STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215216	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dennett Rehab Center	1113 Mary Drive Oakland, MD 21550

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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 - Few	Reasonably accommodate the needs and preferences of each resident. 34484 Based on observation, medical record review, and interview, the facility staff failed to honor the needs and preferences of a resident. This was evident for 2 (#205, #1) of 41 residents reviewed during an annual/complaint survey. The findings include: 1) Review of Resident #205's medical record on 11/19/24 revealed the Resident was admitted to the facility in October 2021 and the Resident resided in the same room his/her entire stay until April 2024. Interview with Resident #205's representative (RP) on 11/19/24 at 1:30 PM, the RP stated on 2/19/24 the facility notified him/her the facility was going to move the Resident's bed away from the wall due to the State making them. At that time the RP told the facility they did not want the bed moved. The RP stated the Resident had slept with bed against the wall at home and since the Resident was admitted to the facility the bed had been against the wall. The RP also stated the Resident's chair was arranged so the Resident could look out the window at the birds. The RP stated he/she arrived at the facility because he/she knew the Resident would be upset. The RP stated when he/she arrived at the facility the facility staff was moving the Resident's bed and chair. At that time the facility also packed up the Resident's belongings in cardboard boxes and put on floor. The RP stated the facility staff did not include the Resident or the Resident's representative in the decision-making process of moving any of the Resident's furniture or belongings. The RP stated he/she had many discussions with the Administrator to please put the Resident's bed and chair back in the original position. During interview with the Administrator on 11/19/24 at 5:25 PM, the Administrator was asked why the Resident's bed was moved. The Administrator stated we were doing a trial of moving all beds that were against the wall away from the wall. The Administrator was asked if the Resident and RP were involved in that decision. The Administrator stated I did not make the call to the RP but I was the one to move the Resident's furniture back after talking to the RP. Interview with Staff #18 on 11/20/24 at 8:07 AM, Staff #18 stated the Resident had his/her bed against the wall and chair facing the bed and he/she liked it that way. Staff #18 stated the Resident's eye sight was not that good but he/she was able to get up to the bathroom on his/her own and could look out the window from his/her chair before the bed and chair were moved. Observation of the Resident's room at that time, Staff #18 explained the placement of Resident #205's bed when it was against the wall and the Resident's chair at that time. (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 - Few	During interview with the Director of Rehabilitation (DOR) on 11/20/24 at 8:15 AM, the DOR was asked if she remembered when Resident #205's bed was moved away from the wall. The DOR stated yes. The DOR was asked why it was moved. The DOR stated we were doing a trial to see how it went but the Resident didn't like it so we moved him/her back. The DOR was asked how long the bed was away from the wall. The DOR stated she did not remember. During interview with the Administrator on 11/20/24 at 8:21 AM, the Surveyor reviewed the concern of moving Resident #205's bed and chair against the Resident and RP's wishes. The Administrator at that time confirmed the Surveyor's findings. Further interview with Resident #205's RP on 11/20/24 at 8:58 AM, the RP stated the Resident had his/her bed away from the wall and chair in the corner for approximately one month with multiple emails to the facility to request it be moved back until it finally was. The Surveyor reviewed the findings with the Regional Director of Clinical Operations on 11/20/24 at 9:25 AM. 31145 2) On 11/20/24 at 9:10 AM observation was made of Resident #1 sitting in a wheelchair by a desk in the room. Resident #1 was holding his/her private area stating that he/she had to go to the bathroom. The surveyor asked Resident #1 if he/she pushed the call bell to call for staff. Resident #1 pointed to the other side of the room and said the call bell was over there on the floor. Observation was made of the call bell on the floor between the wall and the bed. At that time the surveyor pushed the call bell button and geriatric nursing assistant (GNA) #4 responded. GNA #4 was informed that Resident #1 could not reach the call bell and had to go to the bathroom. GNA #4 stated that the call bell was supposed to be next to the resident when the resident was up in the wheelchair. Review of Resident #1's care plan, at risk for falls related to paraplegia, cognitive deficit had the intervention, maintain call light within reach when resident in room. Reinforce use of call light to call for assistance when he/she needs to move from bed, chair, wheelchair, toilet, etc. On 11/20/24 at 10:45 AM The Nursing Home Administrator and Director of Nursing were informed of the observation.