STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegany Health Nursing and Rehab	730 Furnace Street Cumberland, MD 21502

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 18819 Based on reviews of the facility investigation and all pertinent administrative documents, a closed clinical record, and staff interview, it was determined that the facility failed to ensure that a resident remained free of abuse. This was true for 1 (Residents #901) of 11 facility reported incidents reviewed during an annual recertification survey. The facility implemented effective and thorough corrective measures following this incident prior to the start of this survey. The facilitie's plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 09/10/20. The findings include: The facility's investigation related to the facility reported the incident MD00157948 in which GNA2 was witnessed kicking Resident #901 on the right lower leg on 09/04/2020. This incident was reviewed by the survey team on 01/21/2025 at 1 PM. In the investigation, the facility substantiated through witnesses that GNA2 kicked Resident #901 on the right lower leg and created a skin tear. Resident #901 was attempting to remove food and meal trays from the food cart located at the third-floor nurses' station. The facility suspended GNA2 immediately upon report of the incident and began the investigation that substantiated the allegation. GNA2 was terminated by the facility on 09/04/2020. A review of LPN5's witness statement revealed that staff were wheeling residents to their rooms for the dinner meal. LPN5 witnessed GNA2 speak to Resident #901 and told her/him that S/he had already eaten his/her meal and to go back to his/her room. Resident #901 moved forward towards GNA2. That is when GNA2 became verbally aggressive and stated, I told you to move you already ate. Resident #901 then told GNA2 to leave her/him alone. GNA2 was then holding Resident #901's wheelchair handles trying to move Resident #901 backwards and kicked Resident #901 and attempted to move Resident #901. Resident #901 screamed out you kicked me, get away from me now and leave me alone. Resident #901 wheeled him/herself down the hall. LPN5 indicated S/he followed Resident #901 and when S/he approached LPN5 witnessed Resident #901 crying and observed the skin tear to the right lower leg. LPN5 indicated that S/he informed the supervisor of the incident. GNA2 was asked to leave the facility and later terminated. During an interview that took place with the Director of Nurses (DON) on 01/24/25 at 4:35 PM, the DON stated that all staff received abuse education, other residents were interviewed, and that this abuse incident was reviewed during the October 2020 QAPI meeting.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Allegany Health Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 730 Furnace Street Cumberland, MD 21502	

