice machine had an orangish film on the surface. During an observation on 01/13/25 at 10:30 AM, in the Southern Shore unit nourishment room, the ice machine had clear and brownish colored smears with debris. During an interview on 01/14/25 at 8:40 AM, the Assistant Dietary Manager (ADM) verified both ice machines had brown colored smears and debris, and the kitchen ice machine had an orangish film on the surface. During an interview on 01/16/25 at 2:45 PM, the Maintenance Director (MTD) stated the maintenance department cleaned the inside of the ice machines and the kitchen cleaned the front and sides. Review of Ice Machine Log dated 2024 provided by the MTD shows quarterly clean-out and filter change [as needed]. The form does not indicate if the entire ice machine is cleaned inside and out. During an interview on 01/17/25 at 12:20 PM, the Director of Nursing (DON) stated she was unsure who the responsibility for keeping the ice machines in the facility clean fell upon. We discussed the interview with the MTD and the interview with the ADM. The DON stated it has been a group effort and housekeeping is also to clean the outside of the ice machines on the units. Policies were requested but were not provided prior to the end of the survey.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 29015 Based on observations, interviews, and policy review the facility failed to ensure that resident information was protected specifically related to electronic medical records. This failure had the potential to cause residents' information to not be safeguarded. Findings include: Review of the facility's policy titled Electronic Medical Records dated 03/14, revealed The facility will make reasonable efforts to limit the use or disclosure of protected health information to only the minimum necessary to accomplish the intended purpose of use or disclosure. During an observation of Registered Nurse (RN)4, on 01/16/25 at 11:03 AM, during a blood sugar check, RN4 left the computer unlocked, and unattended on top of the medication cart, exposing the resident's information, while she was washing her hands in the resident's bathroom. RN4 confirmed she had left the computer open, and stated she should not have left the computer unlocked. During observation conducted during the medication pass task on 01/17/25 at 8:17 AM, with Unit Manager (UM)2, UM2 left the computer on top of the medication cart opened with resident information exposed, while she went to obtain cups for the cart. The computer was not within reach or sight of UM2. During an interview at 8:31 AM, the UM2 stated she should have locked the computer. During an interview with the Director of Nursing (DON) on 01/17/25 at 11:08 AM, the DON stated that exposing protected health information was an unacceptable practice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29015 Based on observations, interviews, record review, and policy review the facility failed to ensure that staff donned appropriate Personal Protective Equipment (PPE) for one Resident(R)293) of one resident that was on contact precautions. Additionally, the facility failed to ensure staff protected medications from becoming contaminated. These failed practices could result in increased spread of infections among residents. Findings include: Review of the facility's undated policy titled Isolation-Categories of Transmission-Based Precautions revealed Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents .Contact Precautions-1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. According to CDC recommendations, when caring for a patient with MSSA (Methicillin-susceptible Staphylococcus aureus) infection and an intravenous catheter, contact isolation PPE would include a gown and gloves that should be worn for all interactions involving contact with the patient and their environment; this is because the primary transmission route for MSSA is through direct contact with contaminated surfaces or body fluids. Key points about contact isolation for MSSA with a catheter: PPE required: Gown and gloves are mandatory for all patient interactions. Rationale: A gown protects clothing from potential contamination, while gloves prevent hand contamination with bacteria that could be transferred to other surfaces or patients. When to wear: [NAME] PPE upon entering the patient's room and remove it before exiting. Other considerations: Dedicated equipment: Use dedicated patient care equipment (like blood pressure cuffs) whenever possible to minimize cross-contamination. Hand hygiene: Perform thorough hand hygiene before and after patient contact, even when wearing gloves. Environmental cleaning: Regularly disinfect frequently touched surfaces in the patient's room. 1. Review of R293's undated Admission Record located in the electric medical record (EMR) under the Profile tab, indicated R293 was admitted on [DATE], with diagnoses including methicillin susceptible staphylococcus aureus (MSSA) infections, pneumonia, and congestive heart failure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R293's Orders located in the EMR under the Order tab, revealed an order for resident on contact precautions due to MSSA infection. Review of R293's Care Plan located in the EMR under Care Plan tab, dated 01/08/25, revealed R293 has MSSA- colonization .Interventions: Contact Isolation: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry . Resident care equipment to be appropriately cleaned, disinfected or sterilized according to facility protocol. Review of R293's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/10/25, located in the EMR under the MDS tab, Brief Interview of Mental Status (BIMS) score is a 15 out of 15, indicating the resident was cognitively intact. Additionally, this MDS indicated the resident is on isolation or quarantine for active infectious disease. During an observation conducted on 01/15/25 at 12:08 PM of R293's room, there was a sign on room door documenting Contact Precautions: clean hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before the room is exited. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During an observation on 01/15/25 at 12:42 PM of Registered Nurse (RN)2, RN2 was observed entering R293's room and connecting R293's intravenous antibiotic to the residents peripherally inserted central catheter (PICC) line. RN2 was observed not wearing any PPE while he was in the resident's room and conducting resident care. Upon exiting R293's room, RN2 was questioned if he should have been wearing PPE while in the resident's room since R293 was in contact isolation. RN2 stated doesn't believe he needed to wear PPE, because the resident only has pneumonia in his lungs. During an interview on 01/15/25 at 12:59 PM, Infection Control Preventionist (ICP) stated R293 was on contact isolation because R293's blood cultures came back positive for having MSSA bacteremia in his blood. The ICP stated the contact isolation sign is on the door, it instructs the staff of what is expected to do, and that there is no exception. During an interview on 01/15/25 at 1:11PM, Unit Manager (UM)2, stated it is expected that staff providing care to don PPE upon entering room and doff PPE when they exited the room. 2. Review of the facility's policy titled Administering Medications dated 12/12, revealed Medications shall be administered in a safe and timely manner, and as prescribed Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. During medication pass observation on 01/16/25 at 9:20AM, Medication Technician (MT)1 dropped the medication Atenolol (blood pressure medication) on top of the medication cart, picked the pill up with bare hands and put back into the medication cup, with the intent to administer the medication. Upon interviewing MT1 during this observation, MT1 stated she should have disposed of the medication after dropping it and should not have touched the pill with her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During medication pass observation conducted on 01/17/25 at 8:26AM, UM2 was observed dropping a Clonidine (blood pressure) pill on top of a piece of paper on top of the medication cart. UM2 proceeded to scoop it up in medication cup with the intention of administering it to the resident. Upon interviewing UM2 during the observation, UM2 stated at least I didn't touch it with my hands. UM2 stated she wasn't sure if the paper was clean or not. During an interview with the Director of Nursing (DON) on 01/17/25 at 11:08AM, observations were shared with the DON. The DON stated that all staff are expected to follow all isolation precautions, and that when medication is dropped, it should have been disposed of appropriately.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review, interview, and facility document review, the facility failed to have a functional Antibiotic Stewardship Program that followed the McGeer Criteria for an antibiotic prescribed for one of three residents reviewed for antibiotic usage (Resident (R) 28) out of 29 sampled residents. This failure had the potential to affect residents being prescribed antibiotics that were potentially unnecessary. Findings include: Review of the facility's policy titled, Antibiotic Stewardship dated 09/25/24 stated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program . The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents . When a nurse calls the physician/prescriber to communicate a suspected infection, he or she will have the following information available: a. Signs and symptoms . Review of R28's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R28 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus and morbid obesity. Review of R28's Physician Orders located under the Orders tab in the EMR revealed an order dated 11/05/24 for Ciprofloxacin (an antibiotic medication) 500 mg, give one tablet by mouth every 24 hours for UTI (Urinary Tract Infection) for five days. Review of R28's Nursing Progress Note, dated 11/01/24 and located under the Progress Note tab in the EMR revealed Urine specimen collected. There was no documentation prior to this date of R28 having a change in condition that warranted a urine specimen nor of the physician giving an order for the urine specimen to be collected. During an interview on 01/16/25 at 10:10 AM, the Infection Preventionist (IP) stated, The only entry I see is the 11/1 [11/01/24] that says a urine specimen was collected. When asked if the resident met question #1 on the McGeer's Surveillance Form which stated, .must fulfill both 1 and 2, with at least one of the following signs or symptoms acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate, The IP stated, I don't know the sign and symptoms the resident was having because the nurse did not document them. During an interview on 01/17/25 at 5:20 PM, the Director of Nursing (DON) stated, It is the responsibility of the IP nurse to review each resident's chart to make sure that each antibiotic ordered meets McGeer's criteria. If it does not, then education needs to be provided to staff.