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 31145 Based on medical record review, facility documentation review, and interviews, it was determined the facility staff failed to protect a resident from verbal abuse from facility staff. This was evident for 2 (#213, #202) of 16 facility reported incidents reviewed during an annual/complaint survey. The findings include: On 11/18/24 at 4:30 PM a review of Resident #213's medical record revealed the resident was admitted to the facility in March 2018 with diagnoses that included but were not limited to cerebral infarction (stroke) with hemiplegia and hemiparesis affecting the left non-dominate side, chronic obstructive pulmonary disease, and depression. Review of facility reported incident MD00180784 revealed on 1/2/22 at 5:35 PM LPN #10 and geriatric nursing assistant (GNA) #9 overheard GNA #29 coming out of Resident #213's room cussing verbally at Resident #213. Review of the investigative packet that was given to the surveyor revealed a written statement from GNA #9 that documented she was walking down the hall and heard GNA #29 and Resident #213 arguing and heard GNA #29 say to Resident #213 that she was not putting up with his/her bleeping bleep tonight and Resident #213 said, bleep you and GNA #29 said, right back at you. Review of LPN #10's written statement documented that she heard GNA #29 yelling at Resident #213 from the hallway. It was documented that GNA #29 stated to Resident #213, I'm not dealing with your f .ing s t (expletive language) tonight. GNA #29 then walked up the 400 hallway toward the nurse's station with GNA #9 and she was telling GNA #9 that Resident #213 told her, f k you (expletive language) and she said, right back at you, because I'm done taking your s t (expletive language). Further review of the investigation revealed GNA #29 was suspended for 5 days and would have to complete abuse/dignity training before returning to work. Review of an in-service training report revealed on 1/7/22 GNA #29 received abuse, resident rights, and dignity training from the previous Staff Developer, Staff #30. On 11/18/24 at 4:53 PM a call was placed for LPN #10 and a message left. LPN #10 did not return the surveyor's call. On 11/18/24 at 4:55 PM a call was placed to GNA #9, and a message was left. GNA #9 did not return the surveyor's call On 11/19/24 at 11:25 AM Staff #30 was interviewed about the incident. Staff #30 stated that she did not remember the incident specifically, but remembered GNA #29 and stated, She was always not a very good employee. She was mouthy. That is the only time she was that way with the residents that I know of. She was that way with the staff members. The resident was a difficult patient, but [he/she] didn't deserve to be talked to that way. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 11:45 AM the incident was discussed with the Nursing Home Administrator (NHA) and the Regional Director of Clinical Operations. Both confirmed the surveyor findings and they both stated they were not employed at the facility at the time of the incident. 34484 2. Review of facility reported incident MD00206050 on 11/18/24 revealed a Visitor on 5/26/24 witnessed a facility staff verbally abuse Resident #202. Review of Resident #202's medical record on 11/18/24 revealed the Resident was admitted to the facility in March 2022 with a diagnosis to include Alzheimer's disease. Alzheimer's disease is a brain disorder that gradually destroys memory and thinking skills, and eventually leads to dementia. Review of the facility investigation provided by the Administrator on 11/18/24 revealed a written statement from the Administrator that stated she spoke to the Visitor on 5/26/24. At that time the Visitor told the Administrator while visiting another resident, he/she overheard Staff #32 tell Resident #202 that he was going to put the Resident in a f---ing cage. The Visitor stated he/she looked out and saw Staff #32 call the Resident a f---ing b-----d. The Visitor told the Administrator she believed it was because Staff #32 was trying to get the Resident to leave another resident's room and Resident #202 would not lift his/her legs. Further review of Resident #202's medical record revealed the Resident was assessed by psych services on 5/30/24 and documented the Resident did not recall the incident due to poor cognition. During interview with the Visitor