| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215220 | A. Building<br>B. Wing | 01/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Chapel Hill Nursing Center | 4511 Robosson Road<br>Randallstown, MD 21133 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>51213<br><br>Based on observation and an interview with facility staff, it was determined that the facility failed to ensure the environment of resident care was kept clean, comfortable and safe for resident use. This was evidenced by the floor radiator heater in the bathrooms observed with significant damage, rust build up along the floor radiator heaters, end caps were not in place which exposed sharp edges. This was evident for 2 of 5 bathrooms observed during the recertification survey.<br><br>The findings include:<br><br>On 01/08/25 at 01:45 PM it was observed that the bathroom floor radiator heater in rooms 36/38 (they are adjoining rooms and share a bathroom) had no cap at the end of it. Two sharp rusted edges were exposed and sticking out. A resident using the bathroom could potentially cut their leg on the rusted sharp edges. Two long flat metal pieces were also observed leaning on the wall in the bathroom for rooms 36/38. The two long pieces of metal were leaning on the wall from floor to ceiling opposite the toilet and sink. These two long metal pieces were not secured to the wall. The paper towel dispenser was also missing in the bathroom for rooms 36/38. Resident #5 used the bathroom frequently.<br><br>On 01/08/25 at 1:55 PM the bathroom floor radiator heater for rooms 35/37 (they are adjoining rooms and share a bathroom) was observed with no cap on the end of it. Two sharp rusted edges were exposed and sticking out, where a resident using the bathroom could possibly cut their leg. Resident #40 used the bathroom daily.<br><br>On 01/08/25 at 2:00 PM The Director of Maintenance, Staff # 8, was interviewed and shown, in rooms 36/38, the floor radiator heater had no cover or cap at the end of it and the edges were sharp, rusted and exposed. Staff #8 was also shown the 2 long white flat metal pieces with rust on them reaching from the floor to the ceiling leaning against the wall in the bathroom on the opposite wall from the toilet. He agreed that this should not be there and stated he would remove those pieces of metal. Staff#8 was also shown that the paper towel dispenser was missing from the wall.<br><br>On 01/08/25 at 2:05 PM in rooms 35/37, The Director of Maintenance, Staff # 8, was shown the floor radiator heater was rusted, had no cover or cap on the ends and was pulled up towards the toilet with two sharp edges exposed. Staff #8 pushed the rusted steel down and stated that radiator heater should have a cap on it for safety.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215220 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/16/2025 |
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| NAME OF PROVIDER OR SUPPLIER Chapel Hill Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 4511 Robosson Road Randallstown, MD 21133 | |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/09/25 at 01:18 PM it was observed that a cap was put on the floor radiator heater in the bathroom for rooms 35/37. No cap was put on the floor radiator heater in the bathroom for rooms 36/38, sharp edges remained exposed. Resident #5 continues to use the bathroom daily. The two flat metal pieces were removed, and the paper towel dispenser was put on the wall.<br><br>On 01/10/25 at 10:15 AM in rooms 36/38, the floor radiator heater was observed again with no cap on the end of it exposing the sharp edges. Resident #5 continues to use the rest room daily. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>43096<br><br>Based on medical record review, facility investigation review, and staff interview, it was determined that the facility failed to 1) thoroughly investigate a resident's allegation of unknown origin of injury, 2) educate all staff to prevent similar elopement episodes in the future, and 3) thoroughly investigate an allegation of abuse, and provide documentation for the incident of an allegation of abuse. This was evident for 3 (Resident #30, #23, #19) of 36 residents reviewed during this recertification/complaint survey.<br><br>The findings include:<br><br>1) A review of the facility's self-reported incident, MD00187097, on 1/09/25 around 10 AM revealed that Resident #30 was found with a bruise on his/her left flank and coccyx on 12/28/22. The facility investigated this incident as an unknown origin of injury through staff interviews, hospital follow-ups, and ADL (Activities of Daily Living) evaluations. However, there was no documentation for other residents' interviews.<br><br>On 1/09/25 at 1:05 PM, the surveyor interviewed the Nursing Home Administrator (NHA). The NHA stated that the facility staff performed residents' interviews (if they were capable) to verify their safety when an unknown origin of injury was reported. The surveyor reviewed the investigation of Resident #30's reported incident with the NHA. He validated that there were no other resident interviews.