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observation, interview, record review, and policy review, the facility failed to ensure residents were free of physical restraints for one of 22 sampled residents (Resident (R) 44). R44 was observed in a geriatric chair and a wheelchair with an added lap tray which prevented R44 from standing up for staff convenience. This failure placed R44 at risk for increased anxiety, agitation, and a diminished quality of life. Findings include: Review of the facility's policy titled, Restraint Policy, revised May 2023 revealed Residents have the right to be free from a restraint of any kind and the right to function at their highest level in the least restrictive environment possible. Restraints will not be used unless the facility's interdisciplinary team has completed an assessment and evaluation to identify causative medical or environmental factors and has considered less restrictive alternatives, except in the case of an emergency . the use of restraints is a measure of last resort to protect the safety of the resident or others and must not extend beyond the immediate episode. Physical restraints will never to be used as a disciplinary action or for staff convenience. Medical symptoms that warrant the use of restraints will be documented in the resident's medical record, ongoing assessments, and care plan. The physician's order for restraints should reflect the presence of a qualifying medical symptom. The facility will engage in a systematic and gradual process toward reduction of restraint use. Restraints must be reviewed at least monthly to evaluate necessity and appropriateness. Falls do not constitute self-injurious behavior or a medical condition that warrants the use of physical restraint. In the past, some types of restraints were used to prevent falls. However, the risks for serious injury related to restraints and the lack of supporting evidence for restraint efficacy in fall prevention, have led to the eradication of that practice. 'Convenience: Any action taken by the facility to control residents' behavior or maintain patients/residents with a lesser amount of effort by the facility and not the resident's best interest.' 'Freedom of Movement': Any change in place or position for the body or any part of the body that the person is physically able to control.' .'Removes Easily': The manual method, device, material, or equipment can be removed intentionally by the resident in the same manner it was applied by the staff considering the resident's physical condition and ability to accomplish objective (i.e.) transfer to a chair, gets to the bathroom in time). Complete Restraint Assessment, if appropriate, then obtain order for: type of restraint, duration (time frame) to be utilized, medical diagnosis or symptom necessitating restraint use, parameters for use (including release schedule), frequency of checking, removal schedule .Documented therapy evaluation. The interdisciplinary team meets as soon as possible to review the assessment and to consider if alternatives and interventions have been selected and implemented for how each resident can attain the highest level of functioning with the least restrictive measures. Review each resident currently using a restraint device, at least monthly and for any change of condition. Attempt gradual reduction of restraint use by implementing interventions which may serve as enablers and reminders. Reduction attempts should be documented, including the resident response to the interventions. The plan of care should be updated at least quarterly and with any significant change, including the medical symptoms which continue to warrant the need for a restraint. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R44's undated Face Sheet, located in the resident's Electronic Medical Record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE]. Review R44's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 11/26/24 and located under the resident's EMR under the Resident Assessment Instrument (RAI) tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15which indicated the resident was cognitively intact. The MDS identified R44's utilized assistive devices of a wheelchair and a walker. The MDS also indicated the resident had a history of falls. R44 required partial or moderate assistance with upper/lower body dressing, maximum assistance with putting on/taking off footwear; sit to stand needs supervision or touching assistance, speech therapy/occupational therapy/physical therapy was administered 6 days week. Review of R44's Care Plan, revised 01/14/25 and located in the resident's EMR under the RAI tab revealed no problem, goal, or interventions for the use of the geriatric chair with a lap tray which prevented her from rising. and the lap tray over her wheelchair. Review of R44's EMR revealed no documented evidence the facility assessed R44 for the use of a geriatric chair or for the use of a lap tray. assessments for the use of the geriatric chair or a lap tray on her wheelchair. Observation on 01/20/25 at 10:12 AM revealed R44 was seated in a geriatric chair near the nurses' station. R44 attempted to get out of the geriatric chair and staff immediately told her to sit back down. Observation on 01/21/25 at 3:18 PM revealed R44 was assisted with two staff people walking her down the hallway, then she was returned to sit in the geriatric chair. The staff reclined the resident back and placed an over the bed table over her lap. Observation on 01/20/25 at 3:31 PM of R44 revealed she was seated in a geriatric chair by the nurse's station. She had an overbed table positioned over her lap and the geriatric chair was in a reclined position. She tried to get out of the geriatric chair by trying to sit up and swing her legs over the side of the chair, staff would place her legs back in the chair and gently have her sit back in the chair. Observation on 01/21/25 12:30 PM of R44 revealed she was seated in the geriatric chair with an overbed table over the top. The head of the chair was up, and she was eating her lunch. Observation on 01/21/25 at 3:00 PM revealed R44 was seated in a wheelchair with a black padded tray over the front of the wheelchair. She appeared agitated and was trying to move the tray off. Staff were intervening to keep the tray down, so she was unable to get out of the wheelchair. There were no wheelchair pedals on, and her feet were dangling. During an interview at the time of the observation, Licensed Practical Nurses (LPN) 1 and LPN2 stated they had not noticed she did not have pedals on the wheelchair. They agreed her feet were just dangling down. LPN2said if the chair was lower, she could put her feet on the floor. They agreed R44 was at risk for falls and that is why she is kept in the geriatric chair or the wheelchair with a lap tray. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/23/25 at 11:55 AM with Registered (RN) 1 and RN2 revealed RN1 completed the MDS assessments for long-term care residents. RN1 had not completed an assessment or care plan for R44 as she had received skilled services. RN2 stated she completed the skilled services residents MDS assessments and care plans. They agreed the care plan had not been revised for R44 for the use of restrictive devices. They had not been aware she had been placed in a geriatric chair and wheelchair with a lap tray. Interview on 01/23/25 at 12:36 PM with the DON and Administrator revealed they had not considered the geriatric chair with overbed table or the wheelchair with the lap tray as restraints. They agreed there had been no assessment or care planning completed to ensure safety with the use of those devices. Observation and interview on 01/23/25 at 3:00 PM revealed R44 was seated in a wheelchair with a lap tray. Her feet did not touch the floor, and she did not have any foot pedals. She was eating a cookie and had a drink on the tray. When asked why she wanted to get out of the chair to walk, R44 stated she had things to do at her house. When asked how she felt about the lap tray, she told me she felt nervous and anxious when she was not able to stand up and walk where she wanted to go. She was able to lift the lap tray up after numerous requests. Interview on 01/23/25 at 3:30 PM with RN3 revealed most of the time R44 would not stay in bed at night so she would be brought out in the geriatric chair to the nurses' station. She would then sleep in the geriatric chair. RN3 stated when R44 was in the geriatric chair, she was leaned back in a full reclined position with an overbed table over the top. RN3 also stated R44 was unable to get out of the geriatric chair and she would try to swing her legs over the side at times trying to get out of the chair. Continued interview revealed there were times when staff did not even try to have R44 sleep in her bed, and she was just put into the geriatric chair and left by the nurses' station. RN3 agreed when the geriatric chair was in the reclined position, she was unable to sit up or get out of the geriatric chair.

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

18819

Based on an anonymous complaint, reviews of closed medical records and pertinent administrative policies and records, and staff interview, it was determined that facility administrative staff failed to implement the facility's existing abuse policy and procedures when an allegation of sexual abuse was reported by 2 staff members. This was evident for 1 (Resident #911) of 6 complaints reviewed during an annual recertification survey.

