STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215197	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) On 03/3/25 at 8:30AM a tour of the facility revealed a cool to cold temperature. The residents were noted to have multiple blankets covering them. The conference room where the surveyors were instructed to work was cool to cold. On 03/3/25 at 10AM, complaints MD00214952 and MD00207551 were reviewed and revealed that the residents' rooms' temperature was not at a comfortable level. On 03/3/25 at 11:30AM an interview with the Maintenance Director revealed that Temperatures logs were maintained daily on random rooms. A review of the temperature logs revealed the following: On 02/18/25, room [ROOM NUMBER] temperature was recorded at 70 degrees. On 02/29/25, Rooms #22, # 26, and #41 temperature were recorded at 70 degrees. On 02/21/25, Rooms #10, # 16, #32 and #41 temperature were recorded at 70 degrees. On 03/4/25 at 11:23AM, The Maintenance Director was informed that the residents' room temperature did not meet the Federal and state regulations to maintain a minimum design air temperature.Based on observation and interviews, it was determined that the facility failed to provide 1) a safe, clean, comfortable, homelike environment and 2) an environment that included comfortable temperature levels. This finding was found to be evident on a tour of the laundry department, 3 (Rooms #25, #26 and #28) of 8 resident rooms observed for safe, clean, comfortable, homelike environment and 2 of 15 complaints reviewed during the recertification survey. The findings include: 1) On 03/03/25 at 08:15 AM the surveyor observed Residents' rooms with items in disrepair on the initial tour of the nursing unit: the dresser was cracked with chipped wood and a wooden mouse trap with a metal spring was behind the door on the floor in room [ROOM NUMBER]; the door frame and door cracked in room [ROOM NUMBER]; bathroom sink faucet loose, water basin on bathroom floor, doors marred, dressers marred with chipped wood and black writing on one of the dresser tops in room [ROOM NUMBER]. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing (DON) was interviewed at 10:10 AM on 03/03/25 and asked about the mouse trap in room [ROOM NUMBER]. The DON observed the mouse trap and stated that she was not aware that this type of mouse trap was used in the facility and that she would notify housekeeping and maintenance. During the tour of the laundry department on 03/05/25 at 06:56 AM with the Environmental Services Director (EVSD) #16 the surveyor observed the following in disrepair in the clean laundry area: chipped and missing floor tiles; missing ceiling panel; chipped and loose doorframe; loose baseboard pulling away from the wall; missing door to the cabinet. In an interview on 03/05/25 at 08:15 AM with the Environmental Services Director (EVSD) #16 he acknowledged the disrepair in the laundry department, and he stated that maintenance was notified. In an interview with the Maintenance Director for follow-up at 08:30 AM on 03/05/25 he stated that he was notified by the Director of Nursing (DON) and the Environmental Services Director about the mouse trap in the Resident room, and the concerns in the laundry department. The Maintenance Director stated that the mouse trap was removed, and that the facility does not use this type of mouse trap. Additionally, the Maintenance Director stated that he replaced the missing ceiling panel.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation and staff interview, it was determined that the facility failed provide a family meeting to discuss grievances regarding the care of a resident. This was evident for1 (Resident #336) of 44 residents reviewed during the recertification survey. The findings include: On 03/3/25 at 9:56AM, the surveyor reviewed a complaint (MD#00201345) from Resident #336's family stating that they requested a family meeting with the facility's social service department regarding grievances regarding inadequate care of Resident #336. The review of the resident's medical record on 03/3/25 at 10:00AM revealed no evidence that the facility social services department provided the resident's family with a family meeting. During a interview with the Director of Nursing (DON) on 03/6/23 at 7:58AM, the DON reviewed Resident #336's medical record and confirmed that the resident's family did not receive the requested meeting.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review and interview, the facility staff failed to thoroughly investigate a facility reported incident of resident-to-resident abuse. This was evident for 1 (Resident #330) of 44 residents reviewed during survey. The findings include: Review of Residents #330 and Resident #333's facility reported incident (MD 00181638) on 03/6/25 at 10:05AM revealed the Resident #330 alleged that Resident #333 touched his/her private area. Review of the facility investigation documents on 03/6/25 at 10:10AM revealed that the facility was unable to substantiate abuse. Further review of the facility investigation documents revealed that the facility failed to interview other residents and staff members regarding abuse before concluding that the alleged resident-to-resident abuse was unsubstantiated. During an interview with the Director of Nursing on 03/6/25 at 11:00AM, the DON confirmed that the facility failed to thoroughly investigation Resident #330's allegation of abuse

