STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215191	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mallard Bay Nursing and Rehab	520 Glenburn Avenue Cambridge, MD 21613

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 31145 Based on observations, medical record review, and interview, it was determined the facility failed to ensure that the resident's call light was within reach, per the individualized care plans, to allow access to assistance when needed and failed to position a resident comfortably in a chair. This was evident for 6 (#9, #3, #44, #40, #45, #29) residents observed on 2 of 3 nursing units during a random tour during a complaint survey. The findings include: A tour of the facility was conducted on 4/29/25 at 10:28 AM along with the Director of Nursing (DON). 1) Observation was made of Resident #9 lying in bed. Resident #9's call bell was observed hanging down the wall and the call bell button was lying under the bed on the floor. The DON stated, that is not supposed to be hanging there like that. The DON placed the call bell on top of the resident. Review of Resident #9's care plan, has an ADL (activities of daily living) self-care performance deficit r/t (related to) muscle weakness, had the intervention, encourage the resident to use bell to call for assistance. A second care plan, at risk for falls r/t weakness, had the intervention, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 2) Observation was made of Resident #3 lying in bed. Resident #3's call bell was observed on the floor underneath the privacy curtain. The DON was shown the call bell and she immediately picked up the call bell and placed in next to Resident #3. Review of Resident #3's care plan, has an ADL self-care performance deficit, with the intervention, Encourage the resident to use bell to call for assistance. A second care plan, is at risk for falls r/t weakness and limited mobility, had the intervention, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 3) Observation was made of Resident #44 in the room. The call bell was not within reach. The DON picked up the call bell and gave it the Resident #44. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #44's care plan, has an ADL self-care performance deficit r/t deconditioning, had the intervention, Encourage the resident to use bell to call for assistance. A second care plan, is high risk for falls r/t deconditioning, confusion, gait/balance problems, unaware of safety needs, and frequent falls had the intervention, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 4) Observation was made of Resident #40 sitting in a semi-reclining wheelchair with his/her legs bent and hanging in the air. The resident had a reclining chair in the room that she/he could have been sitting in where the legs would have had something to rest on. Resident #40 was stretching his/her leg and had nothing to rest the leg on. Additionally, Resident #40's call bell was found hanging down the wall and the call button was under the privacy curtain. At that time the DON placed the call bell next to the resident and informed a geriatric nursing assistant (GNA) to put the resident in the reclining chair. Review of Resident #40's care plan for at risk for falls had the intervention, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. 5) Observation was made of Resident #45 lying in bed. Resident #45's call bell was draped over the lights on the wall that was to the left of the bed and out of reach of the resident. The DON was shown the call bell on the wall light and said, why is that wrapped around the light? The DON unwound the call bell cord and placed it on top of the resident. Review of Resident #45's care plan, is at risk for falling r/t unsteady balance, had the intervention, keep call light in reach at all times when in room. 6) Observation was made of Resident #29 sitting in his/her room with the call bell on the floor. The DON picked up the call bell and placed it next to Resident #29. Review of Resident #29's care plan, has an ADL self-care performance deficit r/t cognitive deficit, dementia, had the intervention, Encourage the resident to use bell to call for assistance. After the tour concluded on 4/29/25 at 10:45 AM an interview was conducted with the DON about the call bells. The DON, who corrected the issues on tour, stated she would need to be doing some in-services on call bells.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to notify a resident's physician and/or representative for a change in condition. This was evident for 4 (#6, #5, #17, #21) of 52 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #6's medical record on 4/23/25 revealed the Resident was admitted to the facility in November 2024 and was transferred to the hospital on 12/18/24. Review of the Resident's vital signs on the following dates and times prior to the Resident's transfer to the hospital revealed the Resident had an elevated heart rate on: 12/13/24 at 8:19 AM heart rate of 121, 12/13/24 at 10:03 PM heart rate of 110, 12/17/24 at 7:34 AM heart rate of 114. The Resident's heart rate on 12/18/24 at 9:38 AM was 135 and the Resident was transferred to the hospital. Further review of the Resident's medical record revealed the facility staff failed to notify Resident #6's physician of the elevated heart rates on 12/13/24 at 8:19 AM, 12/13/24 at 10:03 PM and 12/17/24 at 7:34 AM. Interview with the Medical Director on 4/25/25 at 12:30 PM confirmed the facility staff failed to notify the Resident's physician on 12/13/24 and 12/17/24 when the Resident had an elevated heart rate. 31145 2) On 4/23/25 at 11:07 AM a review of complaint MD00215433 alleged that 4 days after admission Resident #5's blood sugar dropped in the 30's after 2 incidents of hypoglycemia (low blood sugar) and the resident was transferred to the emergency room . The complainant alleges she was not notified of the initial incident of low blood sugar. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included cerebral infarction (stroke) and type 2 diabetes mellitus. Review of February 2025 physician's orders revealed the resident was prescribed Jardiance 10 mg. every day for diabetes, Tirzepatide 2.5 mg/0.5 ml injection every Wednesday for diabetes, and glipizide 10 mg. twice per day for diabetes. The physician also ordered to check blood sugar in the morning related to diabetes. A blood sugar level below 70 mg/dL (3.9 mmol/L) is considered low. A blood sugar level below 54 mg/dL (3.0 mmol/L) is a cause for immediate action. Review of the February 2025 Medication Administration Record (MAR) documented on 2/26/26 at 6:00 AM the blood sugar reading was 59. A blood sugar reading on 2/27/25 at 6:00 AM was 53. There was no documentation that the physician was notified. There was no documentation that the RP was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 2/28/25 at 20:39 health status note documented the resident's blood sugar reading was 36 and the resident went into respiratory distress and was unstable and had to be transported to the emergency room . Prompt notification to the physician of the previous low blood sugars would have allowed for timely intervention and adjustment to the medication. On 4/25/25 at 8:40 AM the Director of Nursing (DON) was interviewed and confirmed that there was no physician or RP notification related to the low blood sugars. 3a) On 4/28/25 at 8:00 AM a review complaint MD00200383 was conducted, and it alleged that in December 2023 Resident #17 had a missing front tooth, that it could have been a crown or veneer, but it was noticeable. A review of Resident #17's medical record was conducted. A social service note dated 12/8/23, that was not entered into the medical record until 1/30/24, documented that the social worker received a call from the Ombudsman stating Resident #17's daughter had called to complain, stating that she thought there was a communication problem with the facility. The Ombudsman also stated she received a call from Resident #17's grandson stating Resident #17 had a missing front tooth and apparently the family was not notified. Further review of Resident #17's medical record failed to produce any further documentation about Resident #17's missing front tooth. There was no documentation in the medical record that the responsible party was notified of the missing tooth. On 4/28/25 at 11:50 AM Resident #17 was observed lying in bed. Resident #17 was asked if he/she had a missing front tooth. Resident #17 opened his/her mouth and there was a missing front tooth. On 4/28/25 at 1:57 PM an interview was conducted with the Medical Director and the Director of Nursing (DON). Both stated they could not find any documentation that the family was notified about the missing tooth and that nothing had been done about the tooth since. Cross Reference F791 3b) A continued review of Resident #17's medical record revealed on 2/3/25 that the resident had a documented weight of 183.8 pounds (lbs.). There was no weight in March 2025. A weight was taken on 4/1/25, 4/2/25, and 4/3/25, which was documented as 166.6 lbs. which was a 17.2 lb. weight loss which was a 9.4 % weight loss. There was no documentation found in the medical record that the dietician, physician, and responsible party were notified. On 4/28/25 at 12:26 PM an interview was conducted with LPN #22. LPN #22 was asked about the weight process, and she stated, the GNAs (geriatric nursing assistants) weigh and the nurse puts the weight in the system. The Director of Nursing is then alerted. The surveyor asked LPN #22 who notified the dietician, and her response was, I don't know who is notifying the dietician. Do we have one. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/28/25 at 1:57 PM an interview was conducted with the Medical Director and the DON. They both stated they would have expected to be notified about the weight loss. Cross Reference F692. 4) On 4/24/25 at 8:25 AM a review of Resident #21's medical record revealed Resident #21 was admitted to the facility in February 2023 with diagnoses that included Cerebral infarction due to thrombosis of right posterior cerebral artery, major depressive disorder that was recurrent, and repeated falls. Review of the weight section of Resident #21's medical record revealed on 5/5/24 Resident #21's documented weight was 129.2 lbs. There were no weights documented from 5/5/24 until 9/5/24 when the weight was documented as 121.4 lbs. Resident #21 had gradual weight gain monthly until 1/2/25 when the documented weight was 126.6 lbs. The 2/5/25 weight was 117.6 lbs. which was a 9 lb./7.1 percent weight loss in 1 month. Further review of the medical record failed to produce documentation that the dietician and the physician were notified of the weight loss on 2/5/25. On 4/28/25 at 1:57 PM an interview was conducted with the Medical Director and the DON. They both stated they would have expected to be notified about the weight loss. Cross Reference F692

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 34484 Based on medical record review and interview, the facility staff failed to respect a resident's privacy (Resident #8). This was evident for 1 of 52 residents reviewed during a complaint survey. The findings include: Review of Resident #8's medical record on 4/24/25 revealed the Resident was admitted to the facility in July 2024 and was assessed by the facility staff on 1/17/25 to have a BIMS (Brief Interview for Mental Status) of 15 out of 15, fully alert and oriented. During interview with Resident #8 on 4/24/25 at 8:07 AM, the Resident stated he/she recently had a visitor who is a friend of the Resident in his/her room. Resident #8 stated during the visit a housekeeper (Staff #12) approached the visitor and told the visitor that they couldn't use his/her phone. The Resident stated he/she used to work with the visitor's mother and when the visitor would come in to visit she would bring me snacks and we would facetime the visitor's mom. The Resident stated we had done this many times and that he/she didn't believe Staff #12 should have done that. Interview with Staff #12 on 4/24/25 at 9:30 AM, Staff #12 stated she was coming through the dining room and was going past Resident #12's room when she saw the visitor with her phone out and filming around the room and then hovered over the Resident. Staff #12 stated she told the visitor at that time they are not allowed to have their phone out, the visitor told me to mind my own business so I left and got the Director of Nursing. Further interview with the Resident on 4/25/25 at 10:59 AM, the Resident was asked if Staff #12 came in his/her room, the Resident stated Staff #12 was standing in the doorway or just inside the doorway at the time. Resident #8 stated I guess she (Staff #12) thought the visitor was doing something wrong but she has been here multiple times and whenever she comes to visit we facetime her mom and she also shows me pictures of her family. Resident #8 said I didn't see any problem with that, that is what we normally do. Further interview with Staff #12 on 4/29/25 at 10:15 AM, Staff #12 stated she saw the visitor in the Resident's room with her phone out and told her she couldn't have her phone out. Staff #12 asked if she saw the visitor taking pictures outside the Resident's room and Staff #12 stated no. Staff #12 stated I tell everyone that they can't have their cell phone out. Interview with the Administrator on 4/29/25 at 10:23 AM the Administrator was asked if residents are allowed to facetime while in their rooms. The Administrator confirmed yes a resident has a right to facetime whoever they want with a visitor at any time in their room. Further interview with Resident #8 on 4/29/25 at 10:40 AM, Resident #8 confirmed he/she was in his/her room with the visitor alone and there were no other residents in his/her room at the time of the incident with Staff #12.