<br><br>2) On 1/13/25 at 10:14 AM, the surveyor reviewed the facility's investigation documentation for self-reported incident, MD00174880. The incident stated that Resident #23 left the facility building on 11/27/21, which was noticed by a staff member (#36). The staff member followed the resident and brought him/her back to the facility.<br><br>Further review of the facility's investigation revealed that the facility failed to interview Staff #36, who initially saw Resident #23 leave the building via camera. Also, it was noted that the facility provided in-service training to staff about 'Supervision during smoke break' and 'Resident safety' on the same day the incident occurred. However, the training attendance record indicated that only 9 nursing staff members, including Nurses and aides, signed.<br><br>During an interview with the Nursing Home Administrator (NHA) on 1/13/25 at 12:47 PM, he confirmed that the facility had more than 9 nursing staff members. He stated that he expected to educate all staff about the elopement incident to prevent a similar event. Also, the NHA verified that the facility's investigation did not include a statement/interview with Staff #36. The surveyor shared concerns, and the NHA validated them.<br><br>51213<br><br>3) On 1/10/2025 at 9:02 AM records reviewed of facility investigative material, revealed the Initial report for MD00163206 was filed with The Office of Healthcare Quality (OHCQ) on 2/3/2021 at 7:15 AM involving an allegation of abuse from employee to resident. The final report was also filed with OHCQ on the same day 2/3/2021 and at the same time 7:15 AM.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/10/2024 at 12:40 PM the Administrator was interviewed and asked if they had a copy of the final report within 5 days of the incident with the conclusion of the investigation? The Administrator replied, when I spoke with the former Administrator, I was told the report was filed and completed on the same day. The Administrator was then asked if they could provide any witness statements from the employees that worked with Resident #19, the alleged abused person, about what happened during the time the abuse was reported. And if any skin assessments were completed on the other residents the GNA # 26 took care of during that shift? And any documentation about abuse training that was given to all staff after the incident. The Administrator replied, No I have given you all the documentation that I have pertaining to this incident. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409<br><br>Based on medical record review and staff interviews, it was determined that the facility failed to notify the resident/resident representative in writing about the bed hold policy when the resident was transferred/discharged from the facility to an acute care facility. This was evident for 1 (resident #51) of 2 residents reviewed who were transferred to an acute care facility during the recertification survey.<br><br>The findings include:<br><br>Review of the medical record for resident #51 on 01/14/25 at 11:25 AM revealed that resident #51 was admitted to the facility on [DATE] and was sent to an acute care facility on 11/05/24 for a change in his/her medical condition. Further review of the medical record failed to produce written evidence that the resident and /or the resident representative were given written notice of the bed hold policy. The facility's documentation on eINTERACT transfer form reveals Bed hold policy was not sent.<br><br>The bed hold policy was provided during an interview with the Director of Nursing (DON) on 01/14/25 at 2:12 PM; however, he/she was unable to produce written evidence that the resident or resident representative was given written notice of the policy.<br><br>During an interview with the Social Worker, staff #10, on 7/9/24 at 3pm, she revealed she was unable to locate a copy of the bed hold policy that was given to the resident /resident representative. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>43096<br><br>Based on the medical record review and staff interview, it was determined the facility staff failed to revise the interdisciplinary care plans to meet the resident's needs. This was evident for 2 ( Resident #30, #13) of 9 residents reviewed for abuse and 36 residents reviewed for for care plan timing and revision during the survey process.<br><br>The findings include:<br><br>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. The interdisciplinary team meets and develops care plans once the facility staff completes a comprehensive resident assessment. 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 assuring 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 are accurate and appropriate for the resident.