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to 1) revise the resident's comprehensive care plan, 2) hold care plan meetings, 3) Reassess the effectiveness of the care plan approaches and 4) have quarterly care plan meetings with the Interdisciplinary Team. This was evident for 5 (Resident #27, #48, #58, #52 and #46) of 44 residents reviewed for care plan timing and revision during the recertification survey. The findings include: An arteriovenous (AV) fistula shunt is a surgical procedure that creates a direct connection between an artery and a vein. This allows blood to flow from the high-pressure artery into the low-pressure vein, increasing blood flow in the vein. AV fistula shunts are primarily used to provide long-term vascular access for hemodialysis, a treatment for chronic kidney disease. According to CMS (Centers for Medicare and Medicaid Services), a care plan meeting is a structured, interdisciplinary conference where staff, residents, and families discuss and review the resident's care plan, ensuring needs are met and goals are achieved. In long-term care facilities, care plans should be reviewed and updated at least every 90 days, or more frequently if a resident's condition changes significantly. 1) During the initial tour of the nursing unit on 03/03/25 at 08:30 AM the surveyor observed Resident #27 with an AV fistula shunt to the left upper arm. Resident #27 stated that he/she goes to dialysis every Tuesday, Thursday and Saturday. The surveyor conducted a record review of Resident #27's medical record at 11:45 AM on 03/5/25. Review of the medical record revealed that Resident #27 had a care plan for 11 staples in the left forearm area and 10 staples in the left arm fistula site with an initiation date of 10/21/24. The care plan had a revision on date of 01/06/25; however, this problem remained on the care plan and was still on the care plan as of the record review date by the surveyor. An interview was conducted with the Director of Nursing (DON) on 03/10/25 at 9:05 AM. The surveyor conveyed to the DON that Resident #27 had a care plan dated 10/21/24 for staples to the left forearm and the left arm AV fistula shunt with a revision date of 01/06/25, and that this problem was still on the care plan. The DON acknowledged the surveyor. No additional information was provided by the facility at the time of exit. 2) On 03/03/25 at 8:52 AM, Resident #48 stated that he/she has not been involved in any care plan meetings. On 03/06/25 at 8:21 AM, a review of Resident #48's medical record revealed that he/she was readmitted on [DATE]. His/her BIMS (Brief Interview for Mental Status) score was 14, which indicated he/she was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of progress notes revealed no supporting documentations that care plan meetings occurred for Resident #48. On 03/06/25 at 8:35 AM, in an interview with the Social Worker (SW), she described that when scheduling a care plan meeting, the facility notified the residents and the resident representatives either by calling or by talking to them personally. She added that starting March of this year, she started sending meeting notifications. She stated that she scheduled the meeting according to cycle or to the Assessment Reference Date (ARD) of the Minimum Data Set (MDS) schedule and for new admissions, she stated that the facility conducted a baseline care plan meeting within 72 hours. She checked Resident #48's medical record for any documentation related to any care plan meetings and she confirmed that there were none. On 03/06/25 at 8:42 AM, the Director of Nursing (DON) was made aware of the concern. On 03/07/25 at 11:49 PM, the DON confirmed that the facility had no record to prove that care plan meetings were held for Resident #48. 