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of facility documentation, medical record, and staff interview, it was determined the facility failed to ensure that a resident was free from neglect when the facility failed to provide the required services to meet the needs of the resident. This was evident for 1 (#46) of 52 residents reviewed during a complaint survey. The findings include: On 4/24/25 at 2:46 PM a review of an anonymous complaint alleged the facility needed to be investigated as they were doing illegal things. A review of the grievance log for November 2024 documented a grievance filed on 11/25/24 for substandard quality of care for Resident #46. Review of the grievance investigation revealed a witness statement from Staff #9 that documented that on the morning of 11/25/24 at 8:10 AM Staff #54 went to Staff #9's office and stated that Resident #46 was visibly upset this morning when she entered the resident's room and disclosed to her that he/she was left sitting in a soiled brief from 10:30 PM until 8:00 AM when Staff #54 entered the room. Staff #54 immediately had Staff #31 get Resident #46 cleaned up. The witness statement documented that Staff #9 went down and spoke to Resident #46 who relayed that he/she was changed around 10:30 PM by the 3-11 GNA (geriatric nursing assistant) and then was not changed at all the rest of the evening. Resident #46 stated he/she rang the call bell several times and the night shift GNA, Staff #55 came in and just turned the call bell off and did not provide care. It was documented Resident #46 was alert and oriented times 4 with a BIMS (Brief interview of mental status) was 15 which was the highest score for mental acuity. A witness statement for an interview conducted with Staff #55 revealed that evening was the first night ever having Resident #46 or the unit and she said she didn't know the resident. Staff #55 stated that she and the other GNA, Staff #30, took the entire unit together. Staff #55 could not remember how many rounds she did during the night and stated that she did not answer any call bells. A witness statement for an interview conducted with Staff #30, she stated that her and Staff #55 worked together on the unit and that Staff #30 did not answer any call bells for Resident #46. Staff #30 was asked if she changed Resident #46 or completed a round on the resident at any time in the shift, Staff #30 stated that Staff #55 handled that end of the hall, and they met up at room [ROOM NUMBER] and proceeded to do care together on other rooms. Review of Resident #46's medical record revealed the resident was admitted to the facility on [DATE] after a diving accident in August 2024 that left the resident with quadriplegia, depression, anxiety disorder, and chronic pain. Quadriplegia is a condition characterized by partial or complete paralysis of all four limbs (both arms and legs) and the torso, typically caused by damage to the spinal cord, usually in the cervical (neck) region. Resident #46 was totally dependent on staff for all aspects of activities of daily living. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 3:05 PM Staff #31 was interviewed and stated Resident #46 was total care. Staff #31 stated that the particular morning he came in and was trying to figure out his group. Resident #46 rang the bell and was extremely upset, crying and said night shift didn't change him/her. Staff #31 stated when he came in the facility the resident's call bell was ringing and he was not sure how long it was ringing before he got there. Staff #31 stated Resident #46 was wet, and the bed was soaked with all urine. Resident #46 was laying in it and it was way more urine that it should have been. Staff #31 stated he got the resident cleaned up and changed the sheets. Staff #31 stated he did not get report from the night shift GNAs and there used to be a problem with the aides sleeping at night. On 4/29/25 at 1:04 PM an interview was conducted with the Director of Nursing (DON) and the Medical Director. The case was reviewed with both of them, and both agreed it was neglect. The DON provided documentation that Staff #55 was written up for unsatisfactory work and failure to follow company policy. Review of Staff #55's corrective action notice dated 11/26/24 documented, failure to follow company policy with assigned care groups, substandard care, and falsifying documentation. Resident reported not change or checked on for employee's entire shift.

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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** 31145 Based on reviews of facility reported incidents and interview, it was determined the facility failed to report allegations of abuse to the regulatory agency, the Office of Health Care Quality (OHCQ) within 2 hours of the allegation. This was evident for 4 (#9, #19, #18, #17) of 13 residents reviewed for facility reported incidents during a complaint survey. The findings include: 1) On 4/24/25 at 7:17 AM a review of facility reported incident MD00213274 was conducted and revealed Resident #9 reported to his/her daughter that a nurse hurt his/her arm. There was swelling to the right hand. The date of injury was unknown. Resident #9's daughter reported the incident via text message to Staff #9, the Assistant Director of Nursing (ADON) on 1/5/25 at 11:45 AM. The ADON then reported it to the Director of Nursing (DON) on 1/5/25 at 11:50 AM and the Nursing Home Administrator (NHA) was notified on 1/5/25 at noon. Review of the email confirmation of when the initial report was sent to OHCQ was dated 1/6/25 at 2:40 PM which was not within 2 hours of an injury of unknown origin of suspected abuse. On 4/24/25 at 8:34 AM an interview was conducted with the Director of Nursing (DON). The timeline of when the report was submitted to OHCQ was discussed and the DON confirmed it was reported late. 2) On 4/25/25 at 6:55 PM a review of facility reported incident MD00205553 was conducted and revealed an allegation that the administrator played a voice note of the staff meeting, the description, and Resident #19 stated it was [him/her] but when showed a picture the resident said it was not [him/her]. Review of the intake form that was received at OHCQ documented the date of the incident was 4/25/24. Review of the email confirmation that was given to the surveyor documented the initial report was submitted to OHCQ on 5/9/24 at 4:29 PM. There was no email confirmation as to when the final report was sent to OHCQ. 3) On 4/23/25 at 3:24 PM a review of complaint MD00205813 was conducted and revealed Resident #18 was sent to the emergency roiagnom on [DATE]. While in the emergency room bruising was noted to the resident's left side of the face and it appeared to be in different stages of healing as bruising was red, yellow, and purple. Resident #18 was unable to state what happened or caused the swelling and bruising. Resident #18 was unable to recall if he/she fell or was hit. It was alleged that a nurse from the emergency room called the facility to inquire about the bruising and swelling and was informed by the on-duty nurse that it was being investigated by management. Review of a 5/15/24 at 9:15 AM nursing note documented, I noticed bruising to resident left eye down to [his/her] cheek bone. Resident denied any discomfort at that time. Resident denies falling or anyone coming into the room and striking [him/her] in the eye. The note documented the Certified Registered Nurse Practitioner (CRNP) was aware of the bruising noted to the resident's left eye/cheek and an x-ray was ordered for the left eye. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 at 10:25 AM the Director of Nursing (DON) was asked if the bruising to the left eye and cheek, an injury of unknown origin, was submitted to OHCQ. The DON stated that the reportable incident of injury of unknown origin was not submitted to OHCQ, and an investigation was not done. 4) On 4/29/25 at 9:00 AM a review of facility reported incident MD00205865 was conducted. Resident #17 alleged that a male came into the room on 5/9/24 to give the resident medications. After the resident took the medications from the aide, the aide threw water in the resident's face. Review of the investigative packet given to the surveyor documented the incident was reported on 5/17/24 at 4:53 PM which was not within 2 hours of alleged abuse. On 4/29/25 at 9:01 AM the DON confirmed she could not find any further information. She was not employed at the facility during that time.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of facility reported incidents and staff interview, it was determined the facility failed to provide documentation that allegations of abuse were thoroughly investigated. This was evident for 7 (#18, #21, #40,#19, #17, #20, #39) residents of 13 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 4/23/25 at 3:24 PM a review of complaint MD00205813 was conducted and revealed Resident #18 was sent to the emergency roiagnom on [DATE]. While in the emergency room bruising was noted to the resident's left side of the face and it appeared to be in different stages of healing as bruising was red, yellow, and purple. Resident #18 was unable to state what happened or caused the swelling and bruising. Resident #18 was unable to recall if he/she fell or was hit. It was alleged that a nurse from the emergency room called the facility to inquire about the bruising and swelling and was informed by the on-duty nurse that it was being investigated by management. Review of a 5/15/24 at 9:15 AM nursing note documented, I noticed bruising to resident left eye down to [his/her] cheek bone. Resident denied any discomfort at that time. Resident denies falling or anyone coming into the room and striking [him/her] in the eye. The note documented the Certified Registered Nurse Practitioner (CRNP) was aware of the bruising noted to the resident's left eye/cheek and an x-ray was ordered for the left eye. On 4/29/25 at 10:25 AM the Director of Nursing (DON) was asked if the bruising to the left eye and cheek, an injury of unknown origin, was investigated by the facility and submitted to OHCQ. The DON stated that the reportable incident of injury of unknown origin was not formally investigated as she did not have any documentation to give to the surveyor. 2) On 4/24/25 at 8:42 AM a review of facility reported incident MD00205016 was conducted and revealed Resident #21 alleged that during the 11-7 shift on 4/23/24, one of the geriatric nursing assistants (GNAs) placed the resident's hearing aids in the ear and smacked the resident on the ear and then proceeded to poke the resident in the arm. Review of the facility's investigation packet that was given to the surveyor on 4/23/25 consisted of statements from Resident #21, statements from 2 registered nurses, the accused GNA and 5 other GNAs. There were no statements from residents on the accused GNA's assignment for the evening of 4/23/24 or assessments of residents that were cognitively impaired. On 4/24/25 at 9:11 AM an interview was conducted with the Director of Nursing (DON). The DON was asked what the investigation should consist of. The DON stated that she would interview all staff that worked and/or took care of the resident. She would interview the resident and the resident's roommate if the resident was cognitively intact. She would interview or assess all residents on the alleged GNA's assignment. The DON was informed that there were no other residents interviewed. The DON stated she was not employed at the facility during that time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 4/24/25 at 6:41 PM a review of facility reported incident MD00189330 was conducted and revealed an allegation that a scream was heard from Resident #40's room and the resident was noted on the floor with a contusion to the forehead and laceration to the left middle finger and index finger. Review of the packet that was given to the surveyor was void of an investigation or staff interviews. On 4/29/25 at 8:59 AM the DON confirmed there was no investigation in the packet. 4) On 4/25/25 at 6:55 PM a review of facility reported incident MD00205553 was conducted and revealed an allegation that the administrator played a voice note of the staff meeting, the description, and Resident #19 stated it was [him/her] but when showed a picture the resident said it was not [him/her]. Review of the documentation that was given to the surveyor from Staff #13 was the initial report form that had an x next to mental/verbal abuse. It documented the incident occurred in room, other agencies were notified which was the Ombudsman, and the name of the person submitting the report. Staff #13 stated that was all she had and there was no other documentation of an investigation. 