<br><br>1) During a portion of investigating the facility's self-reported incident, MD00212723, on 1/09/25 at 9:51 AM, it was noted that Resident #30 had reported on 12/14/23 that he/she did not feel safe returning due to he/she was touched by someone.<br><br>Further review of the facility's investigation packet revealed that the facility started investigating this incident on 12/14/24, including interviewing staff and other residents. The interview revealed no visitors for Resident #30 before the incident. Also, their investigation revealed that Resident #30 had a same-gender roommate.<br><br>During an interview with the Nursing Home Administrator (NHA) on 1/09/25 at 11:00 AM, he stated that the facility concluded that no opposite-gender visitors or staff cared for Resident #30 before the incident. He noted that the resident was confused that he/she had an opposite-gender roommate, and they touched Resident #30.<br><br>On 1/09/25 around 2 PM, the surveyor reviewed Resident #30's care plan. The review revealed that there was no updated care plan after the incident.<br><br>In an interview with the Director of Nursing (DON) on 1/09/25 at 2:30 PM, she stated that the DON or the Assistant Director of Nursing should update/revise residents' care plans upon their admission, regularly, and as needed.<br><br>On 1/10/25 at 8 AM, the surveyor reviewed Resident #30's care plan with the DON. The DON verified that the care plan was not updated after the incident.<br><br>49409<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2) On 01/10/25 at 11 AM, a medical record review for Resident #13 revealed that an initial order from 12/15/23 for Ativan Tablet 0.5 MG every 12 hours as needed for anxiety was placed for 14 days. The order was renewed to manage resident behaviors on 01/02/24 for 14 days, 01/22/24 for 14 days, and 02/19/24 for 14 days. The interdisciplinary team care plan goals and interventions did not reflect Resident #13's behavior changes requiring anxiolytic administration (Ativan).<br><br>The Activity's care plan goals were initiated during the resident's admission on 12/18/2023, and a revision was done on 01/08/2025. Interventions were also initiated on 12/18/2023 without any specific interventional updates.<br><br>A review of individual residents' daily participation records reflects resident participation, but does not reflect the effectiveness or outcome of the activity offered.<br><br>Review of quarterly activity assessments dated 03/11/24, 06/04/24, 08/29/24, 11/22/24 a) doesn't reflect revised goals or interventions, b) changes to activity focuses (Revised strengths, problems, preferences); not answered, c) describe changes to goals, not answered, d) describe changes to interventions /approaches; not answered.<br><br>An interview with staff # 51 on 01/13/25 at 09:14 AM confirmed that the Activity Director updates the care plans to reflect any change in resident care.<br><br>This was reviewed and confirmed with the Activity Director, Director of Nursing (DON), and the Nursing home administrator (NHA) that the facility staff failed to review and revise care plans for Resident # 13 to reflect current and appropriate interventions. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409<br><br>Based on observations, staff interviews, and record review, it was determined that the facility failed to maintain a functional communication system for a non-English speaking resident (Resident # 51). This was evident for 1 of 1 resident reviewed for communication, including language and other functional communication systems, during the recertification survey.<br><br>The findings include:<br><br>On 01/08/25 at 10:15 AM, the surveyor attempted to interview resident # 51 in his/her room. The resident was not able to answer questions, except for occasional response of yes .yes.<br><br>On 01/08/25 at 9:15 AM, during an interview with Licensed Practical Nurse (LPN) Staff # 42, when asked what language resident #51 speaks and how he/she communicates, Staff #42 stated, Resident # 51 doesn't speak English, and he/she speaks only Russian, but he/she can express what he/she wants with basic sign language. During business hours, an employee from another department helps when needed, but off hours and weekends, we have to call the resident's family to assist with communication.<br><br>On 01/08/25 at 10:23 AM, during an interview with Geriatric Nursing Assistant (GNA) staff # 41, when asked about communicating with resident # 51, staff #41 stated that we speak in English, he/she appears to understand, and he/she tried to communicate back. For basic things we can follow his/her gestures, but asking further medical questions, staff calls the family to assist.<br><br>On 01/13/25 at 11 AM, a review of resident #51's medical record revealed that he/she was admitted to the facility on [DATE], and his/her native language was Russian. Further review of resident #51's care plan dated 11/11/24 revealed that the resident speaks non-English, but there is no evidence of an intervention to utilize any tools to assist resident #51's communication.