STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215226	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab at Autumn Lake Healthcare	515 Brightfield Road Lutherville, MD 21093

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50385 Based on observations and staff interview, it was determined that the facility failed to treat each resident with dignity by not ensuring that residents' foley drainage bags were covered. This was evident for 2 (Resident #1 and Resident #504) of 5 residents reviewed for dignity. The findings include: A foley drainage bag, or urinary drainage bag, is a medical device used to collect urine from a catheterized patient. The drainage bag is usually worn on the leg or attached to a bed. During observation rounds on 6/12/24 at 7:50 am, Resident #1 was noted to have a foley catheter bag attached to their bed. The foley drainage bag was uncovered and had amber colored liquid. The bag was attached to the door side of the bed. Resident #1's door was open, and the foley drainage bag was visible from the hallway. On 6/12/24 at 7:54 am, the surveyor interviewed Unit Manager Licensed Practical Nurse (LPN) #6. When asked if residents with foley bags should have covers on the bags, LPN #6 stated foley bags should be covered and that she would ensure that the foley bags were covered. On 6/24/24 at 2:01 PM, Resident #504 was observed ambulating in a wheelchair in the hallway of Unit 3. Attached to the wheelchair was a foley bag with amber colored liquid visible in the bag. There was no covering on the foley bag.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50385 Based on record review and staff interviews, it was determined that the facility failed to ensure that a current copy of a resident's advance directive was in the resident's medical record. This was evident for 1 (Resident #512) of 5 residents reviewed for advanced directives. The findings include: During Record review on 6/13/24 at 1:45 PM, there was no record of an advance directive in Resident #512's electronic chart or paper chart. Based on medical records, the resident was admitted on [DATE]. On 6/13/24 at 2:15 PM, in an interview with the Director of Nursing (DON #17), DON #17 stated that the resident did have a Medical Orders for Life-Sustaining Treatment (MOLST) form created on 5/31/2024. DON #17 provided a copy of resident's MOLST form, which was signed by Doctor #31 on 5/31/2024. DON #17 stated the Doctor had completed the form and left the MOLST form on their desk instead of placing it in the paper chart or uploading it in the electronic chart. The MOLST form was not in Resident #512's chart for nursing staff to use from 5/30/2024 until 6/13/2024. DON #17 stated that if a resident does not have a MOLST or advanced directive then the resident would be considered Full Code. On 6/17/24 at 10:33 AM, the surveyor reviewed the paper chart after surveyor intervention, and a copy of MOLST form was placed in the chart. On 06/17/24 at 1:00 PM during a follow up interview with DON #17, the DON states Medical Director, Doctor #32, addressed Doctor #31 regarding the MOLST form issue.

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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. 42782 Based on record review and interview it was determined that the facility staff failed to notify the state agency of an alleged case of abuse within the 2-hour allotted timeframe and failed to report allegations of abuse to the state health department and to law enforcement. This was found to be evident for 2 (Resident # 83 and Resident #101) of 15 residents reviewed for abuse during the facility's survey. The findings include: 1. On 06/18/24 at 9:20 am surveyor received a copy of the facility's investigation of the facility reported incident MD00183880. Review of the self-report form revealed the alleged incident occurred on 09/25/22 during 3 pm to 11 pm shift. The alleged incident was reported to the state agency on 09/26/22 at 1 pm which was outside of the 2-hour allotted timeframe for reporting alleged abuse case. On 06/20/24 at 10:34 am a review of the facility's Abuse, Neglect, and Exhibition policy revealed under Section VII Reporting Abuse Reporting of all alleged violations to the Administrator, state agency, Adult Protective Services and to all other required agencies immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. On 06/21/24 at 10:29 am during an interview with Administrator #3 who verbalized any concern is followed up with them and the Director of Nursing. They discuss the issue and determine if it is reportable. For alleged abuse cases they are reported within 2 hours. Interviews are done with staff, residents, and witnesses. The police are notified; the alleged employee is suspended. Other residents are interviewed to see if there are any concerns. Administrator #3 was made aware the facility reported incident was reported outside of the allotted 2-hour window, verbalized understanding. 30440 2. During a screening of residents during the facility's annual survey, resident # 83 was interviewed by two surveyors and the resident stated that an agency Registered Nurse (RN) (# 53) was very disrespectful when s/he asked the nurse for a shower. The resident further stated that s/he was called out of their name and the nurse (# 53) was verbally abusive. The resident went on to say that s/he does not feel safe receiving medications from the nurse and that s/he spoke to the Director of Nursing (DON) (# 17) about this incident. On the same date at 9:15 AM an interview was conducted with the DON and the Administrator (# 3), and they were made aware of resident # 83's concerns. The DON stated that she spoke with the resident on 6/11/24 regarding the resident concerns. During a subsequent interview with the DON on 6/12/24 at 1:30 PM, she was asked if the facility reported the abuse allegations to the state office and she responded, no. The DON was asked if law enforcement was notified and she responded, no. She acknowledged that all allegations of abuse are to be reported immediately within the two (2) hour required time frame. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 2:00 PM, the DON informed the survey team that the abuse allegations were reported to the Office of Health Care Quality and provided a copy of the initial report to the survey team. All concerns were discussed with the Administration team at the time of exit on 6/28/24 at 3:00 PM.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 30440 Based on administrative record review and interviews with facility staff, it was determined the facility failed to complete a thorough investigation and maintain documents regarding allegations of resident abuse. This was found to be evident for 4 (Resident #424, Resident #101, Resident #120, and Resident # 99) of 25 residents reviewed for abuse during the facility's survey. Findings include, 1. MD00190231 was reviewed on 6/17/24 at 12:30PM for allegations of abuse. The survey team requested a copy of the facility's investigation for the incident that occurred on 2/27/23 with Resident #424. On the same date at 1:30PM the Regional Nurse (Staff # 9) provided the survey team with a copy of the investigation and upon review, it included the following documents: a list of the resident's diagnosis, an initial 5-day report and a summary page. There were no interviews with residents or staff and no signed statements. The DON was interviewed on the same date at 1:45 PM and she was asked if the facility had any additional documentation of resident and staff interviews as part of their investigation and she stated, no. She further stated that the facility obtained new ownership in May 2023. The DON went on to say that part of completing a thorough investigation is interviews of staff and residents to determine if or not abuse occurred. The DON stated that education would be provided to the staff. On 6/17/24 at 1:45PM the DON provided the survey team a typed statement from the Director of Guest Services (# 22). In the statement, staff # 22 indicated that at the time of the incident residents were interviewed and a handwritten copy of the interviews were provided to the DON. This document was not included in the facility's investigation. The DON again confirmed that they are unable to produce documentation of residents and staff interviews. 42782 2. On 06/18/24 at 9:20 AM, a review of the facility reported incident MD00183880 revealed Resident #101 reported verbal abuse from a Registered Nurse (RN) #50. Further review of the investigation revealed a Geriatric Nursing Assistant (GNA) notified RN#50 of the alleged verbal abuse, but a statement from the GNA was not included in the investigation. The resident was interviewed by Unit Manager #51, but there was not a statement for the surveyor to review. Also, a statement from Resident #101 was not included in the investigation. On 06/21/24 at 10:29 am during an interview with Administrator #3 the surveyor verbalized different parts of the investigation were missing. Administrator #3 verbalized the case happened prior to the change of ownership of the building and that was all that was in the record. 42863 3. The surveyor reviewed MD00165055 on 06.18.24 at 10:30 AM related to a facility reported incident (FRI) dated 03.14.2021. The facility reported that Resident #120 accused RN staff #27 did not stop pushing while administering an enema as requested by the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06.18.24 at 09:15 AM the surveyor interviewed the regional nurse, staff # 9. Staff # 9 stated that the facility incident reports prior to the year 2023 may be in storage and would take a couple of days to retrieve. During an interview with staff #9 on 06.18.24 at 10:38 AM stated that she was not able to find the complete facility report for Resident #120. However, she would look within the system to try to retrieve additional information. The surveyor requested the hard copy of Resident #120's closed record and FRI for the second time on 06. 21.24 at 11:40 AM. The facility failed to provide the complete facility report by the close of the exit conference on 06.28.24 at 3:00 PM. The facility reported incident documents provided did not include any documentation related to post event educational training of facility staff related to resident rights, abuse training, or documentation or the suspension of the alleged perpetrator, RN #27 immediately after the incident was reported by Resident #120. 50457 4. On 6/17/24 at 12:36 pm, the surveyor received a copy of the facility's self-report investigation MD00166760 for Resident #99. The report revealed physical abuse allegation from Geriatric Nursing Assistant (GNA) #51. Further review of investigation revealed no staff interviews or staff written statements, and there was not a copy of the 5-day investigation results. During an interview on 6/21/24 at 10:31am, Administrator #3 and Regional Nurse #9 regarding the process for reporting abuse allegations, the Administrator #3 explained that all grievances reported by staff should be reported to either the Administrator or Director of Nursing. The alleged staff member would be suspended pending an investigation and written statements are gathered from alleged staff members. On 06/21/24 at 11:29 am during an interview with Administrator #3 and Regional Nurse #9, who verbalized that the facility did not have a complete investigation file for MD00166760. All concerns were discussed with the administrative team at the time of exit on 6/28/24 at 3:00PM.