5) On 4/29/25 at 9:00 AM a review of facility reported incident MD00205865 was conducted. Resident #17 alleged that a male came into the room on 5/9/24 to give the resident medications. After the resident took the medications from the aide, the aide threw water in the resident's face. Review of the investigative packet given to the surveyor was void of an investigation. On 4/29/25 at 9:01 AM the DON confirmed she could not find any further information. She was not employed at the facility during that time. 34484 6) Review of MD00205047 revealed Resident #20 reported that on 4/24/24 Staff #45 took his/her remote, call bell and moved his/her bedside table away from him/her. Resident #20 stated he/she didn't fell safe asking Staff #45 for anything throughout the night. Review of the facility documentation related to the investigation revealed the facility staff conducted interviews of facility staff working with Staff #45 on 4/24/24 and could not substantiate abuse had occurred. Further review of the facility investigation revealed the facility staff failed to conduct any interviews with residents that were also assigned to Staff #45 to determine if any other residents had concerns regarding abuse by Staff #45. Interview with the Director of Nursing on 4/25/25 at 9:00 AM confirmed the facility staff failed to complete a thorough investigation of Resident #20's allegation of abuse by Staff #45 on 4/24/24. 37586 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) On 3/11/23 the primary nurse notified the administrator and Director of Nursing that Resident #39 had been found sitting on Resident's #38 right arm while sitting on the bed. Resident #39 had no clothing or incontinent products on from the waist down. Both residents have dementia. The BIMS for Resident #39 was 0 taken on 3/7/23 meaning he/she has severe Dementia (BIMS is a mini mental exam The Mini Mental State Examination (MMSE) is a tool that can be used to systematically and thoroughly assess mental status. It is an 11-question measure that tests five areas of cognitive function:orientation, registration, attention and calculation, recall, and language. The maximum score is 30. A score of 23 or lower is indicative of cognitive impairment. The MMSE takes only 5-10 minutes to administer and is therefore practical to use repeatedly and routinely.) Both residents share a bathroom. Resident #39 was redirected back to his/her room. Resident #38 has a BIMS score of 5/15. On 3/13/23 a staff member placed a note in the (DON's) mailbox that stated Resident #38 who was sitting on Resident #39's bed had the brief half way down and Resident #39 was touching Resident #38 inappropriately. Resident #39 was placed on 1-1 for safety. Local law enforcement was contacted and responded on 3/13/23 at 1:30 PM. There was no case number mentioned or name of the officer responding. There were no interviews taken from any staff member. R.P. was made aware. Nurse Practioner also made aware. Former director of Nursing wrote report. There was also no date when incident report was sent in to OHCQ.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 31145 Based on record review and staff interview it was determined that the facility failed to complete the Comprehensive Minimum Data Set (MDS) assessments which should have included the resident's participation in the resident interviews and failed to complete MDS assessments timely. This was evident for 1 (#18) of 52 residents reviewed for assessment reviews during a complaint survey. The findings Include: The Resident Assessment Instrument (RAI) delineates the process that long term care facilities follow to screen residents, assess resident strengths and needs, plan for resident care delivery, and evaluate the residents' progress and needs on an ongoing basis by returning to additional, periodic screening, assessment and planning throughout a resident admission. The Minimum Data Set (MDS) assessments are an integral part of RAI and include completion of standardized assessment questions. There are comprehensive MDS assessments and periodic non-comprehensive MDS assessments which facilities conduct to maintain an accurate understanding of each resident's most current needs and strengths, and to ensure care planning remains current and effective. The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a Significant Change in Assessment has been completed since the most recent comprehensive assessment was completed. Completion of the Comprehensive Annual MDS assessment including the Care Area Assessments (CAA) must be completed no later than 14 days after the Assessment Reference Date (ARD) (ARD + 14 calendar days). Resident interviews should be conducted within the look-back period of the ARD of the MDS assessment. Information obtained directly from residents allows for the incorporation of the resident's voice in the individualized care plan. In Appendix D of the RAI Manual, CMS notes the critical importance of the assessment interview by documenting that All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives. There are several MDS 3.0 sections that require direct interview of the resident as the primary source of information (e. g., mood, preferences, pain). Self-report is the single most reliable indicator of these topics. Staff should actively seek information from the resident regarding these specific topic areas; however, resident interview/inquiry should become part of a supportive care environment that helps residents fulfill their choices over aspects of their lives. The resident interviews in each comprehensive MDS assessment include interviews assessing mental/cognitive status, resident preferences, mood, and pain. The Brief Interview for Mental Status (BIMS) is a screening tool used to assist with identifying a resident's current cognition. CMS notes that it is a brief screening tool that aids in detecting potential cognitive impairment but does not assess all possible aspects of cognitive impairment. A series of standardized questions are scored with the total screening score falling into one of three cognitive categories: Intact which is 13 to 15 points, Moderate which is 8 to 12 points or Severe cognitive impairment which is 0 to 7 points. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Mood Interview is a validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The numeric value falls into one of five categories: 1 to 4 minimal depression, 5 to 9 mild depression, 10 to14 moderate depression, 15 to 19 moderately severe depression, and 20 to 27 severe depression. 1a) On 4/23/25 at 3:24 PM a review of Resident #18's medical record was conducted and revealed an annual MDS with an ARD of 10/12/24. Review of Section C, Cognitive Patterns that included a BIMS, Staff assessment for short and long-term memory recall, cognitive skills for daily decision making, signs of delirium, and acute onset of mental status changes was not completed. Review of Section D, Mood was not completed as noted with dashes. On 4/29/25 at 8:29 AM an interview was conducted with the MDS Director who sated, social work is responsible for that section. The MDS Director confirmed the section was not done. 1b) Review of Resident #18's annual MDS with an ARD of 10/12/24, Section Z, Assessment Administration, documented that the RN Assessment Coordinator verified assessment completion on 11/27/24. According to the RAI, the MDS completion date must be no later than 14 days after the ARD. Additionally, all other sections of the MDS, with the exception of Section F, Activities, were all completed greater than 2 weeks after the ARD which was 10/12/24. Section K was completed on 11/6/24, Section C, D, S0509 was completed on 11/27/24, and all other sections of the MDS were completed on 11/15/24. On 4/29/25 at 8:29 AM the MDS Director confirmed that the MDS was not submitted timely.

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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. 31145 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 6 (#5, #3, #46, #40, #7, #21) of 52 residents reviewed for complaints during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 4/23/25 at 11:07 AM a review of Resident #5's medical record was conducted and revealed Resident #5 was prescribed Tirzepatide Subcutaneous Solution Auto-injector 2.5 MG/0.5ML (Tirzepatide) Inject 0.5 ml subcutaneously one time a day every Wednesday for type 2 Diabetes Mellitus. Review of Resident #5's admission MDS with an assessment reference date (ARD) of 2/27/25, Section N0300, record the number of days that injections of any type were received during the last 7 days was coded 0. Review of Resident #5's February 2025 Medication Administration Record (MAR) documented the resident received an injection on 2/26/25. The facility failed to capture the injection. On 4/25/25 at 9:20 AM an interview of MDS Coordinator #17 revealed she was new to doing MDS assessments. Reviewed Section N related to the injection for Tirzepatide with Staff #17 who confirmed the error. 2) On 4/24/25 at 9:01 PM a review of facility reported MD00216113 documented that Resident #3 had an unwitnessed fall on 3/24/25 and on 3/25/25 an x-ray was performed, and the resident was found to have a fracture to the left humerus. The humerus is the long bone located in the upper arm, connecting the shoulder to the elbow. Review of the MDS with an ARD of 4/5/25, Section I800, additional active diagnoses, failed to document the fracture. Review of Section J1800, any falls since admission/entry or reentry or prior assessment documented, 0. The facility failed to capture the fall with major injury, bone fracture. Review of the MDS with an ARD of 4/14/25, Section J1700 Fall history on admission/entry or reentry: A. Did the resident have a fall any time in the last month prior to admission/entry or reentry? Was coded 0 and should have been coded yes. C. Did the resident have any fracture related to a fall in the 6 months prior to admission was coded, unable to determine. It should have been coded yes. On 4/25/25 at 9:20 AM an interview was conducted with the MDS Coordinator. She confirmed that she should have captured the fall on both MDS assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 4/24/25 at 2:46 PM Resident #46's medical record was reviewed and revealed on 12/2/24 Resident #46 had a fall. Review of the MDS assessment with an ARD of 12/11/24 MDS, Section J1800 falls since admission, entry or reentry or prior assessment, was coded, no. This was incorrect as the resident had a fall on 12/2/24. Review of Resident #46's December 2024 Medication Administration Record (MAR) documented the medication Lyrica (anti-convulsant) was administered for 7 days prior to the ARD date of 12/11/24. Resident #46 also was administered Oxycodone 15 mg. on 12/10/24. Oxycodone is an opioid medication. Review of Section N, Medications, failed to capture the anti-convulsant and the opioid. On 4/29/25 at 3:22 PM the MDS coordinator confirmed the errors. 4) On 4/24/24 at 6:41 PM a review of Resident #40's medical record revealed several falls were not captured on MDS assessments. Review of the annual MDS assessment with an ARD of 5/3/23, Section J1800 falls since admission, entry or reentry or prior assessment, was coded, no. Review of the medical record revealed on 2/22/23 Resident #40 had a fall in which a finger was broken finger and the resident had to have sutures to fingers. The facility failed to capture the fall with injury. Review of the annual MDS assessment with an ARD of 4/20/24, Section J1800, documented no falls. Review of Resident #40's medical record revealed a 4/20/24 at 16:51 nursing note that documented the resident was found on the floor. Facility staff failed to capture the fall. Review of Section O0110 K1, Special treatments, procedures, and programs, Hospice; failed to capture that Resident #40 was on Hospice. Review of the quarterly MDS assessment with an ARD of 7/20/24, Section O0110 K1, Special treatments, procedures, and programs, Hospice; failed to capture the resident was on Hospice. Review of the quarterly MDS assessment with an ARD of 10/21/24, Section J1800 captured 1 fall. The MDS assessment was incorrect as the resident had 2 falls. One fall on 8/26/24 and one fall on 9/20/24. Review of the quarterly MDS assessment with an ARD of 1/21/25 quarterly MDS, Section J1800, coded no falls. Review of Resident #40's medical record revealed a change in condition note dated 12/22/44 at 15:11 that documented, fall. On 4/29/25 at 8:32 AM the MDS coordinator confirmed the errors. 5) On 4/23/25 at 12:05 PM a review of Resident #7's medical record was conducted. Review of Resident #7's Discharge Assessment - return not anticipated, with an ARD of 2/2/25, Section J, Health Conditions, J0100 Pain management A. received scheduled pain medication regimen, coded the resident as not receiving pain medication regularly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's January 2025 and February 2025 Medication Administration Record (MAR) documented Voltaren Arthritis Pain External Gel 1 % (Diclofenac Sodium (Topical) was administered to bilateral knees topically one time a day for arthritis. The facility failed to capture the use of the analgesic. On 4/30/25 at 12:01 PM the MDS Coordinator was interviewed and confirmed the error. 6) On 4/24/25 at 8:25 AM a review of Resident #21's medical record was conducted. Review of the MDS assessment with an ARD of 3/14/25, Section J0100B pain management, received PRN (when necessary) pain medications or was offered and declined was coded 0 which indicated the resident did not receive any PRN pain medications. Review of Resident #21's March 2025 MAR documented Resident #21 received Extra Strength Tylenol 500 mg. (2) on 3/14/25 for a pain level of 3. On 4/29/25 at 8:27 AM an interview was conducted with the MDS Coordinator, and she confirmed the error.