3) On 03/04/25 at 3:05 PM, a review of Resident #58's medical record revealed that he/she was readmitted on [DATE]. Also, the medical record indicated that a care plan was initiated on 11/23/2024 which stated, uses antidepressant medication Seroquel related to Depression, however, the resident was not on Seroquel (a type of medication used to treat mental health conditions.) On 03/05/25 at 8:27 AM, in an interview with the DON, she stated that care planning was done by the Interdisciplinary Team (IDT) and that she updated most of the care plans. She was made aware that the care plan of Resident #48 for psychotropic medication was not updated. She confirmed the findings and stated that she would make the necessary changes/ updates to the resident's care plan. 4) During a telephone interview with the Legal Guardian for Resident #52 on 03/03/25 at 4:08 PM, it was revealed Resident #52 had not attended any recent care plan meetings and the guardian felt a Care Plan meeting could have been beneficial for the Resident. During a review of Medical Records on 03/03/25 at 7:37 PM it was discovered that Resident #52 required total care from the facility and the last Care Plan Meeting was 7/17/24. The attendees for the meeting included the resident, legal guardian, nursing, and activities. During a review of Resident #46 Medical Records on 03/04/25 at 6:27 PM it was discovered that Resident #46 required total care from the facility and the last Care Plan Meeting was 7/31/24. The attendees included the Resident, nursing, rehab, activities, and social services. During an interview with the Social Worker on 03/05/25 at 9:16 AM she advised she has only been with the facility for 3 months and doesn ' t think care plan meetings are caught up. She reports when the meetings are completed she puts a note in the Social Services electronic medical records. She confirmed Residents #52 and #46 had not had a recent Care Plan Meeting. She reported the staff that would usually attend would include the nurse manager, Director of Nursing, Director of Rehab, and dietician.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to provide transportation services for residents' appointments. This was found to be evident for 1 (Resident #8) of 1 resident reviewed for transportation services during the recertification survey. The findings include: During an interview on [DATE] at 10:18 AM, the surveyor discussed concerns with Resident #8 about his/her wound care. The Resident reported that family members had to call 911 twice to transport him/her from the facility to the hospital for wound treatment. On [DATE] at 09:35 AM, a record review of the wound assessment note from [DATE] showed that there was a wound acquired on [DATE]. On [DATE] at 09:55 AM, a record review of progress notes showed a note from [DATE] stated Appointment(s) for infectious disease and GI [gastrointestinal] scheduled at GWMFA [The [NAME] University Medical Faculty Associates]. Transportation issues due to no DCMA [District of Columbia Medicaid] coverage - expired [DATE]. Spoke with (BOM) [Business Office Manager], will call to get patient re-instated. Another note from [DATE], stated Resident has a schedule appt [appointment] with Infectious Disease for [wound]. At GW [[NAME]] hospital on [DATE] @ 9:00Am with [Doctor #27] every shift for 5 Days. A continued record review showed a social service progress note for [DATE], which stated social services reached out to resident this morning to let [him/her] know about [his/her] appointment to see infectious disease doctor which has now been scheduled for [DATE]. social services explained to resident that we were unable to secure external transportation in time for an earlier anticipated appointment today to see the infectious disease doctor. social services shall follow up with resident regarding [his/her] forthcoming appointment on [DATE]. On [DATE] at approximately 11:12 AM, during an interview with the Unit Manager #2, she reported that Medical Records had the insurance information and would normally be the one that made appointments and set up transportation for residents. She stated that in the interim, when there was not a Medical Records position filled, it had been the nurses who scheduled the transportation for the residents to get to their appointments. On [DATE] at approximately 11:18 AM, an interview was conducted with the BOM (business office manager) #15. She confirmed that Resident #8 ' s insurance coverage had expired in [DATE]. During an interview on [DATE] at 11:36 AM with the Administrator, this surveyor asked what the process is for getting residents to their appointments if there is no insurance in place. She explained that her expectation is that the facility would pay for transportation if the resident does not have insurance. At this time, the Administrator was made aware of the concern that Resident #8 was not provided transportation by the facility to his/her infectious disease appointment, even though he/she did not have insurance in [DATE]. The Administrator confirmed understanding and was apologetic.