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F 0625 Level of Harm - Minimal harm or potential for actual harm 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. 50385 Based on record review and staff interviews, it was determined that the facility failed to provide to the resident a copy of the completed bed hold policy prior to transfer. This was evident for 1 (Resident #1) of 4 residents reviewed for transfer and discharge. The findings include: On 6/17/24 at 9:21 AM, a review of the medical records revealed the resident was sent to the hospital on 6/14/2024. A bed hold notice was identified in the resident's paper chart. The bed hold notice had not been completed and notes [resident's son] approved Bed hold policy via phone initialed KC on the side of the form. The resident's name was not on the bed hold notice nor any of the other fields completed on the form. According to the medical record, the resident was his/her own representative. On 6/17/24 at 2:05 pm, an interview was conducted with Licensed Practical Nurse (LPN) #23. LPN #23 was asked what is expected when notice of transfer is presented to a resident? LPN #23 responded, The resident or representative will sign the notice if they are capable. When asked if Resident #1 could sign the notices prior to discharge, LPN #23 stated, that day he/she was drowsy, and I didn't think he/she was able to sign. When asked if LPN #23 documented this in the resident's chart, the LPN stated, No, I did not. When asked if LPN #23 gave a copy of the notice to the resident prior to discharge, the LPN stated, No I did not.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49304 Based on interview with the resident, review of medical records, and interview with facility staff, it was determined that the facility failed to provide a baseline care plan summary to residents. This was evident for 1 (#85) of 5 residents reviewed for baseline care plan summaries during the survey. The Findings Include: On 6/13/24 at 11:30AM, in an interview with Resident #85, they stated they have not been invited to a care plan meeting nor received a baseline care plan summary or baseline care plan. On 6/14/24 at 1:15 PM, review of the medical record did not reveal any evidence that Resident #85 was given a baseline care plan summary or a copy of a baseline care plan. On 6/21/24 at 10:37 AM, in an interview with the Director of Social Services (DSS) #2 she stated she did not have a baseline care plan for Resident #85. During the interview, she further stated that the nurses could not find a progress note or provide any additional documentation to show as evidence that Resident #85 was given a baseline care plan or baseline care plan summary.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 30440 Based on interview and medical record review, it was determined the facility failed to ensure comprehensive care plans were developed and implemented. This was found to be evident for 2 (Resident #112 and Resident #85) of 18 residents reviewed for care plans during the facility's survey. Findings include: 1. 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 they receive in a facility. It should describe the resident's goals and desired outcomes, the care/services that will be furnished, the resident's discharge plans, and refusals of care and action taken by facility staff to educate the resident. Review of Resident #112's medical record revealed the resident was admitted with the following but not limited diagnosis: Type 1 Diabetes Mellitus (a lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels). MD00203565 was reviewed on 6/25/24 at 4:00 PM for allegations of neglect in which Resident #112 reported not receiving insulin medication when at the facility. The allegation was unsubstantiated. Further record review on the same date revealed resident #112 receives insulin (a hormone that lowers the level of glucose in the blood), however there was no Diabetes care plan in place. An interview was conducted with the DON (# 17) and Regional DON (# 9) on 6/26/24 at 9:45 AM and she was made aware that resident #112 did not have a diabetes care plan. The DON went on to explain that a care plan should have been developed for the resident, specifically to address the resident care concerns related to Diabetes and that education would be provided to her staff. . All concerns were discussed with the administrative team at the time of exit on 6/28/24 at 3:00 PM. 49304 2. On 6/13/24 at 11:31 AM in an interview with Resident #85 they stated they had not been invited or participated in a care plan meeting. Resident #85's medical record was reviewed on 6/14/24 at 1:15PM and revealed the resident's diagnoses included chronic obstructive pulmonary disease, emphysema, atrial fibrillation, and atherosclerotic heart disease, all of which can affect a person's breathing and respiratory care and services needed. However, there was no respiratory care plan that identified a focus, goal, or intervention to address the resident's respiratory care or services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/24 at 3:36 PM, review of the facility's Oxygen Administration policy revealed, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Further review revealed Policy Explanation and Compliance Guidelines section: The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment settings for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 30440 Based on interviews with the resident and facility staff and record reviews, it was determined the facility failed to follow professional standards of nursing practice when administering medications to residents. This was found to be evident for 5 (Resident #60, #15, #502, and #509, #102) of 76 residents reviewed during the survey. The findings include: 1.) Resident # 60 was admitted with the following but not limited diagnosis: Chronic Pain An