on 11/19/24 at 11:00 AM, the Visitor stated he/she had been sitting in a family member's room by the door when he/she heard a resident in the next room yell to Staff #32 to get Resident #202 out of their room. The Visitor stated he/she heard Staff #32 talk to Resident #202 harshly and say he was going to put the Resident in a f---ing cage. At that time the Visitor looked out into the hallway and saw Staff #32 trying to get the Resident's feet up and the Resident wasn't doing it. The Visitor stated that is when he/she saw Staff #32 lean down and call the Resident a f---ing b-----d, and yelled at the Resident, well you just stay here then Interview with the Regional Director of Clinical Services on 11/18/24 at 5:14 PM confirmed the facility substantiated the verbal abuse of Resident #202 by Staff #32 and the facility reported Staff #32 to the Board of Nursing in May 2024.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on review of facility reported incidents with documentation and interview, it was determined the facility failed to report allegations of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (#213) of 16 facility reported incidents reviewed during an annual and complaint survey. The findings include: On 11/18/24 at 4:30 PM a review of facility reported incident MD00180784 was conducted and revealed on 1/2/22 at 5:35 PM LPN #9 and geriatric nursing assistant (GNA) #9 overheard GNA #29 coming out of Resident #213's room cussing verbally at Resident #213. Review of the investigative packet that was given to the surveyor revealed a failed fax confirmation sheet dated 1/3/22 at 9:56 AM. Also, the date at the top left of the Comprehensive and Extended Care Facilities Self-Report Form was dated 1/3/22 at 9:33 AM. There were no other fax or email confirmation sheets included in the investigation. The incident was not reported within 2 hours of the alleged verbal abuse and there was no documentation of when the final 5-day report was sent to the state agency. On 11/19/24 at 11:45 AM the Nursing Home Administrator (NHA) and the Regional Director of Clinical Operations stated there was no other documentation they could provide to the surveyor. Both confirmed the surveyor findings and they both stated they were not employed at the facility at the time of the incident.

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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. 31145 Based on review of a facility reported incident investigation and staff interview, it was determined the facility failed to thoroughly investigate an incident of alleged verbal abuse. This was evident for 1 (#213) of 16 facility reported incidents reviewed during an annual and complaint survey. The findings include: On 11/18/24 at 4:30 PM a review of facility reported incident MD00180784 was conducted and revealed on 1/2/22 at 5:35 PM LPN #10 and geriatric nursing assistant (GNA) #9 overheard GNA #29 coming out of Resident #213's room cussing verbally at Resident #213. Review of the investigative packet that was given to the surveyor revealed a written statement from GNA #9 and LPN #10. There were no other staff interviews and there were no resident interviews about the care they received from GNA #29 or if GNA #29 was ever verbally abusive to those residents. On 11/19/24 at 11:45 AM the Nursing Home Administrator (NHA) and the Regional Director of Clinical Operations stated there was no other documentation they could provide to the surveyor. Both confirmed that the investigation was incomplete, and they both stated they were not employed at the facility at the time of the incident.

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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** 34484 Based on medical record review and interview, the facility staff failed to provide treatment and services in accordance with professional standards of practice (Resident #203). This was evident for 1 of 41 residents reviewed during an annual/complaint survey. The findings include: Review of Resident #203's medical record on [DATE] revealed the Resident was admitted to the facility on [DATE] at approximately 11:00 AM from the hospital with diagnosis to include chronic obstructive pulmonary disease (COPD) and chronic respiratory failure. Review of the Resident's admission physician orders revealed the Resident was ordered 4 different respiratory inhalers that were flagged as potential allergy and the LPN #5 messaged the Medical Director with the allergy concerns. Review of the facility investigation provided by the Administrator of the Resident's care revealed a message was sent to the Medical Director on [DATE] at 2:46 PM. Further review of Resident #203's medical record revealed a nurse's note on [DATE] at 9:35 PM that stated, Resident's family member called wondering where the Resident's medications were. The