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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. 31145 Based on observation, medical record review, and staff interview, it was determined that facility staff failed to develop a comprehensive, resident centered care plan for nutrition. This was evident for 1 (#17) of 52 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 4/28/25 at 8:00 AM a review of Resident #17's medical record was conducted. Review of the weight section of the medical revealed on 2/3/25 the resident had a documented weight of 183.8 pounds (lbs.). There was no weight in March 2025. A weight was taken on 4/1/25, 4/2/25, and 4/3/25, which was documented as 166.6 lbs. which was a 17.2 lb. weight loss which was a 9.4 % weight loss. Resident #17 was currently on a No salt packet, finger food, thin liquid diet with ice cream and pudding twice per day. Review of the care plan section of Resident #17's medical record failed to produce a nutritional care plan. On 4/28/25 at 2:48 PM the dietician was interviewed and stated that she was at the facility on Thursdays for 12 hours a week. She stated, I try to do notes but given the time limitations I look at weight loss, wounds, and risk. The surveyor asked her if she was responsible for a nutritional care plan and she stated that she should have had a care plan. The dietician kept saying that she has been there for a long time and doesn't have an answer for why a nutritional care plan was not in the medical record, but she was the one that did the care plan. The dietician stated, 12 hours is all I am offered a week based on my contract. I try to hit the high priority areas. I can't get to everything. On 4/29/25 at 9:40 AM the Medical Director informed the surveyor that he reviewed the medical record in its entirety and confirmed the surveyor's findings.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34484 Based on medical record review and interview, the facility staff failed to have quarterly care plan meetings for residents and failed to update a care plan after a change in condition. This was evident for 3 (#12, #3, #17) of 52 residents reviewed during a complaint survey. The findings include: Once the facility staff completes an in-depth assessment (MDS) of the resident, the interdisciplinary team meet and develop care plans. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the resident's specific needs. The care plan is a means of communicating and organizing the actions and assure the resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the resident to ensure the interventions on the care plan is accurate and appropriate for the resident. Care plan meetings are held each quarter and as needed. 1. Review of Resident #12's medical record on 4/23/25 revealed the Resident was admitted to the facility in June 2024. Interview with the Resident #12 on 4/30/25 at 10:25 AM the Resident was asked if he/she has been having care plan meetings, the Resident stated did have one recently but can't remember having one since admission in June 2024. Further review of Resident #12's medical record revealed the facility staff completed a quarterly MDS assessment 9/25/24 and 11/22/24. Review of Resident's medical record revealed the only documented care plan meeting was on 4/23/25. Interview with the Director of Nursing on 4/30/25 at 12:15 PM confirmed the facility staff failed to have a quarterly care plan meeting for Resident #12 since admission in June 2024 until 4/30/25. 31145 2) On 4/24/25 at 9:01 PM a review of facility reported MD00216113 documented that Resident #3 had an unwitnessed fall on 3/24/25 and on 3/25/25 an x-ray was performed, and the resident was found to have a fracture to the left humerus. The humerus is the long bone located in the upper arm, connecting the shoulder to the elbow. Review of a 3/23/25 at 15:31 (3:31 PM) nursing note documented, patient is confused and constantly trying to edge [his/her] way out of bed as [she/he] has slid into the floor prior to today. Patient was caught this afternoon with [his/her] legs off the bed. Aids and nurses has replaced [him/her] in the bed multiple times. A 3/24/25 at 8:45 PM nurse practitioner note documented, Pt. has had 2 falls in last 24 hours. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's at risk for falls related to weakness and limited mobility care plan that was created on 9/1/23 had 8 interventions. The care plan was not updated since 10/1/23 for new interventions after the multiple falls. On 4/25/25 at 11:05 AM an interview was conducted with the Director of Nursing (DON). The DON was informed that the care plan was not updated after the fall. The DON confirmed that the care plan should have been updated for fall mats. 3) On 4/28/25 at 8:00 AM a review complaint MD00200383 was conducted and revealed an allegation that in September 2023 Resident #17's responsible party had complained that they had not received any communication from the social worker since May 2023. The complaint alleged that no one had reached out until December 2023. Review of social work notes in Resident #17's medical record revealed there were no social work notes from 5/30/23 until 12/8/23. Review of care plan meetings for Resident #17 revealed a care plan meeting was held on 12/5/23, however only 2 facility staff attended which were the social services assistant and 1 unknown titled person. There was no documentation that family or the resident was invited to the care plan meeting. On 3/21/24 it was documented that only social services and activities personnel attended the care plan meeting with the daughter. No nursing personnel were present. There was no meeting in June 2024. There was a 9/4/24 care plan meeting. There was no care plan meeting in December 2024. On 4/23/25 at 10:06 AM an interview was conducted with the Social Work Assistant (Staff #4) who stated she has been at the facility almost 3 weeks. Staff #4 stated, we do not have a full-time social worker here. I do care plan meetings and take notes and put them in chart. The assistant is here to help the director. Cross Reference F 850 On 4/28/25 at 3:25 PM an interview was conducted with the DON who confirmed the surveyor's findings that there were no care plan meetings from 5/30/23 to 12/8/23, 6/2024, and 12/2024.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 31145 Based on complaint, record review, and interview, it was determined the facility failed to have documentation that residents were offered and/or received a shower on the resident's assigned shower day. This was evident for 6 (#16, #27, #52, #50, #51, #41) of 52 residents reviewed for complaints during a complaint survey. The findings include: 1) On 4/23/25 at 3:55 PM a review of complaint MD00206200 alleged the facility was short staffed and residents were laying in their urine and feces and not receiving proper care. Review of Resident #16's medical record revealed the resident was admitted to the facility in February 2023 as the resident required 24 hour a day nursing care. On 4/24/25 at 10:10 AM an interview was conducted with Resident #16 who stated that there was not enough staff and that showers were not being given and that he/she has not had a shower in a year. Resident #16 stated he/she has only had bed baths. Resident #16 stated, I never refuse a shower. Review of Resident #16's care plan documented Resident #16 had a self-care deficit related to paraplegia and impaired mobility. Paraplegia is a condition characterized by the loss of movement and sensation in the lower body. Review of geriatric nursing assistant (GNA) activities of daily living (ADL) documentation for showers for May 2024 documented the resident did not receive any showers for the month. Resident #16 received bed baths on 15 of the 31 days in May. There was no documentation that Resident #16 was offered and refused a shower. Review of GNA ADL documentation for February 2025 documented Resident #16's shower days were Tuesdays and Fridays. Review of the GNA shower day documentation revealed the resident refused a shower on 2/4/25 and 2/25/25. The other Tuesdays and Fridays, 2/7/25, 2/11/25, 2/14/25, 2/18/25, 2/21/25, and 2/18/25 documented not applicable (N/A). Review of February 2025 bathing documentation documented bed baths were given daily except 2/1/25, 2/2/25, 2/22/25, and 2/23/25. Review of GNA ADL documentation for March 2025 documented that on Resident #16's assigned shower days the resident refused on 3/4/25, 3/11/25, 3/18/25, and 3/25/25. The other days, 3/7/25, 3/21/25 and 3/28/25 was documented, not applicable. It was documented on 3/14/25 a shower was given. Review of GNA ADL documentation for April 2025 documented that on Resident #16's assigned shower days the resident refused a shower on 4/1/25 and 4/15/25. On 4/4/25, 4/11/25, 4/18/25, and 4/22/25 were documented, not applicable. On 4/8/25 it was documented a partial bath was given. On 4/23/25 at 11:10 AM an interview was conducted with RN #7 who stated that she documents in PCC (electronic medical record) when a resident refuses a shower under behaviors. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 at 9:08 AM an interview was conducted with the Director of Nursing (DON). The DON stated she identified the shower issue when she first started at the facility in July 2024. The DON stated she was trying to cross over the shower schedule into PCC to make staff aware and that they need to document if a resident refuses. If a resident refuses then the staff need to try reapproaching the resident at a later time. 2) On 4/28/25 at 3:29 PM review of complaint MD00199437 alleged all residents at the nursing facility were not given showers like scheduled dating back to 2023. Review of complaint MD00214363 alleged neglect along with other residents. Complaint MD00197946 alleged the level of care was horrendous. Complaint MD00213182 alleged that their loved one never got a shower. Complaint MD00203182 alleged that staff was not able to provide appropriate care to residents like showers. Complaint MD00190955 alleged major basic hygiene was not being met. 2a) Review of Resident #27's GNA documentation for bathing for September 2023, November 2023, March 2024, and April 2024 documented the resident received a bed bath daily, however, did not receive a shower. Review of April 2025 GNA documentation revealed 1 documented shower on 4/28/25. All other days were bed baths. There was no documentation provided to the surveyor to support the resident received a shower or refused a shower in the previous months. 2b) On 4/30/25 at 8:50 AM Resident #52 was interviewed and stated, I don't get help with my bath. Unless I specify directly I don't get help. I am supposed to get a shower on Tuesday and Fridays. I did not get one yesterday, but I got one last Friday. They don't tell me why. Review of Resident #52's April 2025 GNA documentation for the type of bath performed documented no showers for the month of April. Resident #52 refused once on 4/16/25. The other shower days were documented as non-applicable. 2c) On 4/30/25 at 8:54 AM Resident #50 was interviewed and stated, I would like a shower every week. I never refuse showers. I love showers. Review of Resident #50's April 2025 GNA documentation for the type of bath performed documented bed baths. There were no showers given or documentation of showers refused from 4/1/25 to 4/30/25. 2d) On 4/30/25 at 8:56 AM Resident #51 was interviewed and stated, I have had no showers. They say they don't have time. Review of Resident #51's April 2025 GNA documentation for the type of bath performed documented bed baths and 3 showers that were given on 4/2/25, 4/8/25, and 4/16/25. All other days were bed baths. The DON stated all residents are scheduled for at least 2 shower days a week. On 4/30/25 at 8:52 AM Staff #40 stated if they have 4 GNAs on the shift then showers can be given. If there are 3 GNAs it depends on the work load and if there are only 2 GNAs that means they each have 18 residents on day shift and showers are not given. Staff #40 stated that some residents require the assistance of 2 GNAs and if they don't have enough GNAs on the unit then the showers can't be given. On 4/30/25 at 11:08 AM the concerns regarding showers were again reiterated to the DON who stated she was aware of the issue and working to correct the problem. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	37586 3) On 2/23/23 daughter reported that Resident #41 would be soaked with urine and feces every time she came to visit which she stated was every day. A review of Resident #41's bowel and bladder records indicated the resident was not given incontinent care on the following days. Bowel 1/28 and 1/29/23 night shift 1/30/23 eve shift 1/31/23 night shift 2/5/23 day shift 2/2/23 eve. shift and night shift 2/3/23 night shift 2/4/23 night shift 2/5/23 day shift Toileting 1/30/23 eve shift 1/31/23 eve shift 2/2/23 eve. shift 2/3/23 eve. shift 2/4/23 day shift 2/5/23 day shift 2/7/23 night shift