interview was conducted with Resident # 60 on 6/13/24 at 11:15 AM and the resident stated that s/he cannot get medications on time. The resident went on to say that s/he puts the call light on at 2:00 PM to receive PRN (as needed) oxycodone (a controlled medication used to treat moderate to severe pain) and the medication is not given until 4:00 PM, after the next shift comes on duty. The resident also stated that his/her scheduled medications are given late as well. The DON was made aware of the resident concerns on 6/13/24 at 1:45 PM and a request was made by the survey team for access via point click care electronic computer system to review the medication administration audit reports. The facility later provided a copy of the medication administration audit report for Resident # 60. Upon review of resident # 60 medication administration audit report on 6/21/24 at 10:00 AM for the dates: 6/12/24 -6/13/24, it revealed the following: 1. HCL 5 mg (1) tablet every 4 hours for pain was documented on 6/12/24 as administered at 16:11 PM (4:11 PM). 2.Voltaren Gel 1% Apply to back three times a day for pain scheduled for 6/12/24 at 14:00 PM (2 PM) and the documented administration time is 6/12/24 at 16:11 PM (4:11 PM). 3.Cephalexin Oral 500 mg 1 tablet every 12 hours for urinary tract infection (UTI) until 6/16/24 scheduled for 6/13/24 at 9:00 AM and the documented administrated time is 6/13/24 12:53 PM. 4.Apixaban 5 mg 1 tablet two times a day for Atrial Fibrillation (irregular heartbeat) scheduled for 6/13/24 at 9:00 AM and the documented administration time is 12:53 PM. 5.Lamotrigine 200 mg 1 tablet two times a day for Schizoaffective Disorder (Mental Health Disorder) scheduled for 6/13/24 at 9:00 AM and the documented administration time is 12:53 PM. 6.Lidocaine External Patch 4% apply topically 1 time a day for pain scheduled for 6/13/24 at 9:00 AM and the documented administration time is 12:53 PM. 7.Amiodarone HCL 200 mg 1 tablet two times a day for Atrial Fibrillation scheduled for 6/13/24 at 9:00 AM and the documented administration time is 12:53 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8.Gabapentin Capsule 400 mg 2 tablets two times a day for neuro pain scheduled for 6/13/24 at 9:00 AM and the documented administration time is 12:53 PM. 9.Metformin 500 mg 1 tablet two times a day for Diabetes Mellitus scheduled for 6/13/24 at 9:00 AM and the documented administration time is 12:54 PM. 10.Sennosides-Docusate Sodium 8.6-50 mg 2 tablets two times a day for constipation with parameters scheduled on 6/13/24 at 9:00 AM and the documented administration time is 12:54 PM. 11.Lisinopril 10 mg 1 tablet one time a day for Hypertension (HTN) with parameters scheduled on 6/13/24 at 9:00 AM and the documented administration time is 12:54 PM. 12.Risperidone 3 mg 1 tablet two times a day for schizoaffective disorder scheduled on 6/13/24 at 9:00 AM and the documented administration time is 12:54 PM. 13. Multivitamin 1 tablet one time a day for supplement scheduled on 6/13/24 at 9:00 AM and the documented administration time is 12:54 PM. 14.Lactulose 20 gm/30 ml give 30 ml two times a day for constipation with parameters scheduled on 6/13/24 at 9:00 AM and the documented administration time is 12:54 PM. An interview was conducted with the DON on 6/21/24 and she stated that the facility has identified this as a concern and is currently educating staff regarding giving medications within the time frame of one hour before or after the scheduled time and PRN pain medication when requested. 49304 2.) It is a standard of nursing practice to document administered medications immediately after administration. Failing to do this results in an inaccurate record where it cannot be determined when a medication was actually given and has the potential to result in medication errors (such as a resident receiving a dose twice, or two doses of a medication being given too close in time). Resident #15's medication administration audit record (MAAR) was reviewed on 6/20/24 at 2:05 PM for the period of 5/1/24 to 6/20/24. The review revealed multiple staff documenting medication late with some medication documented up to 7 hours late. In an interview with the DON, on 6/21/24 at 1:39 PM, made aware of the above concerns and when asked about the expectation regarding medication administration times, she stated the expectation is to administer 1 hour before or 1 hour after the ordered time and to document the medication after it is administered. 3.) Resident MAARs were reviewed for the following residents: Resident #502 on 6/25/24 at 11:29 AM for the period of 12/7/2022 to 1/14/2023 Resident #509 on 6/24/24 at 3:01 PM for the period of 2/1/23 to 2/25/23 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of these MAARs demonstrated a pattern of multiple staff documenting medications late with some medications documented several hours late. All concerns were discussed with the Administration team at the time of exit on 6/28/24 at 3:00 PM. 50457 4.) On 06/20/24 at 1:29 pm A review of the medication administration audit for Resident # 102 revealed that it was documented multiple doses of Tylenol 500 mg 2 tablets were not given as ordered. Tylenol Extra 500 mg (two tablets) was scheduled to be administered on 05/17/24 at 2:00 pm. However, the medication was given at 7:40 pm. Tylenol Extra 500 mg (2 tablets) was scheduled on 05/14/24 2:00 pm and given at 05/14/24 at 7:03 pm. Tylenol Extra 500mg (2 tablets) was scheduled on 05/04/24 2:00 pm and given at 05/04/24 at 4:07 pm. Tylenol Extra 500mg (2 tablets) was scheduled on 05/01/24 2:00 pm and given at 05/28/24 at 3:58 pm. Tylenol Extra 500mg (2 tablets) was scheduled on 04/15/24 2:00 pm and given at 04/15/24 at 4:37 pm. On 06/21/24 at 1:32 pm during an interview with Director of Nursing (DON) #17 regarding the expectation of medication administration, the DON #17 reported that scheduled medications can be administered up to one hour before or one hour after the due time. DON #17 also mentioned that medication administration audits are overseen by nursing leadership which includes DON#17, Assistant Director of Nursing #8, and the Unit Managers. DON #17 was made aware of the multiple doses of documented late medication administration for Resident #102.