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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. Based on review of a complaint, record review and interview, it was determined that the facility failed to document the incidents of falls, implement and update the interventions to prevent falls for a resident who was identified as a fall risk. This was evident for 1 (Resident #58) of 2 residents reviewed for accidents during the recertification survey. The findings include: On 03/05/25 at 7:35 PM, a review of a complaint MD00213458 dated 01/13/2025 revealed that per the complainant, Resident #58 had a fall incident, and the resident was left on the floor for long periods of time. . A review of the electronic medical record revealed that Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that he/she was cognitively intact. On 03/06/25 at 5:56 PM, a review of Resident #58's care plan that was initiated on 11/20/2024 and revised on 02/6/2025 revealed the following: The resident was at risk for falls r/t paraplegia and limited physical mobility. The following interventions were as follows: o Anticipate and meet needs Date Initiated: 11/20/2024 Revision on: 12/11/2024 o Ensure the bed is in the lowest position Date Initiated: 11/20/2024 o Ensure the call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 11/20/2024 Revision on: 11/20/2024 On 03/07/25 at 11:10 AM, Resident #58 stated that he/she had 3 episodes of fall during his/her stay in the facility but could not recall the dates. On 03/07/25 at 11:30 AM, a review of Resident #58's fall assessments, change in condition and progress notes revealed no evidence that the incidents of falls were recorded since the time of admission. A review of the admission Fall Risk Evaluation dated 11/20/2024 at 10:16 PM indicated that the resident scored 15 which indicated a category of moderate risk for falls. On 03/7/25 at 11:49 AM, the Director of Nursing (DON) confirmed that the resident had incidents of falls, however, she couldn't recall how many times. She added that the nurses were expected to document fall incidents under progress notes and the facility should have completed the fall report/investigation and fall assessment, however, the DON confirmed that the facility had no records that these tasks were completed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/10/25 at 7:36 AM, in an interview with the Unit Manager Staff #2, he/she revealed that during a fall incident, the nurses conducted a head-to-toe assessment of the resident and called the attending physician. The nurses would document the fall incident in the medical record under change in condition and the progress notes. He/she stated that the neuro checks would also be initiated. He/she confirmed that the nurses, Staff #2 and/or the DON updated the resident's fall care plan.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on medical record review and staff interview, it was determined that the facility failed to provide adequate management of a resident's Intravenous antibiotic schedule. This was evident for 1 (Resident #324) of 44 resident reviewed during the recertification survey. The findings include: A review of Resident #324's medical records on 03/04/25 at 12:26PM revealed that the resident was ordered Intravenous (IV) antibiotics once a day for 6 weeks from 1/19/23 to 03/18/23 to prevent infection. Further review of resident 324's medical record on 03/04/25 at 12:40PM revealed that the resident was seen by Maximed Associates Inc on 02/01/23 to ensure that the IV antibiotics were affective at preventing infection. Maximed Associates recommended that the resident be given an MRI (a type of diagnostic test that creates detailed images of structures and organs in the body) one week prior to completing the IV antibiotics to determine if the resident needed to prolong IV antibiotics administration. Continued review of Resident #334's medical record on 03/04/25 at 1:00PM revealed that there was no evidence that the resident received the MRI prior to completing the IV antibiotics treatment on 03/04/23. An interview with the Director of Nursing (DON) on 03/04/23 at 1:15PM confirmed that Resident #324 should have received the MRI prior to completing the IV antibiotics treatment on 03/04/23. The DON also confirmed that the facility failed to provide Resident #324 with an MRI necessary for his/her IV antibiotic treatment.