<br><br>On 01/14/25 at 12:28 PM, when reviewing resident #51's communication with the Nursing home administrator (NHA) he/she stated that the staff uses a picture board but was unable to find it or verify that the staff was aware of it. He/she also noted that the staff utilizes Google Translate but could not validate this with the staff. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>51128<br><br>Based on medical record review and resident and staff interviews it was determined the facility staff failed to ensure that the dependent resident's personal hygiene needs were adequately met by offering and providing showers as scheduled. This was evident for 1 (Resident #37) of 2 residents reviewed for Activities of Daily Living (ADL) during this recertification/complaint survey.<br><br>The findings include:<br><br>During an interview with Resident #37 on 01/09/25 at 11:43 AM, when the surveyor asked the Resident if he got showers, the Resident stated Heck no. when asked if he would like a shower, he said Yes.<br><br>On 1/13/2025 at 11:50 AM, an interview was conducted with a Geriatric Nurse Aide (GNA #35) who stated that when residents refused a shower, the GNAs would let the nurse know and document the refusal in the Electronic Health Record. GNA #35 stated that Resident #37 refused showers in the past, and had been getting bed baths.<br><br>A record Review was conducted on 1/13/2025 at 1:16 PM revealed:<br><br>-Order for shower and Skin Check 7-3 Shift Tuesday and Friday, written on 12/20/2024 at 07:00 AM.<br><br>-Resident #37's Brief Interview for Mental Status (BIMS) dated 10/29/2024 revealed a score of 15 indicating adequate cognitive ability.<br><br>-A care plan with an initiation date of 9/20/2024 and revision on 12/13/2024 indicated that Resident #37 has an Activities of Daily Living (ADL) selfcare deficit related to the disease process with an intervention to provide a sponge bath when a full bath or shower cannot be tolerated.<br><br>-GNA Task tab within the past 30 days starting on the week of 12/15/2024, the shower dates for Tuesdays and Fridays are 12/20/2024, 12/2/2024, 12/27/2024, and 12/31/2024 had check marks indicating Resident #37 was given a bed bath.<br><br>There was no documentation that Resident #37 refused a Shower and no documentation that Resident #37 was encouraged to take a shower during this record review.<br><br>On 1/13/2025 at 12:30 PM in an Interview with the Director of Nursing (DON)and the Nursing Home Administrator (NHA), DON stated that if residents refused a shower, it was documented in the Electronic Health Record. The residents could then be offered a bed bath but were encouraged to take showers. When the DON was informed that Resident #37 stated that he had not had a shower, the DON stated that Resident #37 got a bed bath because the facility shower room did not have a chair that reclined and could not accommodate Resident #37 because of his/her diagnosis. Following that statement, the NHA stated that if Resident #37 wanted a shower he would get one. When asked about shower accommodations for other residents who were disabled and could not sit in a shower chair, the DON and NHA did not provide a response.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/14/2025 at 08:00 AM surveyor asked Resident #37 if he had a shower on 1/13/2025, Resident #37 confirmed that he was finally given a shower. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51128<br><br>Based on a review of the medical record and interview with staff it was determined that the facility failed to monitor a resident's significant weight changes. This was evident for 1 (#37) of 2 residents reviewed for nutrition during the recertification/complaint survey.<br><br>The findings include:<br><br>On 1/08/2025 at 1:44 PM, a review of Resident #37's medical record revealed, in a weight tracking system report, Resident #37's weight was documented as 187.2 Lbs. (pounds) on 04/08/2024 and 6/18/2024 Resident #37's weight was documented as 166.5 lbs., which was a 20 lbs weight loss. Further review of Resident #37's medical record revealed a note from the dietician, staff #50 on 5/16/2024 that the resident refused weight, noted with failure to thrive in adult, swallowing difficulty, speech more remote/ slurred, and needs 100% support with meals. However, there was no documentation from a physician that he/she was aware of Resident #37's weight loss, nutritional status, or weight management.<br><br>The weight log was as follows:<br><br>8/2/2024 163.2 Lbs<br><br>7/24/2024 163.0 Lbs<br><br>7/17/2024 163.6 Lbs<br><br>7/9/2024 165.0 Lbs<br><br>6/18/2024 166.5 Lbs<br><br>4/8/2024 187.2 Lbs<br><br>On 1/13/2025 at 12:00 PM, an interview was conducted with the Dietician, Staff #49. When the surveyor asked how the resident's residual weight is communicated between staff, dietician, and physician, Staff #49 stated that the resident has a right to refuse, but he is encouraged to have the weight done, the refusal is documented, and staff should continue to encourage daily. If it has been over a couple of months, then the physician is notified for further intervention.