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 42863 Based on record reviews and interviews the facility failed to provide ADL's (activities of daily living) such as showers according to the resident's preference. This was determined to be true for 1 (Resident # 44) out of 6 residents reviewed for ADL care during the survey. The findings include: At 2:50 PM on 06.18.24 the surveyor spoke with Resident #44 in his/her room. Resident was observed sitting in a wheelchair dressed in clean civilian clothes. The resident stated that s/he had recently moved from the first floor to the second floor within the last week. Resident #44 stated that he/she had received a shower only twice within the last month. This resident stated that her preference was to receive a shower twice per week. Additionally, the resident stated that he/she had discussed this concern with the unit manager and DON within the last month. On 06/20/24 at 01:56 PM Resident #44 stated that he/she was promised to receive a shower on Wednesday and Saturdays. Also, the Resident stated that he/she must be placed in a shower chair for the Geriatric Nursing Assistant (GNA) to provide the shower in the shower room. On 06.20.24 at 2:10 PM the surveyor reviewed the electronic task documentation form that was completed by the geriatric nursing assistants (GNA)'s assigned to Resident #44 which documented that the resident had refused a shower on 06.14.24 and 06.19.24. On 06/20/24 02:15 PM the surveyor spoke with the nurse manager, LPN # 10. The surveyor asked if he/she had spoken with the resident recently. The nurse manager, LPN #10's response was, no and stated that he had planned to meet with the resident this afternoon to discuss some areas of concern related preferred days to shower. On 06/20/24 at 3:15 PM the DON provided the surveyor with a hard copy of the Task form for the month of June 2024. The surveyor reviewed the task form with the DON and ask why there were blank spaces for some dates related to the Resident #44 either receiving or not receiving a bath or shower. The DON stated that the GNA staff would be reeducated regarding the responsibility to accurately document on the task form. On 06.28.24 at 11:30 AM the surveyor received a hard copy of the task form for the month of June 2024. The June task form indicated that on 06.2: no shower was provided, 06.05: there was no data entry for a shower or bath, on 06.08: resident received a shower, for the following dates: the data entry slots were left blank for the following regarding showers: 06.09, 06.15, 6.18, 6.19, 6.21, 6.22, 6.25. The task form document for 17th and 23rd of June showed the resident received assistance with bathing. In summary, the task form record showed the resident was documented as receiving three showers in the month of June 2024 which were on the 8th , the 14th and the 26th. The deficient practice was reviewed with the unit manager, LPN # 10 and the DON prior to the exit conference on 06.28.24.

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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. 49304 Based on observations, review of medical records, and interview with facility staff, it was determined that the facility failed to follow physician orders as evidenced by: 1) ensuring ordered ACE wraps were in place, 2) administering medication as ordered by the physician, and 3) a resident not receiving the ordered amount of oxygen. This was evident for 3 (Residents #40, #15, #37) of 9 residents reviewed during the survey. The findings include: 1) On 6/13/24 during initial tours of the facility and multiple surveyor observations of Resident #40 with the last observation of the day made at 2:12 PM, Resident #40 was observed without any ACE wraps in place anywhere on the resident. Medical record review for Resident #40 on 6/14/24 at 10:20 AM revealed multiple diagnosis including lymphedema, essential (primary) hypertension, pulmonary embolism, personal history of transient ischemic attack, atherosclerotic heart disease of native coronary artery, and chronic kidney disease, stage 4 (severe). Furthermore, Resident #40's physician orders were reviewed and noted the following, ACE wraps toes to knees on in am, off in pm, one time a day for edema, with a facility time code noted as QD 9a (every day at 9:00 AM). The order was created by Physician #31 on 6/12/24 at 5:33 PM. Resident #40 was observed again on 6/14/24 at 10:30 AM. The resident was lying in bed and at that time no ACE wraps were observed on the resident. Surveyor observed on 6/18/24 at 9:21 AM, the resident was lying in bed with no ACE wraps observed on their legs. On 6/18/24 at 10:01 AM, in an interview with Licensed Practical Nurse (LPN) #54, when asked about Resident #40's ACE wraps for his/her legs, she stated this is my first day ever working in this building. When asked if LPN #54 had reviewed Resident #40's orders, she indicated she had not logged on to the system yet as she had a log in, but it had to get reset. On 6/18/24 at 10:09 AM in an interview with Unit Manager (UM) #6, when asked the process for when staff do not have access to the electronic health record (EHR), she stated they can come to one of us [clarified us as the UM, Director of Nursing (DON), or Assistant Director of Nursing (ADON)] and we can email IT (information technology for the EHR). They can also call the IT number. The response time is sometimes quick and sometimes not. During the interview, when asked why Resident #40 was ordered ACE wraps