family member stated dayshift nurse (LPN #5) told him/her and the Resident she had sent a message to the doctor and they had to be patient. Upon reviewing the message sent by dayshift nurse, this writer (LPN#6) saw it was expired. This writer called the Medical Director at the local hospital emergency to see if he was working and spoke to the Medical Director. At that time the Medical Director stated he was sleeping earlier and he saw the message. LPN #6 reviewed the respiratory inhaler allergies with the Medical Director and the Medical Director ordered the Resident to start Albuterol nebulizer treatments every 4 hours. During interview with LPN #6 on [DATE] at 8:43 AM, LPN #6 stated Resident #203 was not in respiratory distress but after receiving the Albuterol nebulizer treatment, the Resident stated it helped him/her. Interview with the Administrator and Director of Nursing on [DATE] at 10:00 AM confirmed the delay in getting Resident #203's physician orders clarified and administering an alternative medication for the Resident.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on review of a facility reported incident, medical record review, observation and interview, it was determined facility staff failed to prevent residents assessed to be at risk for elopement from eloping from the facility (Resident #202 and #204). This was evident for 2 of 7 residents reviewed for elopement. This resulted in an immediate jeopardy for the residents at risk for elopement on 2/15/23 and again on 2/6/24. After the elopement for both incidents, the facility put a plan in place to ensure that no other residents eloped from the facility. Review of the facility's plan of correction, implemented immediately after the facility gained knowledge of the elopements on 2/15/23 and 2/6/24, resulted in the citation being cited as past noncompliance. After removal of the immediacy, the deficient practice continued with a scope and severity of D with potential for more than minimal harm for the remaining residents. The findings include: 1. Review of Facility Reported Incident MD00189063 revealed Resident #202 eloped from the facility on 2/15/23. Review of Resident #202's medical record revealed on 2/15/23 at 12:15 AM the Resident was found in the facility truck in the parking lot by Staff #2 while she was on break. The facility's investigation revealed the facility staff located the Resident's wheelchair in the hallway and believed the Resident exited out of an employee entrance. The Resident was assessed and had no injuries. Observation of all exit doors on 11/18/24 at 11:00 AM with the Maintenance Director revealed a closed employee door that was off the facility's main hallway. Through the employee door there was an employee time clock and past the time clock was a locked set of double doors with a key pad that led to the outside. Also in the main hallway was a closed door with a sign that said laundry. Through the laundry door was a locked set of double doors with a keypad that led to the outside. During an interview with the Maintenance Director on 11/18/24 at 11:00 AM, he stated after the Resident was found in the truck, the facility installed keypads on both sets of employee doors. The Maintenance Director stated before the Resident eloped the employee time clock and laundry exit doors did not have locks and were not locked. The Maintenance Director stated all other doors were locked with keypad codes prior to the incident on 2/15/23. During an interview with the Maintenance Director on 11/19/24 at 7:15 AM, he stated he immediately put a temporary motion alarm in place until the new locks were installed on the 2 employee doors. During interview with Staff #2 on 11/19/24 at 4:51 PM, Staff #2 stated she went out the employee exit on 2/15/23 for a break and saw Resident #202 sitting in a truck on the facility parking lot. Staff #2 stated she stayed with the Resident while contacting staff to assist in returning the Resident inside the facility. Staff #2 stated the Resident seemed fine and not injured. Staff #2 stated the Resident ' s wheelchair was located outside the doors in the main hallway that led to the employee exit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's plan of correction on 11/19/24 provided by the Administrator revealed after Resident #202 eloped on 2/15/23 the facility completed the following interventions: 1) head count for all residents in the facility 2) placed alarms on all exit doors 3) reassessed all residents at risk for elopement 4) staff educated on elopement assessment and prevention and 5) the incident was included in the facility's QAPI (Quality Assurance and Performance Improvement) plan. Interview with the Administrator on 11/19/24 at 7:36 AM confirmed Resident #202 was at risk for elopement on 2/15/23 and did elope from the facility on 2/15/23. The Administrator confirmed alarms were immediately placed on 2/15/23 and the facility was in compliance when all education was completed on 4/10/23. 