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on review of complaint, medical record review, and staff interview, it was determined the facility failed to provide care to meet the needs of a resident's physical, mental, and psychosocial health. This was evident for 8 (#6, #11, #12, #30, #37, #42, #1, #5) of 52 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #6's medical record on [DATE] revealed the Resident was admitted to the facility in [DATE] with a diagnosis to include disorders of the bladder. Further review of the Resident's medical record revealed on [DATE] the physician ordered the Resident to have Macrobid 100 mg two times a day for UTI (urinary tract infection). Macrobid is a antibiotic medication that can be used to treat urinary tract infections. Review of the Resident [DATE]'s Medication Administration Record revealed the Resident only received Macrobid for 4 days (,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE]). The facility staff failed to administer Macrobid on [DATE] even though it is in the facility's medication stock. The Inventory Summary List of the facility's in house medications provided by the Director of Nursing on [DATE] included Macrobid. Also the facility staff failed to recognize the Resident only received Macrobid for 4 days and administer the medication for a 5th day. Interview with the Director of Nursing on [DATE] at 1:17 PM confirmed the facility staff failed to administer Macrobid to Resident #6 for 5 days as ordered by the physician. 2) A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. Review of Resident #11's medical record on [DATE] revealed the Resident was admitted to the facility in 2017 with a diagnosis to include muscle weakness. a) Further review of the Resident's medical record revealed a nurse's note on [DATE] at 3:30 PM that states, Patient was lying on the floor in front of wheelchair. Patient stated he/she was trying to grab snacks off his/her bed when he/she slid out of wheelchair. Neuro checks and vital signs within normal limits. Primary Care Provider responded with the following feedback: Recommendations: Neuro checks and vital signs. Further review of the Resident's medical record revealed no neuro checks documented after the fall on [DATE] at 3:30 PM. b) Further review of Resident #11's medical record revealed on a nurse's note [DATE] at 11:50 PM that stated Resident slid from wheelchair to floor at approximately 7:50 PM. Unwitnessed fall. (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 #11's medical record revealed a nurse practitioner note on [DATE] at 10:57 PM that stated the Resident slid from wheelchair to floor. He/she was helped back into bed. Vital signs within normal limits. Found in room unresponsive and expired 9:28 PM per Emergency Medical Services (EMS). Assessment and Plan: Fall-neuro checked initiated, Vital signs within normal limits, no evidence of injury to head. Further review of the Resident's medical record revealed no neuro checks documented after the fall on [DATE] at 7:50 PM until found at 9:28 PM. Interview of the Director of Nursing on [DATE] at 1:00 PM confirmed there is no evidence in the medical record that facility staff performed neuro checks and documented for Resident #11 for 2 unwitnessed falls on [DATE]. 3) Review of Resident #12's medical record on [DATE] the Resident was admitted to the facility in [DATE] and was readmitted to the facility on [DATE] following a hospitalization with a diagnosis to include infection and inflammatory reaction due to internal joint prosthesis. During interview with Resident #12 on [DATE] at 10:25 AM, with the Resident's nurse (Staff #37) at the bedside, the Resident was showing the Surveyor a list of medications the Resident was previously on and has not been reordered. The Surveyor asked Staff #37 is she had seen the list and Staff #37 stated yes the Nurse Practitioner had reviewed the list in detail and documented in the Resident's medical record why the Resident had not been restarted on medications. Further review of Resident #12's medical record revealed a Nurse Practitioner's (Staff #38) note on [DATE] that stated, Patient was seen due to the patient's significant other requesting another review of the patient's medications. Extensive review of chart performed. Medications are appropriate as ordered. Check Vitamin D, Iron and Magnesium levels as these medications were previously discontinued. Do not restart flomax secondary to renal function. All other medications accounted for. Further review of Resident #12's medical record revealed as of [DATE] no orders were placed to check Vitamin D, Iron and Magnesium levels. During interview with the Medical Director on [DATE] at 10:52 AM, the Surveyor shared Resident's concerns of medications he/she was on prior to hospitalization and still not receiving. Further review of Resident #12's medical record revealed the Medical Director's note on [DATE] at 11:38 AM that stated: I performed a medication reconciliation, reviewing patient's list, current medications, and the last transfer summary. After Surveyor intervention and Medical Director review, Resident #12 was ordered iron, magnesium, Vit D and BNP laboratory tests. The Resident's pantoprazole was increased, zoloft was restarted, flomax was restarted, and nonformulary Uloric medication was changed to allopurinol. Interview with the Medical Director on [DATE] at 11:50 AM confirmed Resident #12 did not receive laboratory tests as noted in Staff #38's [DATE] note and all the Resident's medications had not been reconciled since last readmission on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #42's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included a complicated urinary tract infection and obstructive nephropathy status post nephrostomy tube placement. Review of the hospital discharge summary documented that Infectious Disease staff had started intravenous (IV) Imipenem 500 mg., and it was to be administered every 12 hours for a 7-day course until [DATE]. Review of Resident #42's [DATE] Medication Administration Record (MAR) documented, Imipenem-Cilastatin Intravenous Solution 500 mg. intravenously every 12 hours for 6 days, however, it was put on the MAR only to be given one time per day at 8:00 AM. The medication was given at 8:00 AM on [DATE] and [DATE]. Review of Resident #42's [DATE] MAR documented the medication was given on [DATE] and [DATE] at 8:00 AM. The IV medication was not administered as ordered. The [DATE] 8:00 AM dose was not given. The medication was given at 6:00 PM on [DATE], at 6:00 AM and 6:00 PM on [DATE] and at 6:00 AM on [DATE]. The medication was not administered on [DATE] at 6:00 PM and there was no administration on [DATE]. A [DATE] at 12:04 PM note documented that the times of administration were changed to 6:00 AM and 6:00 PM and the end of the doses was to end after 6:00 AM on [DATE]. On [DATE] at 11:08 AM a nursing note documented that the IV antibiotic was extended to [DATE] to make up for the 2 missed doses. Additionally, on [DATE] at 1:35 PM an interview was conducted with the complainant who stated that Resident #42 received the wrong medication and was deathly ill for 48 hours. The complainant stated that Resident #42 received his/her roommate's medications. Review of a nursing note dated [DATE] documented Resident #42 received Vit D, probiotics, bupropion, loratadine, this morning. Those were not the medications Resident #42 were supposed to receive. The note documented the nurse immediately notified the physician and received orders to monitor the resident. The resident was assessed and monitored throughout the shift and did not have any adverse or side effects from any of the medications. On [DATE] at 10:20 AM the Director of Nursing (DON) confirmed the findings. 7) On [DATE] at 2:37 PM a review of complaint MD00216820 alleged that Resident #1 had not received his/her medication Enbrel and that the facility lowered the dosage of Naproxen without informing the resident first. Review of Resident #1's medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Ankylosing spondylitis (AS), which is a chronic inflammatory disease that primarily affects the spine, causing inflammation and potentially leading to the fusion of vertebrae, resulting in stiffness and reduced flexibility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ,d+[DATE] /25 hospital discharge summary documented the Naproxen 250 mg. was discontinued in the hospital and increased to 500 mg. twice per day. Review of Resident #1's [DATE] MAR documented Naproxen 250 mg. by mouth two times a day for pain. On the evening shift of [DATE] the medication was not available. A [DATE] at 22:35 PM nurse's note documented the resident refused the medication stating the medications were incorrect. A [DATE] at 8:48 AM a nurse's note documented the resident called the nursing station complaining that the staff changed the medications and that his/her rights had been violated because no one told the resident that the dosage had been reduced to 250 mg. The nurse then reviewed the medication list sent by the hospital and discussed it with the resident and the Naproxen was changed to 500 mg. twice per day and the resident received the correct dosage on [DATE] in the evening. The dosage of the medication was not transcribed correctly from the hospital discharge summary to the resident's orders; therefore, the dosage was initially incorrect. Further review of Resident #1's [DATE] MAR documented the Enbrel injection for arthritis every Thursday was not available. Enbrel is a prescription medication that belongs to a class of drugs called tumor necrosis factor (TNF) inhibitors. It is used to treat autoimmune conditions such as Rheumatoid arthritis (RA), Psoriatic arthritis (PsA), Ankylosing spondylitis, and Plaque psoriasis. Enbrel works by blocking the action of TNF, a protein that plays a role in inflammation. By inhibiting TNF, Enbrel can reduce inflammation and improve symptoms in autoimmune conditions. On [DATE] at 12:30 PM an interview was conducted with the Medical Director who knew of Resident #1's medication issues with receiving Enbrel from the sister facility that Resident #1 was residing at prior to admission to this facility. The Medical Director stated that Resident #1 should have been on the Naproxen 500 mg. because that was what he/she was on at the sister facility. On [DATE] at 9:20 AM a second interview was conducted with the Medical Director. He stated that Resident #1 should have been on Naproxen 500 mg. and that it was an error. He also stated that the facility could have reached out to the sister facility to get the Enbrel. 8) On [DATE] at 11:07 AM a review of complaint MD00215433 alleged that 4 days after admission Resident #5's blood sugar dropped in the 30's after 2 incidents of hypoglycemia (low blood sugar) and the resident was transferred to the emergency room . The complainant alleges she was not notified of the initial incident of low blood sugar. Review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE] from an acute care hospital with diagnoses that included cerebral infarction (stroke) and type 2 diabetes mellitus. Review of the medical record was void of any nursing assessments the 5 days the resident was in the facility. There were no assessments on [DATE], [DATE], [DATE], [DATE], and [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of February 2025 physician's orders revealed the resident was prescribed Jardiance 10 mg. every day for diabetes, Tirzepatide 2.5 mg/0.5 ml injection every Wednesday for diabetes, and glipizide 10 mg. twice per day for diabetes. The physician also ordered to check blood sugar in the morning related to diabetes. A blood sugar level below 70 mg/dL (3.9 mmol/L) is considered low. A blood sugar level below 54 mg/dL (3.0 mmol/L) is a cause for immediate action. Review of the February 2025 MAR documented on [DATE] at 6:00 AM the blood sugar reading was 59. A blood sugar reading on [DATE] at 6:00 AM was 53. There was no documentation that the physician was notified. Review of a [DATE] at 20:39 health status note documented the resident went into respiratory distress and the blood sugar reading was 36, the resident was given glucagon, vitals were unstable and 911 was called and the resident was sent out via 911 to the hospital. The note was written by Licensed Practical Nurse (LPN) #8. Glucagon is a hormone produced by the pancreas that raises blood sugar levels. There was no change in condition note found in the medical record. The note documented that the resident went into respiratory distress, however there were no vital signs such as blood pressure, heart rate, respiratory rate, and oxygen saturation rate. There was no documentation whether the resident received oxygen prior to transport and what the rate of oxygen that was given. There was no documentation that a status report was given to the hospital. There were no physician's orders found to administer glucagon. On [DATE] at 10:58 AM a discussion with the DON confirmed there were no daily skilled assessments, no vital signs, no order for glucagon to be given, and no physician notification of decreased blood sugars. On [DATE] at 11:15 AM an interview was conducted with LPN #8. LPN #8 stated Resident #5 was her patient the last day he/she was at the facility. LPN #8 stated it was the beginning of her second shift for the day, and she went to the bathroom which was a long way down the hall. LPN #8 stated when she came back up the hall there was a lot of commotion in Resident #5's room, so she went in and there were 3 to 4 nurses in there and they said the resident's feeding tube was overflowing and then the resident went into respiratory distress. LPN #8 stated the DON was called and she said to give the resident glucagon because of blood sugar in the 30's. LPN #8 stated Resident #5 appeared sick, and his/her breathing was not better, so the resident was sent out. LPN #8 stated it was chaotic because the blood sugar was so low, and the tube feeding was all over and not going in. LPN #8 stated she did not document anything in the medical record because she was not in the room initially when the incident happened.