<br><br>During an interview with the Assistant Director of Nursing (ADON) on 1/14/2025 at 12:46 PM, when asked what the facility does when a resident refuses weight. The ADON stated that the Geriatric Nursing Assistant (GNA) would let the nurse know that the resident refused weight, document in the Electronic Health Record (EHR), and the nurse would also notify the physician. The ADON also stated that the dietitian would attend morning meetings on Tuesdays or Thursdays and discuss weight loss.<br><br>On 1/14/2025 at 2:13 PM, a further record review noted that Resident #37 was hospitalized on [DATE]. The resident was readmitted on [DATE]. The weight on 6/18/2024 was 166.5. There was no further weight documented until 7/17/2024.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/14/2025 at 3:46 PM, a follow-up phone interview was conducted with staff #49 concerning weight management after re-admission. When asked how the baseline body weight was obtained, Staff #49 stated that a resident's body weight was obtained on admission, within the next 3 days, once a week for 4 weeks, then monthly. The surveyor informed Resident #37's case: the resident did not have these weights documented and there was no documentation of refusal or communication with the provider. Staff # 49 shared her professional opinion that Resident #37 should have been encouraged to get weight and other interventions could have been done such as supplements, providing double portions of food, and notifying the provider.<br><br>On 1/16/2025 around 9 AM, the surveyor shared the above concern with the Nursing Home Administrator, he validated the concern. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215220 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/16/2025 |
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| NAME OF PROVIDER OR SUPPLIER Chapel Hill Nursing Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 4511 Robosson Road Randallstown, MD 21133 | |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409<br><br>Based on the medical record review and staff interview the facility failed to ensure that the use of high-risk psychotropic medication was necessary and justified when staff failed to complete behavior monitoring documentation and utilization of nonpharmacological interventions before administering Anxiolytic medication for the resident (#13). This concern was evident for 1 (Resident #13) of 2 residents reviewed for utilization of unnecessary medication during the recertification survey.<br><br>The findings include:<br><br>Resident #13's medical record was reviewed on 01/10/25 at 11:06 AM and revealed that the resident was admitted on [DATE]. Resident #13 was receiving an anxiolytic medication (Ativan) for the diagnosis of Anxiety.<br><br>On 01/10/25 at 11 AM, a medical record review revealed that an initial order from 12/15/23 for Ativan Tablet 0.5 MG every 12 hours as needed for anxiety was placed for 14 days. The order was renewed to manage resident behaviors on 01/02/24 for 14 days, 01/22/24 for 14 days, and 02/19/24 for 14 days.<br><br>Further review of resident # 13's medication administration record on 01/10/25 at 11:35 AM revealed that he/she received Ativan 0.5 mg five times in January 2024, on 22nd, 23rd, 24th ,26th, and 29th.<br><br>Further medical record review on 01/10/25 at 11:45 AM revealed that Nonpharmacological interventions to prevent the usage of psychotropics were not ordered. The facility did not provide nonpharmacological interventions to Resident # 13 before administering Ativan and did not document the types of behaviors that were present requiring anxiolytic administration as needed.<br><br>On 01/10/25 at 12:30 PM, a review of the Treatment Administration Record for the resident did not reveal any task that specifically ordered the monitoring of the resident's psychiatric symptoms, including anxiety.<br><br>On 01/15/25 at 1:33 PM, in an Interview with the Director of Nursing (DON) and the Facility Administrator (NHA) it was revealed that the facility did not monitor Resident #13's behaviors when receiving Anxiolytics and did not perform non-pharmacological interventions before administering psychotropics. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409<br><br>Based on observation and the staff interviews, it was determined that the facility failed to properly store medications, as evidenced by failing to ensure that medication was properly labeled and dated. This was evident in two of the two medication rooms and one of the two refrigerators observed during the recertification survey.<br><br>The findings include:<br><br>On [DATE] at 12:48 PM, the surveyor checked the refrigerator in Units 1 A and B and noted two opened resident-specific insulin vials. Vial one was opened on [DATE], and vial two was opened on [DATE]. Per the facility's medication labeling and storage policy, Multi vials that have been opened or accessed are dated and discarded within 28 days.