2. Review of Facility Reported Incident MD00202296 revealed Resident #204 eloped from the facility on 2/6/24. Review of Resident #204's medical record on 11/18/24 revealed Resident #204 was admitted to the facility on [DATE]. On 2/1/23 a Social Services note stated the Resident had some incidents of wandering since last review. He/she continued to wear the wanderguard to provide him/her with a safe environment. Further review of Resident #204's medical record revealed a nurse's note on 11/14/23 at 3:19 AM that stated the Resident has been wandering this shift. He/she is walking all over the building. When asked where he/she is going he/she says, I'm getting out Staff is within sight of him/her at all times. Review of the facility investigation revealed on 2/6/24 at 6:30 PM the facility staff could not locate the Resident during dinner service. The facility staff called the police who arrived at the facility and were given a picture identification of the Resident and a description of the clothes the Resident was wearing. The police notified the facility on 2/6/24 at 8:30 PM that the Resident had been found in the woods and transported to the hospital without injury. Review of the facility investigation found the exit door on the 700 unit was not completely latched after a delivery of a chair earlier that day. During an interview with the Maintenance Director on 11/18/24 at 11:15 AM, he stated after the incident he created a log to show that he checks that each of the 10 exit doors are checked every morning when he comes in and again prior to him leaving each day. During an interview with the Administrator on 11/18/24 at 12:45 PM, the Administrator stated she has been the Administrator of the facility since February 2024 and there have been no additional elopements since 2/6/24. During an interview with the Maintenance Director on 11/19/24 at 7:10 AM, he was asked why the alarm didn't sound if the 700 unit exit door was ajar, the Maintenance Director stated once the code is put in the alarm does not reset until the door is shut. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview with Staff #12 on 11/19/24 at 4:41 PM, Staff #12 stated she was working on 2/6/24 and saw the Resident sitting in a chair by the nurses' station about 30 minutes prior to delivering his/her dinner tray. Staff #12 stated when she went to deliver his/her dinner tray and the Resident wasn't in his/her room, she immediately started looking for the Resident and asking staff if they had seen him/her. Staff #12 stated when we couldn't find the Resident the facility staff began looking outside for the Resident and that is when I saw footprints outside the 700 unit exit door. Review of the facility's plan of correction on 11/19/24 provided by the Administrator revealed after Resident #204 eloped on 2/6/24 the facility completed the following interventions: 1) all facility entry and exit ways and windows were checked for security, penetration and proper function 2) head count for all residents in the facility to ensure all residents were accounted for 3) all residents reassessed for elopement 4) facility elopement binders checked for accurateness and in use wanderguards were checked for function 5) staff educated on elopement and maintenance educated on daily checks of entry and exit door ways for security, penetration and proper function 6) The incident was included in the facility's QAPI (Quality Assurance and Performance Improvement) plan. Interview with the Administrator on 11/19/24 at 7:40 AM confirmed Resident #204 was at risk for elopement on 2/6/24 and did elope from the facility on 2/6/24. The Administrator confirmed the facility was in compliance when all education was completed on 2/12/24.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 34484 Based on medical record review and interview, the facility staff failed to intervene in a timely manner for a resident with weight loss (Resident #205). This was evident for 1 of 3 residents reviewed for nutrition concerns during an annual survey. The findings include: Review of Resident #205's medical record on 11/19/24 revealed the Resident was admitted to the facility in October 2021 with diagnosis to include dementia. Dementia is a general term for a decline in mental abilities that affects a person's daily life. Review of Resident's weights documented in the electronic medical record revealed on 10/23/23 the Resident weighed 110 pounds. On 11/1/23 the Resident weighed 102 pounds. Further review of Resident #205's medical record revealed the Resident was not assessed by the former Dietitian until 11/13/23, 12 days after the noted weight loss. Review of a dietary note on 11/13/23 at 1:59 PM states: Significant Weight