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to develop and implement a process to determine if residents with a history of trauma, received the appropriate trauma informed care. This was evident for 1 (Resident #328) of 4 residents reviewed for trauma informed care during the recertification survey. The findings include: On 03/03/25 at 12:00PM, a review of complaint MD00193440 and a facility reported incident MD00193348 revealed that Resident #328 alleged that a unidentified male touched the resident inappropriately. A medical record review for Resident #328 on 03/04/25 at 9:30 AM revealed the resident was admitted to the facility on [DATE]. Further review revealed no evidence that a trauma informed assessment or care plan had been completed to ensure the resident received trauma informed care. On 03/05/25 at 10:00AM, an interview of the Director of Nursing (DON) regarding the trauma informed care policy. The DON confirmed resident trauma informed assessments should be done at admission and after a change in condition. The surveyor pointed out that Resident #328 alleged that he/she was touched inappropriately, and a review of the resident's medical record revealed no evidence of a trauma informed care assessment after the resident's allegation. The DON confirmed that there was no evidence of a trauma informed care assessment.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the Nurse Practitioner's (NP#21) admission history and physical progress note included new order for Resident #329 under the plan of care that was not written as orders. This was evident for 1 (Resident #329) of 44 residents reviewed during a recertification survey. The findings include: On 03/04/25 at 11:00 AM, a review of Resident #329's medical record revealed the Resident was admitted to the facility on [DATE] and was discharged to an acute care facility on 07/05/24. Further review of Resident's medical record revealed the NP#21 admission progress note on 06/28/24, with the following plan: Continue all medications as prescribed. Attach live vest and monitor q shift. Neurology consults as needed. PT/OT- evaluation and treatment as required. Pain evaluation as required and Cardiology consult. A review of Resident #329's orders did not include the following, attach live vest and monitor q shift, Neurology consult as needed, Pain evaluation as required and a cardiology consult. On 03/05/25 at 9:15 AM, an interview with the Director of Nursing confirmed that NP#21 no longer works at the facility and the orders were never transcribed to Residents #329 medical record. On 03/05/25 at 9:30AM, an interview with the Medical Director revealed that the NP#21 works independently and should have written the orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to provide adequate behavior monitoring for resident on psychotropic medications. This was evident for 1 (Resident #58) of 4 residents reviewed for unnecessary medications during the recertification survey. The findings include: Psychotropic medications are drugs that affect the brain and central nervous system, altering mood, thoughts, perceptions, and behaviors. They are primarily used to treat mental health conditions, such as anxiety, depression, schizophrenia, and bipolar disorder. On 03/04/25 at 3:05 PM, a review of Resident #58's medical record revealed that he/she was readmitted on [DATE]. His/her BIMS (Brief Interview for Mental Status) was completed on 02/17/25 with a score of 15/15 which indicated that he/she was cognitively intact. A review of Resident #58's active physician orders revealed that he/she was on the following psychotropic medications: 1. Aripiprazole Oral Tablet 2 MG (Aripiprazole) Give 2 mg by mouth one time a day for depression. 2. Clonazepam Oral Tablet 0.5 MG (Clonazepam) Give1 tablet by mouth at bedtime for anxiety. 3. Duloxetine HCl Oral Capsule Delayed Release Sprinkle 20 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day for depression/suicide ideation. Give together with 60mg to equal 80mg. 4. Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG (Duloxetine HCl). Give 60 mg by mouth one time a day for suicidal ideation. 5. Escitalopram Oxalate Oral Tablet 20 MG (Escitalopram Oxalate) Give 20 mg by mouth one time a day for major depressive disorder. 6. Lisdexamfetamine Dimesylate Oral Capsule 40 MG (Lisdexamfetamine Dimesylate) Give 1 capsule by mouth one time a day for depression. 7. Trazodone HCl Oral Tablet 50 MG (Trazodone HCl)Give 1 tablet by mouth at bedtime for depression. On 03/05/25 at 7:59 AM, in an interview with Licensed Practical Nurse (LPN #1), he/she confirmed that the facility had no tools or processes for behavior monitoring for residents on psychotropic medications. On 03/05/25 at 8:36 AM, during an interview with the Director of Nursing (DON), she stated that the facility had behavior monitoring tool in the Treatment Administration Record (TAR). However, after she reviewed the electronic medical record of Resident #58, she confirmed that there was no evidence that behavior monitoring was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215197	A. Building B. Wing	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fox Chase Healthcare	2015 East-West Highway Silver Spring, MD 20910