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37586 Based on record review and incident review of wound care, the facility failed to change a wound dressing. This was evident for 1 (#31) out of 7 residents. Findings include: On 4/24/25 at 2:19 PM a medical record review was conducted for Resident #31. On 9/24/23 daughter went to visit Resident # 31 who has wounds on his/her right foot. The date on the dressing stated 9/23/23 with the initials of Staff #36. Mother went to the unit manager and stated the dressing was not changed on resident right foot as the dressing change indicated it was changed on 9/23/23. It was not changed on 9/22/23. Unit manager at the time Staff #35 stated they must have put the wrong date on the dressing. Mother then stated Don't try that because the nurse stated yesterday that Nurse #39 said she did not have the time to change the dressing because she was the only nurse for 40 residents with no medication aid. Nurse advised the evening nurse to change the dressing which evening nurse failed to do. On 9/18/23 daughter went to visit Resident #31 again., and dressing on the right foot was dated 9/16/23 by Staff #51. Staff #51 was interviewed on 4/24/24 at 11:28AM and stated she did not work on 9/16/23, she worked on 9/17/23 but dated the dressing 9/16/23 instead of 9/17/23. Staff 51 stated she does not remember the resident, but knows she did every dressing change due. She stated I probably put the wrong date on dressing change.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31145 Based on interview and record review, it was determined the facility failed to keep a resident with decreased cognition from exiting the building unsupervised. This was evident for 1 (#47) of 52 residents reviewed during a complaint survey. The findings include: On 4/23/25 at 1:14 PM a review of an anonymous complaint alleged the facility needed to be investigated as they were doing illegal things. On 4/24/25 at 8:39 AM the surveyor received a call from a complainant stating that a resident got out of the building, eloped, and no one knew where the resident was for several hours, that the police were called and brought the resident back to the facility. Review of Resident #47's medical record revealed a 5/25/24 at 13:40 health status note that documented, Resident was not in room during rounds. Building and grounds checked by staff. 911 called. Resident found by staff in the community across the street. 911 returned call, stated found patient (no officer responded.). The resident told the staff he/she was fine and was just out walking. According to the Centers for Medicare and Medicaid Services (CMS), an Elopement occurs when a resident leaves the premises or a safe area without authorization. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. The resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. Review of Resident #47's medical record revealed the resident was admitted to the facility in July 2023 along with his/her spouse. Resident #47 was admitted with diagnoses that included but were not limited to Alzheimer's Disease, depression, and anxiety. BIMS stands for Brief Interview for Mental Status. It is a screening tool used to assist with identifying a resident's current cognition and to help determine if any interventions need to occur. There is a series of questions that are asked to the resident. These questions have a score value attached to them. The total score of all the questions ranges from 0-15. The numeric value falls into one of three cognitive categories: Intact which is 13 to 15 points, Moderate which is 8 to 12 points or Severe cognitive impairment which is 0 to 7 points. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #47's admission Minimum Data Set (MDS) assessment, with an assessment reference date of 7/20/23, coded that Resident #9 had a BIMS score of 8 under Section C, cognition. Section E, wandering, coded no wandering occurred during the lookback period. The resident was assessed to have moderate cognitive impairment. The 10/20/23 BIMS score was 5 which indicated severe cognitive impairment. The 1/20/24 BIMS score was 10 and the 4/21/24 BIMS score was 12. The resident's BIMS scores fluctuated. Continued review of Resident #47's medical record failed to produce an elopement risk evaluation until after 5/25/24. Review of the 5/28/24 elopement risk assessment asked if the following was present: new admission who has made statements questioning the need to be here; Resident is cognitively impaired, with poor decision-making skills or with pertinent diagnoses (dementia, hallucinations); resident alert but non-compliant with facility protocols for leaving unit; or none of the above. The facility checked off none of the above. This was incorrect as the resident was assessed to be cognitively impaired with pertinent diagnosis of Alzheimer's disease. The next question on the elopement risk evaluation asked the question, does the resident exhibit any of the following behaviors which included, opening doors to the outside or elopement. The facility checked off, none of the above. This was incorrect as the resident was able to open the door, go outside and go across the street without being supervised. Furthermore, the 10/22/24 elopement risk assessment documented the same answers. The 4/22/25 elopement risk evaluation asked the question, does the resident have a history of attempting to leave the facility without alerting staff and the response was, no. That was incorrect as the resident left the premises without telling staff. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of care plans for Resident #47 revealed a care plan, is an elopement risk/wanderer r/t resident wanders aimlessly, dementia that was initiated on 11/14/24. The care plan was not initiated until 6 months after the resident eloped. On 4/29/25 at 3:34 PM the Director of Nursing, the Medical Director, and the interim Nursing Home Administrator (NHA) were interviewed. They confirmed a facility reported incident was not sent in to the regulatory agency reporting an unusual occurrence. They stated that the front door was always locked and requires either a code to be entered to go in or out or someone has to buzz the person in or out. (The surveyor corroborated that the front entrance door was coded and all doors in the facility had door codes). They stated that the residents need permission to go out front. We send staff out front when residents are out front. The receptionist knows who are elopement risks and there are pictures. The door is locked, and they are required to open the door. The NHA stated he was not here during that time period, and he said they should have reported the incident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to do quarterly nutrition assessments for residents and failed to recognize a resident's weight loss and notify the physician and dietician. This was evident for 3 (#15, #17, #21) of 52 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #15's medical record on 4/24/25 revealed the Resident was admitted to the facility in 2019 and had a diagnosis to include malnutrition. The Resident was discharged from the facility on 8/17/24. Further review of the Resident's medical record revealed the last nutritional assessment completed on the Resident was 3/2/23 and there were no notes from the Dietitian after 3/2/23. Interview with the Dietitian on 4/25/25 at 9:54 AM, the Dietitian stated she is consulted to work at the facility 12 hours a week. At that time the Dietitian also reviewed Resident #15's medical record and confirmed there is no nutritional assessment or note after 3/2/23 until discharge on [DATE]. The Dietitian stated she does what she can in the 12 hours she is contracted but can not complete everything. The findings were reviewed with the Director of Nursing on 4/25/25 at 10:17 AM that the Dietitian confirmed there is no quarterly nutritional assessments from 3/2/23 through discharge on 8/17/24 for Resident #15. 31145 2) On 4/28/25 at 8:00 AM a review of Resident #17's medical record was conducted. Resident #17 was admitted to the facility in November 2022 with diagnoses that included unspecified dementia, obsessive-compulsive disorder, schizophrenia, delusional disorders, and major depressive disorder. Review of physician's orders revealed Resident #17 was ordered a No salt packet, finger food, thin liquid diet with ice cream and pudding twice per day. A review of the weight section of Resident #17's medical record revealed on 1/2/25 the documented weight was 183.8 pounds (lbs.). On 2/3/25 the resident weight was documented 183.8 lbs. but had the wording, no weights ordered. See last weight obtained. There was no weight documented in March 2025. A weight was taken on 4/1/25, 4/2/25, and 4/3/25, which was documented as 166.6 lbs. which was a 17.2 lb. weight loss which was a 9.4 % weight loss. Further review of evaluations and notes in Resident #17's medical record failed to produce evidence that the dietician, physician, and responsible party were notified. Review of Resident #17's medical record failed to produce nutritional evaluations/assessments or progress notes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan section of Resident #17's medical record failed to produce a nutritional care plan. On 4/28/25 at 12:26 PM an interview was conducted with LPN #22. LPN #22 was asked about the weight process, and she stated, the GNAs (geriatric nursing assistants) weigh and the nurse puts the weight in the system. The Director of Nursing is then alerted. The surveyor asked LPN #22 who notified the dietician, and her response was, I don't know who is notifying the dietician. Do we have one. On 4/28/25 at 1:57 PM an interview was conducted with the Medical Director (MD) and the Director of Nursing (DON). They were informed that there was nothing in the medical to indicate Resident #17 had been followed by the dietician and that the resident had a 9.4% weight loss. They both stated they would have expected to be notified about the weight loss. They both stated that the dietician participated in weekly risk meetings. The MD stated he saw dietary assessments in other resident medical records. The MD stated, yes, that concerns me that there are not any dietary assessments or notes in the record. The DON stated that she puts out the weight list on Monday and by Tuesday or Wednesday, if there is a weight loss, they do a reweight on Wednesday and have a risk meeting on Thursday. The MD and the DON were also informed that the attending physician had seen Resident #17 on 4/17/25 and had used the 1/2/25 weight in his notes instead of the 4/1/25, 4/2/25, or 4/3/25 weight, therefore the weight loss was not addressed. The nurse practitioners had seen the resident 4/21/25, 4/10/25, 4/12/25, and 4/7/25, and there was no mention about the weight loss. The MD stated, I expect them to look at weights and any other information in the medical record that is pertinent in the medical record, and I expect them to address them. On 4/28/25 at 2:48 the dietician was interviewed and stated, I am there on Thursdays, 12 hours a week. I try to do notes but given the time limitations I look at weight loss, wounds and risk. Twice a week I update the weights because Thursday is risk meeting. The dietician stated she became aware of the weight loss and stated it would be discussed at the 4/10/25 risk meeting. The dietician stated, I usually don't document unless we are going to do something like adding a supplement. The dietician stated, I guess I should have documented a nutritional assessment. Twice a week I send out an updated weight list to the DON and unit manager. The dietician confirmed that she should have had a care plan and that she was responsible for the care plan. The dietician stated, I should be doing annual assessments but with only working 12 hours a week I should be hitting my priority. Twelve hours is all I am offered based on my contract. On 4/29/25 at 9:40 AM the MD came in to say that he reviewed the medical record in its entirety and confirmed the surveyor's findings. 3) On 4/24/25 at 8:25 AM a review of complaint MD00197946 alleged, the food and level of care is horrendous. Review of Resident #21's medical record revealed Resident #21 was admitted to the facility in February 2023 with diagnoses that included Cerebral infarction due to thrombosis of right posterior cerebral artery, major depressive disorder that was recurrent, and repeated falls. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the weight section of Resident #21's medical record revealed on 5/5/24 Resident #21's documented weight was 129.2 lbs. There were no weights documented from 5/5/24 until 9/5/24 when the weight was documented as 121.4 lbs. Resident #21 had gradual weight gain monthly until 1/2/25 when the documented weight was 126.6 lbs. The 2/5/25 weight was 117.6 lbs., which was a 9 lb./7.1 percent weight loss in 1 month. Further review of the medical record failed to produce documentation that the dietician and the physician were notified of the weight loss on 2/5/25. Review of a 2/10/25 physician's note documented the weight as, 117.6 pounds (Warnings: -5.0% change, False) on 2/5/25. There was no mention of the resident's weight loss and Physician #52 did not address the weight loss. A 3/5/25 Nurse Practitioner #56 note documented, has not been eating well per staff the past few days. The assessment was, FTT (failure to thrive) unclear etiology. There was nothing about a nutritional consult. A 4/8/25 physician's note documented the weight as, 109.6 pounds (Warnings: -5.0% change, False. -7.5% change, False. -10.0% change, False). Physician #52 did not address or mention the weight loss. On 4/29/25 at 8:53 AM an interview was conducted with the DON who stated there was an issue with the dental clinic and the resident was waiting to be fitted for dentures which was attributing to the weight loss. The DON confirmed that there was no notification of any weight losses. On 4/29/25 at 9:44 AM the issues found were reviewed with the Medical Director who concurred with the findings.