Change, Supplements: none, Recommendation: re-weigh. Further review of the Resident's weights revealed the Resident was not reweighed until 12/1/23 and at the time the facility staff documented the Resident's weight as 103 pounds. The Resident was not assessed by the former Dietitian until 12/22/23 and the Dietitian documented no new recommendations. Further review of the Resident's weights revealed the facility staff documented on 1/1/24 the Resident weighed 102 pounds. The Resident was assessed by the former Dietitian at that time and documented: noted with poor intakes, will reach out to family for any updates on preferences. Further review of the Resident's weights revealed the facility staff documented on 2/2/24 the Resident weighed 99 pounds. The Resident was assessed by the former Dietitian on 2/2/24 and recommended a snack order for 2 PM and 8 PM and documented Supplements: none. During interview with the facility's current Dietitian on 11/20/24 at 8:30 AM, the Dietitian stated she was not the Dietitian that assessed the Resident and she began her position in August 2024. The Surveyor and Dietitian reviewed Resident #205's electronic medical record and at that time the Dietitian stated the Resident should have been reweighed and assessed in a more timely manner after the 11/1/23 documented 8 pound weight loss. The Dietitian also stated at the time of the weight loss, she would have included interventions such as fortified foods and snacks first and then supplements such as a house shake if the increase in fortified foods and snacks were not effective interventions for the Resident. Interview with the Regional Director of Clinical Operations on 11/20/24 at 9:25 AM confirmed the facility staff failed to intervene in a timely manner for Resident #205's weight loss.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to administer pain medications to manage a resident's pain in a timely manner (Resident #203). This was evident for 1 of 41 residents reviewed during an annual/complaint survey. The findings include: Review of Resident #203's medical record on 11/19/24 revealed the Resident was admitted to the facility on [DATE] at approximately 11:00 AM from the hospital with diagnosis to include chronic pain. Further review of Resident #203's medical record revealed a physician order for Hydrocodone-Acetaminophen 10-325 mg 1 tablet every 4 hours as needed for pain. Hydrocodone and acetaminophen combination is used to relieve pain severe enough to require opioid treatment. Interview with Resident #203 on 11/19/24 at 9:04 AM stated he/she was upset when he/she couldn't get his/her pain medication after admission to the facility. During interview with LPN #5 on 11/19/24 at 9:13 AM, LPN #5 stated she was the nurse when the Resident was admitted and sent the orders for the pain medication to the pharmacy. LPN #5 stated the pharmacy notified the facility they needed clarification from the physician. LPN #5 stated she sent a message to the Medical Director but he did not answer. LPN #5 stated Resident #203 was asking for his/her pain medication but she didn't have it. LPN #5 stated she contacted the Director of Nursing at that time and asked her to contact the Medical Director but doesn't believe she got in touch with him. LPN #5 stated she reported this to LPN #6 she was unable to administer the Resident pain medication at change of shift. Review of LPN #6's nurse's note on 4/12/24 at 9:35 PM stated LPN #6 called the Medical Director to clarify the Resident's admission orders and then LPN #6 contacted the pharmacy. LPN #6 stated the pharmacy said everything the Resident needed for the night was in the Ebox. LPN #6 stated when Resident asked for pain medication, he pulled it from the Ebox and administered the pain medication to the Resident. Interview with LPN #6 on 11/20/24 at 8:43 AM confirmed he remembers Resident #203 asking for pain medication and him calling the Medical Director and then getting the medication from the Ebox to give to the Resident. Review of Resident #203's Medication Administration Record (MAR) for April 2024 revealed LPN #6 documented he administered Hydrocodone-Acetaminophen 10-325 mg 1 tablet to the Resident on 4/12/24 at 10:34 PM Further review of Resident #203's medical record revealed on 4/13/24 at 7:10 AM, LPN #5 documented Resident's pain level as a 5 out of 10. A pain level of 5 indicates moderately strong pain. Review of Resident #203's April 2024 MAR revealed the Resident did not receive any pain medication and transferred from the facility on 4/13/24 after 8 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator and Director of Nursing on 11/19/24 at 10:00 AM confirmed the facility staff failed to administer Resident #203's pain medication in a timely manner.