she stated, he/she has lymphedema. When asked when they are to be applied, UM #6 stated, in the morning and removed at night. When asked about the application and removal time on the order, she looked in the EHR and stated, it seems the doctor came in after [me] and also created an order. UM #6 stated, I will update and get rid of one of these orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The second order stated, Apply ace wraps to BLEs (bilateral lower extremities) on in the morning and remove at bedtime every evening and night shift for lymphedema with a facility time code of 3-11/11-7 (ace wraps removed for the 3PM-11PM and 11PM-7AM shift). Therefore, per this order, starting at 7:01AM, the ACE wraps should have been applied to both of the resident's lower legs. When asked why the ACE wraps were not currently on Resident #40's legs, UM #6 stated, Clarification of the orders since there are two ACE wrap orders. However, either order a staff member read in the EHR, the ACE wraps should have been applied to the resident's legs [per the physician orders] at all the above times the resident was observed without ACE wraps. 2) On 6/13/24 10:24 AM in an interview with Resident #15, they stated there are times when they are in pain because their pain medicine has run out and they have to wait for it. Medical record review for Resident #15 on 6/17/24 at 10:33 AM revealed on 4/22/24 the physician ordered: Ibuprofen Oral Tablet 400 MG (Ibuprofen), Give 2 tablet by mouth every 6 hours as needed for pain 1-3, Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate) *Controlled Drug*, Give 1 tablet by mouth every 4 hours as needed for Pain scale 4-5, Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate) *Controlled Drug*, Give 2 tablet by mouth every 4 hours as needed for pain scale 6-10. On 6/21/24 at 12:57 PM review of the Medication Administration Record (MAR) revealed the facility staff documented on: 5/27/24 at 5:00 PM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 5/29/24 at 9:01 AM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 5/31/24 at 5:53 PM a pain score of 8 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 5/31/24 at 10:03 PM a pain score of 8 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/1/24 at 3:00 AM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 6/1/24 at 9:19 AM a pain score of 6 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/1/24 at 2:02: PM a pain score of 8 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/1/24 at 5:55 PM a pain score of 5 and administered 2, 400mg tablet of Ibuprofen Oral Tablet, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/2/24 at 6:13 AM a pain score of 6 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/4/24 at 12:30 AM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 6/4/24 at 4:00 PM a pain score of 4 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 6/11/24 at 12:30 AM a pain score of 0 and administered 2, 15mg tablet of Morphine Sulfate Tablet; however, the documented pain scale and pain medications administered were outside the parameters as indicated by the physician. Interview with the DON and ADON on 6/21/24 at 1:27 PM were notified of the concerns related to administration of pain medication outside of the physician ordered parameters for Resident #15. 50457 3) On 06/13/24 at 09:49 am the surveyor observed Resident #37 resting in bed with oxygen tubing in their nose and the oxygen concentrator was set to humidified 3 liters(L) of oxygen (02) via nasal cannula (NC). On 06/13/24 at 1:43 pm A review of the medical record revealed an order dated 05/02/24, at 6:39 pm for Resident #37 to receive 2 liters of oxygen via nasal cannula continuously. It also specified that after every shift post treatment the resident's heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds should be evaluated. On 06/17/24 at 11:54 am, Resident #37 was observed resting in bed with humified oxygen set at 3L via NC. On 06/17/24 at 11:55 am during an interview with the resident's assigned nurse LPN #14, the surveyor asked how many liters of 02 Resident #37 was ordered. LPN #14 stated it was set to 2 liters. LPN #14 and the surveyor entered Resident #37 room and confirmed that the oxygen concentrator was set at 3 liters. LPN #14 reported they would contact the resident's doctor for a new oxygen order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49304 Based on surveyor observations, review of the medical record, and interview with facility staff, it was determined the facility staff failed to provide residents with respiratory care consistent with professional standards by failing to ensure there was a physician order for oxygen administration/indication, failing to administer oxygen as prescribed, and failing to develop plans of care to address the resident's respiratory needs. This was evident for 1 (#85) of 3 residents reviewed for respiratory care during the investigation phase of the survey. The findings include: Oxygen flow meters are a relatively simple device that consist of a tube through which gas passes and a small, free-moving indicator such as a ball. When valves are open, the gas moves through the flow meter and causes the ball to float. A numbered scale on the tube along with the indicator allows the healthcare provider to determine the flow rate of oxygen. To ensure the most accurate reading of the flow rate, read the flow meter from a close distance, straight in front of the meter, and at eye level with the indicator. On 6/13/24 at 11:32 AM Resident #85 was observed receiving oxygen via nasal cannula at a flow rate of 2.5 Liters per minute (L/min). A nasal cannula is a device that delivers oxygen directly to a person's nostrils via a flexible plastic tube. On 6/14/24 at 1:19 PM during review of Resident #85's medical record, no physician order for oxygen could be found in the electronic health