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/25 at 11:33 AM, a review of the facility's Psychotropic Medication Use policy revealed that Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring and review requirements specific to psychotropic medications: a. Antipsychotics b. Antidepressants c. Antianxiety d. Hypnotics On 03/06/2025 at 7:56 AM, a review of Resident #58's new physician orders revealed that, after surveyor intervention, a behavior monitoring every shift was written on 03/05/2025 at 4:47 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215197	A. Building B. Wing	03/10/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 3) A medical record is the official documentation for 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. On 03/4/24 at 11:30AM, a medical record review determined the facility staff failed to maintain complete and accurate medical records. A request was made to the Director of Nursing (DON) for Resident #326 shower schedule. On 3/5/24 at 10:30AM The DON stated that the shower sheets are on paper and in the medical record, but she/he was unable to locate the shower sheets for Resident #326. Based on medical record review, observation and interview, it was determined that the facility failed to accurately 1) record a medication administration in a resident's medical record, 2) document the route of a medication administered to a resident and 3) maintain complete records in accordance with accepted professional standards. This was evident for 3 (Resident #328, #56 and #326) of 44 residents reviewed during an facility's annual survey. The findings include: 1) Review of resident #328's medical records on 03/03/25 at 9:56AM revealed the resident was ordered to receive injectable insulin at bedtime for control of Diabetes. Review of the resident's medication administration record on 3/3/25 at 10:30AM revealed that the facility failed to record the insulin administration on 1/30/22. During an interview with the Director of Nursing (DON) on 03/3/25 at 10:30AM, the DON confirmed that the facility nursing staff failed to document the insulin administration for Resident #328 on 1/30/22. 2) Tube feeding, also known as enteral nutrition, is a medical procedure where a tube is inserted into the stomach (gastrostomy) or small intestine to provide nutrition and fluids. Tube feeding is used when a person is unable to eat or drink adequately due to conditions such as stroke, head and neck injuries, cancer, gastrointestinal disorders and coma. On 03/03/25 at 08:29 AM during the initial tour of the nursing unit the surveyor observed Resident #56 lying asleep in bed. The surveyor did not observe any indication that the Resident had a tube feeding. The surveyor interviewed Resident #56's Nurse #5 at 08:45 AM on 03/03/25 and asked Nurse #5 if Resident #56 had a feeding tube. Nurse #5 stated that Resident #56 used to have a feeding tube, but it was discontinued and Resident no longer had a feeding tube, and that Resident #56 was able to receive food and medications by mouth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215197	A. Building B. Wing	03/10/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the review of Resident #56's medical record on 03/06/25 at 07:15 AM, the review revealed that Resident #56 had the feeding tube removed on 12/10/24 and that the Resident received a diet. Further review of the medical record specifically the physician orders revealed that Resident #56 had medications ordered to be administered by mouth and by gastrostomy tube. The medications to be administered by gastrostomy tube were Apixaban, Baclofen, Cymbalta, Cardizem, Folic Acid, Gabapentin, Prilosec, Tylenol Extra Strength and Vitamin B12, and the medications to be administered by mouth were Clonidine, Melatonin and Rosuvastatin. The surveyor interviewed the Director of Nursing (DON) at 08:10 AM on 03/07/25 and asked if Resident #56 had a gastrostomy/feeding tube. The DON stated no, the tube was removed a few months ago. The surveyor conveyed to the DON that according to the current physician orders for Resident #56 there were physician orders for administration of medications via mouth and via gastrostomy tube. The DON reviewed Resident #56's physician orders and acknowledged that some medications were ordered to be administered by mouth and some medications were ordered to be administered by gastrostomy tube. The Director of Nursing (DON) stated that she would update the medication orders to reflect all medications to be administered by mouth as Resident #56 did not have a feeding tube.