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 31145 Based on review of complaints, interview, and documentation review, it was determined that the facility failed to have sufficient nursing staff to meet the needs of the residents. This was evident for 9 of 21 complaints submitted to the Office of Health Care Quality (OHCQ), the regulatory agency. This deficient practice had the potential to affect all residents. The findings include: 1) Nine out of twenty-one complaints that the Office of Health Care Quality (OHCQ) received and reviewed on this survey alleged the facility did not having sufficient nursing staff to provide essential care to the residents that resided at the facility. Complaints consisted of geriatric nursing assistants (GNAs) having up to 20-27 residents to take care of during any given shift. There were concerns that the residents were not receiving timely care, not receiving showers, and were not getting changed or toileted every 2 hours, only twice per shift. 2) Review of the Resident Census and Conditions CMS 672 form that was completed by the Nursing Home Administrator upon request from the surveyor documented that 75 of the 75 residents in the building were either totally dependent on staff or required the assistance of 1 to 2 staff for bathing and eating. It was documented that 64 of the 75 residents were either totally dependent or required the assistance of 1 to 2 staff for dressing and 53 of the 75 residents were either totally dependent or required the assistance of 1 or 2 staff members for toilet use. 3) Staff Interviews were conducted during the 3-day survey which began on 11/18/24 and concluded on 11/20/24. On 11/18/24 at 9:49 AM an interview was conducted with the scheduler, staff #1 who stated they use agency every day and that they staff to census. Staff #1 stated they try to get as close to 3.0 PPD (per patient per day hours); that is our goal. GNA #4 was interviewed and stated they work short and can only do 2 rounds on residents during the night with 4 aides. There usually is 1 geriatric nursing assistant (GNA) for 27 residents. GNA #4 stated, it happened this past Saturday on the Far East wing. I took care of them by myself. We go in in the morning and only 2 GNAs in the building for night shift. The residents are supposed to get showers 2 times per week, and you have to take people to the bathroom. You can't get 6 showers done when you are by yourself. I can get them up but when it is time to change them, I have to find someone to help me. If I can't give a shower, I document N/A (not applicable). I did some showers the day before because I figured I would be by myself on Saturday. This past week I was by myself on Monday and Wednesday, and I split between east and new wing. They keep taking new admissions. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	GNA #31 was interviewed and stated there were heavier people on west wing and there was only 1 GNA on the day shift 7/7/24 and 7/24/24 Note: The surveyor validated that claim by reviewing the assignment sheets for those 2 days that were provided by the scheduler. There were 25 residents on the unit. There were residents that did not get turned and changed. Everyone got 1 round done. Just last week it was only 2 GNAs and 3 nurses. Everyone got 2 rounds that night and the nurses answered call bells. I feel we do everything we can, but I think the residents would get better care if we could get better staffing. The Nursing Home Administrator (NHA) was interviewed and stated that they did mandate staff to stay over. The NHA stated they had a STAR system and people know if they will have to stay over. They take turns. They just initiated a bonus program, use agency and just signed more contracted agency. Registered Nurse #24 was interviewed and stated, staffing is awful. Nurses call out and GNAS call out and showers aren't getting done. Sometimes showers are made up on the weekends. GNA #25 was interviewed and stated, today I have 29 residents. I can't get to bathe the residents or do all the rounds I need to do. Meals are late. Water is not passed. I can't do last rounds. Now that we have a hospitality aide that helps. Sometimes I can only do 2 rounds on residents. Interview of a complainant stated things have not gotten better since the last surveyor was out in January. I don't know how they slice it. Define 3 hours per day care or define adequate care. They can't provide the proper care. I hope you can fix this mess. There is 1 aide per floor at least 4 nights a week. GNA #14 was interviewed and stated, we work short daily. If you have help you have 12 residents each that is a good day. They will schedule me with 24 residents, and I refuse to do that. They will pull people. If we have time to do showers we will. Sometimes you have 7 to 8 showers and 2 meals, and you can't do it all. I put either N/A or partial as my documentation for showers. Partial is face, armpit, stomach