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 31145 Based on medical record review and staff interview, it was determined that the facility failed to ensure a physician supervised the care of a resident, as evidenced by the physician failing to evaluate a resident's weight loss. This was evident for 2 (#17, #21) residents reviewed for 42 complaints reviewed during a complaint survey. The findings include: 1) On 4/28/25 at 8:00 AM a review of Resident #17's medical record was conducted. Resident #17 was admitted to the facility in November 2022 with diagnoses that included unspecified dementia, obsessive-compulsive disorder, schizophrenia, delusional disorders, and major depressive disorder. A review of the weight section of Resident #17's medical record revealed on 1/2/25 the documented weight was 183.8 pounds (lbs.). On 2/3/25 the resident weight was documented 183.8 lbs. but had the wording, no weights ordered. See last weight obtained. There was no weight documented in March 2025. A weight was taken on 4/1/25, 4/2/25, and 4/3/25, which was documented as 166.6 lbs. which was a 17.2 lb. weight loss which was a 9.4 percent weight loss. Review of a physician's progress note dated 4/17/25 revealed Physician #52 used the January 2025 weight of 183.8 lbs. instead of the 4/3/25 weight of 166.6 lbs. Without reviewing the weight section of the medical record, the physician missed an opportunity to address the 9.4 percent weight loss. Further review of the medical record revealed Resident #17 was seen by the Nurse Practitioner (NP) #53 on 4/21/25, NP #38 on 4/10/25, 4/12/25, and 4/7/25. There was no mention of Resident #17's weight, therefore the weight loss was not addressed, and interventions were not put in place. On 4/28/25 at 1:57 PM an interview was conducted with the Medical Director (MD) and the Director of Nursing (DON). They were informed that the attending physician had seen Resident #17 on 4/17/25 and had used the 1/2/25 weight in his notes instead of the 4/1/25, 4/2/25, or 4/3/25 weight, therefore the weight loss was not addressed. The nurse practitioners had seen the resident 4/21/25, 4/10/25, 4/12/25, and 4/7/25, and there was no mention about the weight loss. The MD stated, I expect them to look at weights and any other information in the medical record that is pertinent in the medical record, and I expect them to address them. Cross Reference F692 2) On 4/24/25 at 8:25 AM a review of Resident #21's medical record revealed Resident #21 was admitted to the facility in February 2023 with diagnoses that included Cerebral infarction due to thrombosis of right posterior cerebral artery, major depressive disorder that was recurrent, and repeated falls. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the weight section of Resident #21's medical record revealed on 5/5/24 Resident #21's documented weight was 129.2 lbs. There were no weights documented from 5/5/24 until 9/5/24 when the weight was documented as 121.4 lbs. Resident #21 had gradual weight gain monthly until 1/2/25 when the documented weight was 126.6 lbs. The 2/5/25 weight was 117.6 lbs., which was a 9 lb./7.1 percent weight loss in 1 month. Further review of the medical record failed to produce documentation that the dietician and the physician were notified of the weight loss on 2/5/25. Review of a 2/10/25 physician's note documented the weight as, 117.6 pounds (Warnings: -5.0% change, False) on 2/5/25. There was no mention of the resident's weight loss and Physician #52 did not address the weight loss. A 3/5/25 Nurse Practitioner #56 note documented, has not been eating well per staff the past few days. The assessment was, FTT (failure to thrive) unclear etiology. There was nothing about a nutritional consult. A 4/8/25 physician's note documented the weight as, 109.6 pounds (Warnings: -5.0% change, False. -7.5% change, False. -10.0% change, False). Physician #52 did not address or mention the weight loss. On 4/28/25 at 1:57 PM an interview was conducted with the Medical Director who stated, I expect them to look at weights and any other information in the medical record that is pertinent in the medical record, and I expect them to address them. On 4/29/25 at 9:44 AM the Medical Director stated he concurred with the surveyor's findings. Cross Reference F692

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of complaints, documentation review, and interview, it was determined that the facility failed to have sufficient nursing staff to meet the needs of the residents. This was evident for 16 of 42 complaints submitted to the Office of Health Care Quality (OHCQ), the regulatory agency, multiple staff interviews, and review of staffing schedules. This deficient practice had the potential to affect all residents. The findings include: 1) Sixteen out of forty-two complaints that the Office of Health Care Quality (OHCQ) received and reviewed on this survey alleged the facility did not have sufficient nursing staff to provide essential care to the residents that resided at the facility. Complaints consisted of geriatric nursing assistants (GNAs) not having enough time to give resident showers and toilet and change residents. 2) Five of the 16 complaints were related to residents not receiving showers. a) On 4/23/25 at 3:55 PM a review of complaint MD00206200 alleged the facility was short staffed and residents were laying in their urine and feces and not receiving proper care. On 4/24/25 at 10:10 AM an interview was conducted with Resident #16 who stated that there was not enough staff and that showers were not being given and that he/she has not had a shower in a year. Resident #16 stated he/she has only had bed baths. Resident #16 stated, I never refuse a shower. Review of geriatric nursing assistant (GNA) activities of daily living (ADL) documentation for showers for May 2024 documented the resident did not receive any showers for the month. Resident #16 received bed baths on 15 of the 31 days in May. Further review of GNA ADL documentation for February 2025, March 2025, and April 2025 documented Resident #16's missed showers or was not offered. Cross Reference F677 b) On 4/28/25 at 3:29 PM review of complaint MD00199437 alleged all residents at the nursing facility were not given showers like scheduled dating back to 2023. Review of complaint MD00214363 alleged neglect along with other residents. Complaint MD00197946 alleged the level of care was horrendous. Complaint MD00213182 alleged that their loved one never got a shower. Complaint MD00203182 alleged that staff was not able to provide appropriate care to residents like showers. Complaint MD00190955 alleged major basic hygiene was not being met. c) Review of Resident #27's GNA documentation for bathing for September 2023, November 2023, March 2024, and April 2024 documented the resident received a bed bath daily, however, did not receive a shower. Review of April 2025 GNA documentation revealed 1 documented shower on 4/28/25. Cross Reference F677 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d) On 4/30/25 at 8:50 AM Resident #52 was interviewed and stated, I don't get help with my bath. Unless I specify directly I don't get help. I am supposed to get a shower on Tuesday and Fridays. I did not get one yesterday, but I got one last Friday. They don't tell me why. Review of Resident #52's April 2025 GNA documentation for the type of bath performed documented no showers for the month of April. Resident #52 refused once on 4/16/25. The other shower days were documented as non-applicable. Cross Reference F677 e) On 4/30/25 at 8:54 AM Resident #50 was interviewed and stated, I would like a shower every week. I never refuse showers. I love showers. Review of Resident #50's April 2025 GNA documentation for the type of bath performed documented bed baths. There were no showers given or documentation of showers refused from 4/1/25 to 4/30/25. Cross Reference F677 f) On 4/30/25 at 8:56 AM Resident #51 was interviewed and stated, I have had no showers. They say they don't have time. Review of Resident #51's April 2025 GNA documentation for the type of bath performed documented bed baths and 3 showers that were given on 4/2/25, 4/8/25, and 4/16/25. All other days were bed baths. The DON stated all residents are scheduled for at least 2 shower days a week. On 4/30/25 at 8:52 AM Staff #40 stated if they have 4 GNAs on the shift then showers can be given. If there are 3 GNAs it depends on the work load and if there are only 2 GNAs that means they each have 18 residents on day shift and showers are not given. Staff #40 stated that some residents require the assistance of 2 GNAs and if they don't have enough GNAs on the unit then the showers can't be given. On 4/30/25 at 11:08 AM the concerns regarding showers were again reiterated to the DON who stated she was aware of the issue and working to correct the problem. Cross Reference F677 3) Review of complaint MD00197499 alleged that the nurse was too busy to change Resident #31's dressing on the right foot. On 4/24/25 at 2:19 PM a medical record review was conducted for Resident #31. On 9/24/23 the daughter went to visit Resident #31 who had wounds on the right foot. The date on the dressing stated 9/23/23 with the initials of Staff #36. The unit manager was informed that the dressing on the foot had not been changed on 9/23/23 and the unit manager stated they must have put the wrong date on the dressing. The unit manager was informed that Staff #39, the nurse from the previous day stated she did not have the time to change the dressing because she was the only nurse for 40 residents with no medication aid and she requested night shift/evening shift to do the dressing change. There were no notes on 9/24/23 that stated the dressing was changed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/25 at 11:48 AM Staff #39 was interviewed and stated she was too busy to do the dressing change for Resident #31. 4) On 4/24/25 at 2:46 PM a review of an anonymous complaint alleged the facility needed to be investigated as they were doing illegal things. A review of the grievance log for November 2024 documented a grievance filed on 11/25/24 for substandard quality of care for Resident #46. Review of the grievance investigation revealed a witness statement from Staff #9 that documented that on the morning of 11/25/24 at 8:10 AM Staff #54 went to Staff #9's office and stated that Resident #46 was visibly upset this morning when she entered the resident's room and disclosed to her that he/she was left sitting in a soiled brief from 10:30 PM until 8:00 AM when Staff #54 entered the room. A witness statement for an interview conducted with Staff #55 revealed that evening was the first night ever having Resident #46 or the unit and she said she didn't know the resident. Staff #55 stated that she and the other GNA, Staff #30, took the entire unit together. Staff #55 could not remember how many rounds she did during the night and stated that she did not answer any call bells. A witness statement for an interview conducted with Staff #30, she stated that her and Staff #55 worked together on the unit and that Staff #30 did not answer any call bells for Resident #46. Staff #30 was asked if she changed Resident #46 or completed a round on the resident at any time in the shift, Staff #30 stated that Staff #55 handled that end of the hall and they met up at room [ROOM NUMBER] and proceeded to do care together on other rooms. On 4/24/25 at 3:05 PM Staff #31 was interviewed and stated Resident #46 was total care. Staff #31 stated Resident #46 rang the bell and was extremely upset, crying and said night shift didn't change him/her. Staff #31 stated Resident #46 was wet and the bed was soaked with all urine. Resident #46 was laying in it and it was way more urine that it should have been. Staff #31 was asked if they were short staffed and his response was, on a regular day I have 8 to 12 patients. When there are call outs I can get up to 16 people on day shift. Sometimes there are 2 GNAs (geriatric nursing assistants) for 30-40 residents. We can't give showers and serve 3 meals on day shift plus do documentation. On 4/24/25 at 3:15 PM Staff #32 was interviewed and stated she normally has 12 residents on day shift. She said she would have 14 to 15 residents if they only had 3 GNAs. We can't get showers done when we work like that. On 4/24/25 at 4:00 PM Staff #9 was interviewed and that, the GNAs did not change the resident. There were 2 GNAs and they split the floor and they team worked it. I no longer work there because they were unwilling to correct the staffing issues. They would know we were short and they would not be willing to staff with more people and they knew it was bad. 5) On 4/29/25 at 4:36 PM Staff #58 stated, Corporate always had control of staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) On 4/30/25 at 7:09 AM an interview was conducted with Staff #30 who stated, staff was bad about 6 months ago. There were call outs and they tried to get replacements but what can you do for no call no show or say they are coming in and don't come. We need a couple of more good aides and nurses in case there are call outs. 7) On 4/30/25 at 9:18 AM an interview was conducted with the staffing coordinator. He stated, we can go up above a little bit to 3.1 PPD but we are still not supposed to go over 3.1 PPD. There are some days that are hard to staff. We stopped using agency in August 2024. They gave us a deadline and that's it. There are a lot of days where we can't get an RN at night. Maybe 4 out of 7 nights we don't have an RN. 8) Review of staffing sheets and schedules revealed the facility failed to provide staffing at a level to provide a minimum of 3.0 hours of bedside care (PPD) per resident per day per state law. Review of the staffing schedule from 2/14/24 to 3/1/24 documented for 16 of the 17 days reviewed the facility staffing hours were below 3.0 PPD and had the lowest PPD of 2.31 on 2/28/24. Review of complaint MD00213182 alleged that staff did not get patients up; residents would be soiled for hours; residents did not receive showers. Review of the actual worked nursing schedule for 12/22/24 to 1/3/25 revealed for 9 of 13 days the facility staff hours were below 3.0 PPD and had the lowest PPD of 2.32 on 12/25/24. Review of the nursing staffing schedule for 2/24/25 to 3/1/25 revealed for 6 of the 6 days the facility staffing hours were below 3.0 PPD and had the lowest PPD of 2.64 on 2/24/25.