record (HER) or paper chart. Further review revealed Resident #85's diagnoses included chronic obstructive pulmonary disease, emphysema, atrial fibrillation, and atherosclerotic heart disease, all of which can affect a person's breathing and respiratory care and services needed. However, there was no respiratory care plan that identified a focus, goal, or intervention to address the resident's respiratory care or services. During a second observation that took place on 6/17/24 at 11:31 AM, Resident #85 was noted to still be receiving oxygen at a flow rate of 2.5 L/min. On 6/17/24 at 11:34 AM, in an interview with Licensed Practical Nurse (LPN) #19, when asked how many liters of oxygen Resident #85 was currently receiving, she stated they are on 3L. Upon surveyor intervention, LPN #19 bent down to eye level and stated, Oh, they are on 2.5 L, but they are supposed to be on 3 L. When asked how many liters the order stated the resident is supposed to be receiving, LPN #19 looked in the EHR and stated, it is not on their treatment administration record (TAR), and not under their physician orders. When asked if there should be a physician order for a resident to be on oxygen, LPN #19 stated, yes. LPN confirmed there was no oxygen order for Resident #85 in the EHR. On 6/17/24 at 12:15 PM in an interview with LPN #19, she stated I could not find an oxygen order for the resident in the paper chart. She also stated, I notified the Unit Manager (UM) #10 and he is going to follow up with the doctor(Staff #31.) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/24 at 12:19 PM in an interview with UM #10, when asked about an oxygen order for Resident #85, he stated, I did not see there was one. I am trying to figure out what they were on it for. I think it was just for comfort in the hospital. When asked if there should be a physician order for residents receiving oxygen he stated, Yeah, there should be an order for a resident to be on oxygen. On 6/17/24 at 1:03 PM, the Director of Nursing (DON) was made aware of the findings. During the interview, she confirmed there should be an oxygen order for residents receiving oxygen. On 6/17/24 at 2:42 PM in an interview with the DON she stated, I just talked to the medical director and will bring a copy of the oxygen order. On 6/17/24 at 3:36 PM, review of the facility's Oxygen Administration policy stated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Further review revealed Policy Explanation and Compliance Guidelines: 1.Oxygen is administered under orders of a physician, except in the case of emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 3. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment settings for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen. On 6/17/24 at 3:46 PM, the DON provided a copy of an oxygen order for Resident #85 that stated, oxygen 2 liters via nasal cannula every shift for COPD, with an order date of 6/17/24 at 3:44 PM. A third observation of Resident #85's oxygen rate was made on 6/18/24 at 10:47 AM. The oxygen rate at that time was noted to be 2.5 L/min. On 6/18/24 at 10:57 AM in an interview with LPN #28, she stated the only one [resident] who has oxygen on my assignment is Resident #85 and they are receiving 2L. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/24 at 11:16 AM, LPN #28 entered Resident #85's room and reported the resident was receiving 3L and she did not even realize they were supposed to be on 3L of oxygen [surveyor observed resident on 2. 5L]. When asked about the resident's oxygen order, LPN #28 pulled up the resident's orders in the EHR and stated the resident is ordered 2L NC. LPN #28 re-entered the resident's room at 11:19 AM and adjusted the knob on the oxygen flow meter stating the resident was now on the 2L of oxygen [surveyor observed resident on 1.5L]. Upon surveyor intervention, LPN #28 adjusted the knob on the oxygen flow meter to read 2L as per the physician order. On 6/18/24 12:30 PM Regional DON and DON made aware of the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48167 Based on observations and interviews the facility failed to properly monitor medications. This was evident in 1 out of 4 medication storage rooms and carts during the survey. The findings include: During observation rounds on [DATE] at 03:05 PM the following was found in the 1st floor Unit 2 medication room: 1 expired Influenza Vaccine Afluria Quadrivalent 5ml Multi-dose Vial with an expiration date of [DATE]. During an interview and observation round of the 1st floor Unit 2 medication room with Unit Manager staff #6 on [DATE] at 03:15 PM, staff #6 stated and confirmed that there was 1 expired Influenza Vaccine Afluria Quadrivalent 5ml Multi-dose Vial.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50457 Based on interviews and medical record reviews it was determined that the facility staff failed to schedule a dental appointment and arrange transportation to and from the dental appointment. This deficient practice was evident for 1 (#37) of 1 resident record reviewed for dental care during the survey. The findings include: On 06/13/24 at 9:28 am, during an interview with Resident #37, he/she reported that his/her bottom dentures were lost. He/she could not recall which staff member he/she reported the incident to, or the exact month it occurred. Review of the resident's personal belongs log in Point Click Care (PCC) revealed there was no documentation of the resident having dentures upon admission to the facility. The resident reported difficulty eating without having bottom dentures. During an interview with Director of Nursing (DON) #17 on 06/17/24 at 12:23 pm, the DON reported all resident's belongings are logged into PCC under the evaluation tabs at the time of admission, discharge, and readmissions. DON #17 explained that a grievance form would be completed for all reported missing or