and butt. We can't give the residents the care they need. We are supposed to do 4 rounds. Most of the time it is 2 or 3. GNA #15 was interviewed and stated, we work short all the time. Twenty residents on most of the East wing. Sometimes an aide will split the hall. I do what I can do by myself and then I ask one of the other girls for help. Showers are not given all the time. I document N/A if don't have time to give a shower. The administration says we can't have more staff with no applicants. But we still keep getting new admissions. GNA #26 was interviewed and stated, we work short. It is good if we only have 12 residents. It is hard when we have 27 each and that happens a lot. Weekends are hard. On night shift there is 1 GNA per hall. It is hard because we have rehab patients, bedpans, dementia. The residents don't get as much care, and we don't have time to offer as many fluids. RN #27 was interviewed and stated, sometimes we are short, and showers are a real issue. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	LPN #28 was interviewed and stated, we don't have enough staff. Sometimes I am both the nurse and the aide. I come to work at 6:30 PM at night and the aide doesn't show up. Sometimes I am the only nurse with no aide. There are a lot of 2 assist. They are harder and they are groggy. We do the best you can. There are a lot of times the residents can't get showers. When it is med pass time, I can't give narcotics and do GNA work both at the same time. If they are giving a shower and there is no other aide on the floor it is hard. There are 27 residents with 1 aide. On the schedule it says 2 aides, but 1 aide doesn't show up and is not replaced. LPN #21was interviewed and stated, the residents do not get the proper care. It is always rushed to care for them. Sometimes I am the other aide. We will shower the whole floor on the weekends if we can't get to them during the week. 4) Review of the facility assessment on 11/20/24 at 8:31 AM documented the following: Facility Assessment and Staffing Needs: This facility assessment will be used to: Inform staffing decision to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care. Review of the relevant information about the residents documented 55 required medical management, 13 were special high care, 13 were clinically complex, 12 had behavioral symptoms and cognitive performance, 27 had reduced physical functioning, 18 required respiratory treatments, 53 had behavioral/mental health, 76 had medication management, 14 on isolation and 14 for wound care. This was for the time period 7/23/24. For the time period 1/1/24 to 7/23/24 the average daily census was 80.55 with 69.15 being LTC (long term care) and 11.4 being skilled. The total number of nursing adjusted hours per resident day according to the facility assessment was 2.8115 per patient per day. Note that this does not meet the state minimal standards for 3.0 PPD. 5) Review of the actual worked nursing schedules for July 2024 and August 2024 revealed the facility did not meet the state minimal 3.0 PPD for 27 of 31 days reviewed in July and for 19 of 21 days reviewed for August 2024. 6) Review of Resident #1's ADLs (activities for daily living) for bathing for the time period 10/26/24 to 11/19/24; the resident had no showers and 8 bed baths. The remaining documentation was either partial or N/A. Review of Resident #31 ADLs for bathing for the time period 10/26/24 to 11/19/24; the resident had 3 showers on 10/28/24, 11/4/24, and 11/14/24. The resident's shower days were listed as Monday and Thursday. The resident did not have any complete bed baths during that time period. The remaining documentation was either partial or N/A. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #11 ADLs for bathing for the time period 10/26/24 to 11/19/24; the resident had no showers and 3 bed baths on 10/26/24, 10/30/24, and 11/16/24. The resident's care plan documented the resident prefers no showers and only wants bed baths. The remaining documentation was either partial or N/A. Review of Resident #12's ADLs for bathing for the time period 10/26/24 to 11/19/24; the resident had 2 showers on 11/1/24 and 11/12/24, and 1 bed bath on 10/30/24. The resident's care plan documented the resident only wants showers on Friday but would be offered on Tuesday and Friday. Resident #12 did not receive a shower on 11/8/24 or 11/15/24. The remaining documentation was either partial or N/A. Review of Resident #54's ADLs for bathing for the time period 10/26/24 to 11/19/24; the resident had 3 showers on 11/1/24, 11/12/24, and 11/15/24. The resident had a bed bath on 10/30/24 and 11/5/24. The resident's shower days were Wednesday and Saturday. The remaining documentation was either partial or N/A. On 11/20/24 at 10:45 AM the NHA and Director of Nursing were informed of the staffing concerns.