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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** 31145 Based on review of complaints, medical record review, and interview, it was determined the facility failed to provide timely medication to meet the needs of the residents. This was evident for 1 (#1) of 42 residents reviewed for complaints during a complaint survey. The findings include: 1) On 4/23/25 at 2:37 PM a review of complaint MD00216820 alleged that Resident #1 had not received his/her medications as ordered. Review of Resident #1's medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included Ankylosing spondylitis (AS), which is a chronic inflammatory disease that primarily affects the spine, causing inflammation and potentially leading to the fusion of vertebrae, resulting in stiffness and reduced flexibility and visual loss. Review of Resident #1's 4/16 /25 hospital discharge summary documented the medication Biolle Gel Tears Ophthalmic Gel 1%, 1 drop in both eyes was to be administered 3 times a day for dry eyes. Review of Resident #1's April 2025 Medication Administration Record (MAR) documented the eye drops were not available on 4/17/25, 4/18/25, 4/19/25, 4/20/25, 4/21/25, and 4/22/25. Nursing notes written on 4/17/25, 4/18/25, and 4/19/25 documented 3 times per day that the drops were unavailable and they were waiting pharmacy delivery. On 4/19/25 a nurse's note wrote that the drops were out of stock. It was after the resident did not receive the drops for 3 days that the Nurse Practitioner was made aware. The nurses continued to document 3 times per day that the drops were unavailable until a note written on 4/22/25 documented, Printed request sent to pharmacy, awaiting arrival and sent printed request to pharmacy to please send medication. The medication was delivered, and Resident received the first dose on 4/23/25 which was 7 days after admission. On 4/28/25 at 10:05 AM discussed with the Director of Nursing (DON) the concern related to all medications and their availability from pharmacy. The DON confirmed the findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 31145 Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to monitor the blood pressure prior to administering a blood pressure medication per physician's orders. This was evident for 2 (#7, #21) of 52 residents reviewed during a complaint survey. The findings include: 1) On 4/23/25 at 12:05 PM a review of complaint MD00214363 alleged that Resident #7 was not receiving medication as prescribed. A review of Resident #7's medical record was conducted and revealed a physician's order for Losartan Potassium 50 mg. one time a day for hypertension. The order stated to hold the medication for a SBP (systolic blood pressure) less than 110. The top number of the blood pressure refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. Review of Resident #7's January 2025 Medication Administration Record (MAR) documented that the SBP was not within physician ordered parameters on 1/19/25 and 1/21/25 and the medication was given as evidenced by a check mark and the nurse's initials in the box corresponding to the medication and date. The b/p on 1/19/25 was 104/78 and the b/p on 1/21/25 was 104/68. There were no nursing or emar (electronic) MAR notes that documented the medication was held. A 1/21/25 at 20:07 PM NP (nurse practitioner) note documented to stop the Losartan secondary to hypotension (low blood pressure) and to monitor the vital signs. On 4/30/25 at 11:26 AM discussed with the Director of Nursing (DON) who confirmed that the medication should have been held. Discussed that it was given by registered nurses. The DON stated, I will need to do in-services. 2) On 4/24/25 at 8:25 AM a review of Resident #21's medical record was conducted. Review of Resident #21's January, February, March, and April 2025 MAR documented the blood pressure medication Metoprolol Tartrate 25 mg., give 0.5 tablet two times per day. Hold for SBP less than 110 or heart rate less than 60. There was no place next to the medication on the MAR where the blood pressure was documented prior to the medication being administered. Review of the vital sign section of the medical record revealed Resident #21's blood pressure was only monitored 5 times out of 62 times the medication was given in January 2025. Continued review revealed in February 2025 the blood pressure was only monitored 7 times out of 56 times the medication was given, and the medication was given on 2/11/25 when the blood pressure was 105/70, which was outside of physician ordered parameters. In March 2025 the blood pressure was only monitored 5 times out of 62 times the medication was given and in April 2025 the blood pressure was only monitored 3 times out of 56 times the medication was given up until 4/28/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 2:00 PM an interview was conducted with Certified Medicine Aide (CMA) #57. CMA #57 stated that she checks the blood pressure, and the system will mark yes when you initial that the meds were given. CMA #57 stated she would leave a note and let the nurse know if the blood pressure was outside of parameters. On 4/29/25 at 8:53 AM the DON confirmed the issue with the blood pressure parameters and the blood pressure not being documented prior to giving the medication. On 4/29/25 at 9:44 AM the issue was reviewed with the Medical Director, and he concurred with the surveyor's findings.

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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. 31145 Based on medical record review, observation, and interview, it was determined the facility staff failed to provide dental care for a resident with a missing tooth. This was evident for 1 (#17) of 42 residents reviewed for complaints during a complaint survey. The findings include: On 4/28/25 at 8:00 AM a review complaint MD00200383 was conducted and alleged that in December 2023 Resident #17 had a missing front tooth, that it could have been a crown or veneer, but it was noticeable. A review of Resident #17's medical record was conducted. A social service note dated 12/8/23, that was not entered into the medical record until 1/30/24, documented that the social worker received a call from the Ombudsman stating Resident #17's daughter had called to complain, stating that she thought there was a communication problem with the facility. The Ombudsman also stated she received a call from Resident #17's grandson stating Resident #17 had a missing front tooth and apparently the family was not notified. Further review of Resident #17's medical record failed to produce any further documentation about Resident #17's missing front tooth. Review of the electronic and paper medical record failed to produce documentation that the resident had been seen by a dentist. There were no nutritional assessments found in the medical record that would have included information about the resident's mouth/teeth status. Resident #17 has been a resident of the facility since November 2022 and continues to reside in the facility. On 4/28/25 at 11:50 AM Resident #17 was observed lying in bed. Resident #17 was asked if he/she had a missing front tooth. Resident #17 opened his/her mouth and there was a missing front tooth. On 4/28/25 at 1:57 PM an interview was conducted with the Medical Director and the Director of Nursing (DON). They were informed that there was no documentation about the missing tooth and there were no nutritional assessments where the teeth would have been evaluated. The Medical Director stated, yes, that concerns me. I expect them to look at weights and any other information in the medical record that is pertinent in the medical record, and I expect them to address them. They should be offered dental services. I feel everyone should be screened and evaluated for dental treatment. If they have teeth that need to be attended to. The Medical Director stated they have quarterly dental assessments and then if a problem is found they should be seen by the dentist.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ staff that are licensed, certified, or registered in accordance with state laws. 34484 Based on facility record review and interview, it was determined the facility failed to have a full time licensed Nursing Home Administrator (NHA) authorized by the State of Maryland from 11/9/22 until 11/15/23 and 2/4/24 until 3/4/24. This is being cited as past noncompliance since the facility currently has had a licensed administrator in place that was verified by the Surveyor on 4/24/25. The findings include: On 4/24/25 the Surveyor asked the Administrator to provide a timeline of the NHAs for the facility since November 2022 to investigate an anonymous complaint the facility had been operating without a full time licensed Nursing Home Administrator. Review of the timeline list of the facility's NHAs provided by the current Administrator on 4/24/25 revealed Staff #46 was the Administrator 11/9/22-1/1/23, Staff #47 was the Administrator 12/12/22-6/30/23, Staff #48 was the Administrator 7/3/23-9/29/23, Staff #49 was the Administrator 11/15/23-2/4/24, Staff #50 was the Administrator 3/4/24-8/18/24, and Staff #1, the current Administrator, has been at the facility since 8/19/24. During interview with the Administrator on 4/24/25 at 2:10 PM the Surveyor reviewed the list provided by the Administrator advised the Administrator the Surveyor could not verify Staff #46, #47 and #48 had NHA license in Maryland. During interview with the Administrator on 4/24/25 at 2:20 PM, the Administrator confirmed the facility did not have a licensed Nursing Home Administrator authorized by the State of Maryland from 11/9/22 until 11/15/23 and again from 2/4/24 until 3/4/24.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to obtain outside services for a resident in a timely manner (Resident #12). This was evident for 1 of 52 residents reviewed during a complaint survey. The findings include: Review of Resident #12's medical record on 4/23/25 the Resident was admitted to the facility in June 2024 and was readmitted to the facility on [DATE] following a hospitalization with a diagnosis to include infection and inflammatory reaction due to internal joint prosthesis. Review of the Resident's hospital discharge summary revealed the Resident needs a follow up with Infectious Disease physician. Further review of the medical record revealed the Resident has not been seen by the Infectious Disease physician or has an appointment scheduled. Interview with the Director of Nursing on 4/30/25 at 9:40 AM confirmed the facility staff failed to schedule an appointment for Resident #12 to see the Infectious Disease physician.

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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. 34484 Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards (Resident #30). This was evident for 1 of 52 residents reviewed during a complaint survey. The findings include. A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. Review of Resident #30's medical record on 4/23/25 revealed the Resident was admitted to the facility 6/10/23 to following orthopedic surgery for rehabilitation and was discharged from the facility on 6/29/23. During interview with Resident #30's representative (RP) on 4/23/25 at 1:38 PM, the RP stated he/she received a call from the facility on the morning of 6/29/23 that the Resident had fallen and they were sending him/her to the hospital. The RP stated he/she would like to have more information regarding the Resident's fall. Further review of the Resident's medical record revealed the last nurse's note and evaluation prior to the Resident's fall on 6/29/23 was on 6/28/23 at 4:41 PM. The only nurse's note on 6/29/23 was at 10:50 AM that states the Resident's RP called stating the Resident was being transferred to shock trauma. Interview with the Director of Nursing on 4/25/25 at 11:40 AM confirmed the facility staff failed to maintain a complete medical record for Resident #30 to include nurse's notes, assessments and discharge information related to the Resident's fall on 6/29/23 and transfer to the hospital.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 31145 Based on staff interview, it was determined the facility failed to obtain a full-time social worker when the certified number of beds exceeded 120 in the facility. Currently the facility was licensed for 160 certified beds. This was evident for 1 out of 1 required personnel and had the potential to affect all residents. The findings include: On 4/23/25 at 10:06 AM Staff 4, the Social Work Assistant was interviewed and stated she had been employed at the facility for almost 3 weeks and was full-time. Staff #4 stated, we do not have a full-time social worker here. Staff #4 described her duties and stated, I have a check off list that I have to do. The assistant is here to help the Director. Staff #4 stated she had an administration degree for the medical front and back desk and was a certified medical assistant and had a certification in activities. Staff #4 stated she was previously an activities director. Staff #4 stated she was trained by the Regional Social Services Director and that the Regional Director was always on call. On 4/24/25 at 2:50 PM an interview was conducted with the interim Nursing Home Administrator (NHA). The NHA confirmed Staff #4 was not a licensed certified social worker and the facility did not currently have a full time qualified social worker on staff.