<br><br>On [DATE] at 12:50 PM, the Surveyor checked the supplies along with the Licensed Practical Nurse(LPN) # 45 at Unit 2 A and B medication storage room and noted an expired spill kit (Econo kit). The kit expired on [DATE] and contained a scoop, a red bag, and gloves. The surveyor also noted three Condom catheter packs (Ref Numbers 7000 ) expired on<br><br>[DATE].<br><br>The findings were reviewed with the Assistant Director of Nursing (ADON) on [DATE] at 1 PM. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>50904<br><br>Based on observations and interviews with the facility staff, it was determined that the dietary staff 1) Failed to maintain the temperature logs on the refrigerator and freezer, 2) failed to date and label foods stored in the refrigerator and freezer with expiration dates and, 3) failed to put on beard covers while handling the resident's food. These were identified during 2 out of 4 observations of kitchen food service operations during the recertification survey and has the potential to affect all residents.<br><br>The findings include:<br><br>1) On 01/08/25 at 08:28 AM, during the initial tour of the kitchen, the surveyor observed that the temperature logs on the doors of the refrigerator (1 and 2) and freezers (1 and 2) were not charted from 01/04/2025 - 01/06/2025. The Dietary Manager Staff #12 stated that the temperature logs were not completed because they were short staff during those days. The copies of the temperature logs were requested for and provided to the surveyor.<br><br>On 01/09/2024 at 07:58 AM, during a follow-up visit to the kitchen, surveyor observed that the temperature logs on the refrigerators and the freezers for the missing dates had been completed, and when the Dietary Manager Staff #12 was asked about it she could not give a reason. The newly completed temperature log copies were also asked for and provided to the surveyor.<br><br>2) On 01/08/25 at 08:30 AM, during the initial tour of the kitchen, the surveyor observed that a large bowl of beefaroni meal, tomatoes, carrots and cheese in the refrigerator were not dated or labeled with an expiration date. The sour cream also did not have an open date and the frozen vegetables and French fries in the freezer had no expiration dates. On the same day at 08:38 am, the Dietary Manager Staff #12 stated that the beefaroni meal was prepared on 01/07/2025 and was to be used as resident's dinner on 01/08/2025. She stated that the meals and other items should have been dated and labeled accordingly, and she proceeded to date and label them.<br><br>3) On 01/08/25 at 08:42 AM, during the initial tour of the kitchen, Dietary Aide staff #13 was seen without a beard cover while handling the resident's food from the cook to the meal cart. When he was asked about the beard cover, he stated that he did not know that he needed to wear one.<br><br>On 01/09/25 08:06 AM during a follow-up visit to the kitchen, 2 Dietary Aides (Staff #13 and #14) were both seen handling residents' food from the cook to the meal cart without bear covers despite having beards. Dietary Staff #13 stated that he had informed the Dietary Manager about it and that it was being ordered.<br><br>On 01/09/25 at 08:23 AM, the Dietary Manager Staff #12 and the Administrator were informed about the concerns with the beard covers and the Administrator stated that he had placed orders for the beard cover which should be arriving soon. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>50904<br><br>Based on observation, review of resident's immunizations records, and interviews with residents and facility staff, it was determined that the facility failed to 1) prevent infection in a resident with an indwelling catheter and failed to protect the resident's dignity, 2) perform Tuberculosis screening on all admissions, and 3)ensure that medication administration methods were free from contamination in a manner that minimized the potential spread of infection. This was evidenced by 2 residents (Residents #57 and #207) of 36 residents reviewed during the recertification/complaint survey, and a Registered Nurse (RN) (Staff#43), not sanitizing hands between residents during medication administration during this recertification/complaint survey.<br><br>1) On 01/08/25 at 12:21 PM during an initial tour of the facility, the surveyor observed that Resident #207's Foley bag was seen on the floor in a pillowcase. LPN staff#6's attention was called to see resident Foley's bag. When she was asked what was used to cover the Foley bag, she stated that it was a pillowcase and stated that she was not the person who put the bag in a pillowcase and that it was not the right thing to use. Then, she went ahead to remove the pillowcase and tied the Foley bag to the side of the bed and off the floor. Resident #207 mentioned to the nurse and surveyor that the Director of Nursing had put the Foley bag in the pillowcase.