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review, interview, facility document review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to provide education for the residents to receive flu and/or pneumococcal vaccines; and failed to obtained a consent/declination for the flu and pneumococcal vaccinations for four of five residents (Resident (R) 11, R13, R66, and R8) out of 29 sample residents. This failure had the potential to put these residents at more risk of developing flu and pneumonia. Findings include: Review of CDC website titled, Pneumococcal Vaccination: Summary of Who and When to Vaccinate, located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html, last reviewed 09/12/24, indicated .CDC recommends pneumococcal vaccination for all adults [AGE] years or older. The tables below provide detailed information . For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you .Give one dose of PCV20 [pneumococcal conjugate vaccines] or PCV21 . If PCV15 is used, this should be followed by a dose of PPSV23 [pneumococcal polysaccharide vaccine] at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak .If PCV20 or PCV21 is used, Give a dose of PCV15 at least one year later .For adults [AGE] years or older who have only received a PPSV23, CDC recommends you .May give one dose of PCV20 or PCV21 .The PCV20 or PCV15 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults [AGE] years or older who have only received PCV13, CDC recommends you .Give PPSV23 as previously recommended For adults who have received PCV13, Give one dose of PCV20 or PCV21 or PPSV23 to be administered at least a year later . If PCV20 and PCV21 are used, their pneumococcal vaccinations are complete . Review of the facility's policy titled Influenza Vaccine dated March 2022, which was provided by the facility, stated .Prior to the vaccination, the resident (or resident's legal representative) . will be provided information and education .(See current vaccine information statements at https://www.cdc.gov/vaccines/hcp/vis/index.html for educational materials.) Provision of such education shall be documented in the resident's . medical record. Review of the facility's policy titled Pneumococcal Vaccine dated October 2023, which was provided by the facility, stated, .Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination . Administration of the pneumococcal vaccines are made in accordance with the current Centers for Disease Control and Prevention (CDC) recommendations at the time if the vaccination. 1. Review of R11's updated Face Sheet located under the Profile' tab in the electronic medical record (EMR) revealed the resident was readmitted to the facility on [DATE] with the diagnosis of diabetes mellitus, and chronic obstructive pulmonary disease. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R11's Immunizations located in the EMR under the Immunization tab in the EMR revealed R11 received the flu vaccine on 11/04/24; however, there was no documented evidence the resident and/or the resident representative received education on the flu vaccine. Continued review revealed R11 received the PPSV on 09/23/19; however, it was documented on 12/15/21 R11 refused a pneumococcal vaccine. There was no documented evidence the resident and/or the resident representative received education on the pneumococcal vaccination or was offered the pneumococcal vaccination since 09/23/19. 2. Review of R13's undated Face Sheet located in the EMR under the Profile tab revealed R13 was readmitted to the facility on [DATE] with the diagnosis of asthma, and myocardial infarction. Review of R13's Immunizations located under the Immunization tab in the EMR revealed R13 was administered a flu vaccine on 11/01/24; however, there was no documented evidence the resident and/or the resident representative received education on the flu vaccine Continued review revealed no documented evidence the resident and/or the resident representative received education on the pneumococcal vaccination or was offered the pneumococcal vaccination. 3. Review of R66's undated Face Sheet located under the Profile tab in the EMR revealed R66 was admitted to the facility on [DATE] with the diagnosis of atrial fibrillation, stage four pressure ulcer, and hypertension. Review of R66's Immunizations located under the Immunization tab in the EMR revealed R66 was administered a flu vaccine on 11/01/24; however, there was no documented evidence the resident and/or the resident representative received education on the flu vaccine. Continued review revealed R66 received a PPSV 23 pneumococcal vaccination on 06/09/17; however, there was no documented evidence the resident and/or the resident representative received education on the pneumococcal vaccination or was offered a pneumococcal vaccination since being admitted to the facility. 4. Review of R8's undated Face Sheet located under the Profile tab in the EMR revealed R8 was readmitted to the facility on [DATE] with the diagnosis of heart failure, atrial fibrillation, and vascular dementia. Review of R8's Immunizations located under the Immunization tab in the EMR revealed R8 was administered a flu vaccine on 11/01/24; however, there was no documented evidence the resident and/or the resident representative received education on the flu vaccine. Continued review revealed R8 received a Pneumovax Dose 1 on 06/06/19 and a PCV 13 on 12/27/21; however, there was no documented evidence the resident and/or the resident representative received education on the pneumococcal vaccination or was offered a pneumococcal vaccination since being admitted to the facility. During an interview on 01/17/25 at 3:20 PM, the Infection Preventionist (IP) and the Director of Nursing (DON) were asked who was responsible for collecting information and giving the residents the vaccine they were eligible for. The IP replied, The nurses when they do the admissions get a consent for the vaccines signed that the resident is needing .they get the doctor's order for which particular vaccine is needed and then [the vaccine] is ordered from the pharmacy. Once it is received from pharmacy, I don't know what the process is for nursing. The DON stated, It is the responsibility of the IP nurse to review the vaccinations of each resident to make sure the vaccines are up to date, and they are being offered. The IP stated she did provide education and consents for both the flu and pneumococcal vaccinations; however, she erroneously marked No on the forms which indicated she did not provide education or offered the vaccinations.