misplaced personal items. Residents are encouraged to report missing items to the Nurse Supervisor, Unit Manager, or Guest Services. On 06/17/24 at 12:23 pm the surveyor and DON #17 reviewed Resident #37's personal belongings log in PCC at the time of admission, which revealed the staff documented that Resident #37 had eyeglasses and an eyeglass case upon admission. On 06/17/24 at 1:10 pm, a review of the grievance form received from the DON#17 and completed by Director of Guest Services (DGS) #22 revealed that Resident #37's family member reported his/her lower dentures missing on 12/28/23 at 1:30 pm. DGS #22 spoke with Resident #37's family member and explained that the dentures were not listed on the personal inventory form. Resident #37's family member stated they would contact the resident's insurance company for a replacement. The grievance form noted that the facility staff would schedule a dental appointment for Resident #37 and the facility agreed to cover transportation costs. On 06/17/24 at 01:57 pm during an interview with DON #17 and Regional Nurse #9 regarding a resident's grievance, the surveyor inquired if the dental appointment and transportation had been arranged. DON #17 and Regional Nurse #9 were unable to confirm transportation arrangements were made. On 06/20/24 at 10:16 am a follow up with Regional Nurse #9 regarding the dental appointment and transportation arrangements. Regional Nurse #9 reported that there was no documentation to verify the dental appointment was scheduled or transportation arrangement were made.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49304 Based on record review and interview with facility staff, it was determined the facility failed to provide documentation whether a resident had signs and symptoms of abuse immediately following an allegation of abuse and failed to provide documentation to verify monthly pharmacy review was completed in 2024. This was evident for 3 (#508, #11, #21) of 15 residents reviewed during the survey. The findings include: 1) Review of the facility's Abuse, Neglect and Exploitation Policy on 6/25/24 at 3:01 PM revealed in the Investigation of Alleged Abuse, Neglect and Exploitation section, Written procedures for investigations include: Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation. Further review of the policy in the Protection of Resident section, Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed . Resident #508's medical record was reviewed on 6/26/24 at 11:22 AM. During the review, there was no evidence of documentation whether the resident had signs and symptoms of abuse promptly following an allegation of abuse. On 6/26/24 at 12:17 PM in an interview with the Assistant Director of Nursing (ADON), when asked for documentation the physician was notified, she stated I did not see a progress note or documentation that the physician was notified, but I did bring a copy of the x-ray ordered by the physician. Review of the Radiology Results Report on 6/26/24 at 12:44 PM revealed, Findings: There is shoulder arthritis .There is no acute fracture. However, the alleged abuse occurred on the 5/29/23 11PM-7AM shift and the x-ray order date and time was 5/31/23 at 10:18 AM. On 6/26/24 at 12:51PM in an interview with the ADON, when asked the expectation if a resident alleges abuse, she stated the expectation is that nurses complete a change in condition or risk management. On 6/26/24 at 2:00 PM, review of the facility's policy, Charting and Documentation revealed, All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Furthermore, it stated, All incidents, accidents, or changes in the resident's condition must be recorded. On ADON 6/26/24 at 2:18PM in an interview with the ADON she stated, I do not see a change in condition or risk management in the medical record for Resident #508. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 12:25PM in an interview with the DON, when asked after Resident #508 reported an allegation of abuse if a nurse assessed the resident, she stated the expectation was to complete a head to toe assessment and document a progress note or a change in condition. During the interview, she reported there was no progress note or change in condition from a nurse that is documented in the resident's medical record. 50457 2) On 06/17/24 at 11:30 am A review of Resident #11 and Resident #21, paper charts and electronic medical records, revealed there were no files or documentation to verify the monthly pharmacy reviews were completed. On 06/17/24 at 11:40 am During an interview with License Practical Nurse (LPN) Unit Manager (UM) #11 verbalized uncertainty about where to locate the pharmacy reviews. They mentioned that they would contact the pharmacy to obtain this information. The surveyor waited, but LPN UM #11 was unable to confirm the pharmacy reviews for Resident #11 and Resident #21 were completed. On 06/17/24 at 11:43 am During an interview with LPN #34, they checked Resident #11 and #21 charts for the pharmacy reviews and reported they did not see a pharmacy reviews for either resident. LPN #34 explained that when pharmacy reviews are received, the doctor reviews them, and decides the next course of action. However, LPN #34 was not sure about the process of how the pharmacy review is received. On 06/17/24 at 12:02 pm, during an interview with Director of Nursing (DON) #17, they explained that they print the pharmacy reviews, and the Medical Director reviews them. They also report that they keep copies of the reviews in a binder in their office. The surveyor accompanied the DON #17 to their office to review the requested pharmacy reviews for Resident #11 and Resident #21. DON#17 was unable to locate any pharmacy reviews for both residents. On 6/28/24 prior to existing the facility, the DON was not able to provide evidence of monthly pharmacy review for Resident #11 nor Resident #21.