<br><br>On the same day at 12:32 PM, the surveyor also observed that Resident #57's Foley bag was seen on the floor in a pillowcase. LPN #7's attention was called to see resident's Foley bag. When she was asked what was used to cover the folly bag, she stated that it was a pillowcase and went ahead to remove it. She told the surveyor that she knew that it should not be on the floor and that the pillowcase was not the right thing to use for the bag and did not know what could be used instead of the pillowcase.<br><br>On the same day at 12:50 PM, the surveyor met with the Director of Nursing (DON) in the Hallway and was informed about the identified concerns and she stated that she knew the pillowcase was not the right thing to use and that she improvised. She added that the Geriatric Nursing Assistants (GNAs) must have left the Foley bags on the floor during the resident's care. She also informed the surveyor that the facility had ordered some dignity bags which would be used to cover the Foley bags.<br><br>51213<br><br>2) On 1/13/25 at 11:15 AM, record review of resident's immunizations revealed that Resident #57 was given step 1 of the purified protein derivative (PPD) skin test to screen for Tuberculosis (TB) on 8/23/24. Review of the Medication Administration Record (MAR) revealed no documentation that step 2 PPD skin test was administered to Resident #57.<br><br>On 1/13/25 at 1:15 PM the surveyor asked the IP nurse Staff #1 and the Director of Nursing (DON) if they could provide any documentation for Resident #57, showing that their step 2 PPD skin test was given. They replied they do not have any documentation that Resident #57 received their second PPD skin test.<br><br>49409<br><br>(continued on next page) |

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| | 215220 | A. Building<br>B. Wing | 01/16/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) During the medication administration observation on 01/15/25 at 11:34 AM, observed RN, Staff #43, medication administration for residents #13, #34, #36, #48, and #51. RN Staff # 43 failed to clean hands between resident medication prep and going room to room. During the middle of the medication administration, one of the residents asked for assistance to open a beverage bottle, which Staff #43 opened without cleaning his/ her hands. Staff #43 administered medication to the residents in room # 9 and did not use sanitizer or wash hands before going to another room. Staff #43 said he/she uses the dispenser on the wall frequently but forgot this time.<br><br>In an interview with RN, staff #43, on 01/15/25 at 12:30 pm, he/she stated that he/she used the medication container lid to measure Miralax powder and put the cap back on the container, after measuring.<br><br>On 01/15/25 at 12:40 PM, an interview with the Assistant Director of Nursing (ADON) revealed that using the medication container lid to measure the medication is breaching the principles of infection control, as the medication does come in contact with an external surface of the lid, and possibly hands may come in contact with the medication.<br><br>These concerns were brought to the attention of the Director of Nursing on 01/15/25 at 1:30 PM. |

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| F 0943<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.<br><br>43096<br><br>Based on record review and staff interview, it was determined the facility failed to provide evidence that all nursing staff had received education on abuse, neglect, and exploitation training annually. This was evident for 6 (nurse #11, #28, #38, and Nurse Aides #35, #39, and #40) of 6 nursing staff training records reviewed during the recertification/complaint survey.<br><br>The findings include:<br><br>On 1/15/25 at 11:29 AM, the surveyor reviewed randomly selected six nursing staff ( nurse #11, #28, #38, and Nurse Aides #35, #39, and #40) employee files for their training records from 2022 to current. The review revealed that a Registered Nurse ( RN #11) was hired in June 2019, a Licensed Practical Nurse (LPN #28) was hired in January 2023, and LPN #38 was hired in May 2022. There was no abuse, neglect, and exploitation training for all of them. Also, the Geriatric Nurse Aide #40 (hired in September 2017), #39 (hired in March 2019), and #35 (hired in January 2023) did not have any training records for abuse, neglect and exploitation annually.<br><br>During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 1/15/25 at 12:26 PM, the DON stated that the facility offered abuse training annually and/or when an abuse incident occurred. She also added that she had the nursing staff's in-service training records. The surveyor requested that all the training records for the nursing staff regarding the required annual training, abuse, neglect, and exploitation be submitted.<br><br>On 1/15/25 at 2:06 PM, the NHA provided documentation for staff education, including abuse, neglect, and exploitation in 2023. However, he confirmed that the facility had no records for 2022 and 2024. |