The findings include:

Review of anonymous complaint MD00194310 on 01/21/2025 at 1 PM, revealed an allegation that Resident #911 was observed sexually assaulting Resident #911's on or around July 12, 2023. The anonymous complaint also listed allegations that included: the facility administration requiring the licensed nurse to take back their nursing documentation about the incident and the facility did not report the allegation of resident-to-resident sexual abuse to the State Survey Agency.

In an interview with the facility Director of Social Work on 01/21/25 at 3:55 PM, the Director of Social Work was asked if there ever was an allegation of sexual abuse regarding Resident #913. The Director of Social Work stated yes. The Director of Social Work then stated that a GNA reported an allegation of sexual abuse regarding Resident's #913 and #911. The Director of Social Work reported that the GNA #1 stated that she/he observed Resident #913 with his hands inside Resident #911's brief touching Resident #911's genitals. The Social Work Director stated that she/he had not heard of this occurring in the past. The Director of Social Work stated she/he informed the facility Administrator and the Director of Nurses right away on the day the allegation was reported to him/her. The Director of Social Work stated that he/she and the other facility Social Worker initiated an investigation into the allegation of sexual abuse but could not recall the exact day of the allegation.

In an interview with the facility Administrator on 01/21/25 at 4:35 PM, the nurse surveyor requested the facility investigative documents into the staff witnessed allegation of sexual abuse that allegedly occurred between Residents #911 and #913 on or around July 12, 2023.

In an interview with the facility Administrator, DON, Director of Social Work, and the Corporate Nurse on 01/22/2025 at 10:45 AM, the facility Administrator stated a staff nurse documented in Resident #913's medical record an incident between Residents #913 and #911 which occurred on 06/30/23. The time of the note was 3:43 PM. The medical record indicated that the 06/30/23, 3:43 PM nursing progress note was changed to read Invalid. The facility Administrator stated that only the staff nurse that wrote the progress note can change the progress note to read as Invalid. The facility Administrator stated that there were no administrative documents or investigative records regarding the alleged resident sexual abuse between Resident's #911 and #913 from 06/30/23. The facility Administrator also stated that there were no staff or other resident witness statements. The local police and the State Survey Agency were not notified either. The facility Administrator and DON stated that the staff were aware that Resident #913's had a history of intrusive behaviors while residing in the facility.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN #3 on 01/22/25 at 2:52 PM, LPN #3 stated that S/he was the nurse who reported the allegation of resident-to-resident sexual abuse to the nursing supervisor (RN #4) on 06/30/23. LPN #3 stated that S/he documented the incident in Resident #913's, the alleged perpetrator's medical record. LPN #3 stated that S/he was not aware of how the 06/30/23, 3:43 PM progress note was labeled Invalid. LPN #3 stated that on 06/30/23 S/he was informed by GNA #1 that S/he witnessed sexual abuse between Residents #911 and #913 on 06/30/23. LPN #3 stated that GNA #1 was a new GNA and was observed in a frantic state and could hardly inform her/him of the S/he witnessed. LPN #3 stated that after being informed by GNA #1, LPN #3 went immediately to Resident #911's room and separated Resident #911 and #913. LPN #3 also stated that S/he was not asked to formally write a witness statement or was interviewed by any administrative staff regarding the 06/30/23 alleged resident to resident sexual abuse. A review of the facility abuse, neglect, exploitation, or mistreatment policy on 01/22/25 revealed that: 1) the facility's leadership ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, 2) the facility's leadership shall report immediately, but not later than 2 hours, after the allegation received of suspected abuse to the State Survey Agency, 3) the facility's leadership will conduct a prompt investigation of any allegation received of suspected abuse and will implement immediate action to safeguard resident, and 4) the facility's leadership will provide notification to the proper authorities.

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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 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. 18819 Based on an anonymous complaint, reviews of closed medical records and pertinent administrative policies and records, and staff interview, it was determined that facility administrative staff failed to report an allegation of resident to resident sexual abuse to the State Survey Agency. This was evident for 1 (Resident #911) of 6 complaints reviewed during an annual recertification survey. The findings include: Review of anonymous complaint MD00194310 on 01/21/2025 at 1 PM, revealed an allegation that Resident #913 was observed sexually assaulting Resident #911's on or around July 12, 2023. The anonymous complaint also listed allegations that included: the facility administration requiring the licensed nurse to take back their nursing documentation about the incident and the facility did not report the allegation of resident-to-resident sexual abuse to the State Survey Agency. In an interview with the facility Director of Social Work on 01/21/25 at 3:55 PM, the Director of Social Work was asked if there ever was an allegation of sexual abuse regarding Resident #913. The Director of Social Work stated yes. The Director of Social Work then stated that a GNA reported an allegation of sexual abuse regarding Resident's #913 and #911. The Director of Social Work reported that the GNA #1 stated that she/he observed Resident #913 with his/her hands inside Resident #911's brief touching Resident #911's genitals. The Social Work Director stated that she/he had not heard of this occurring in the past. The Director of Social Work stated she/he informed the facility Administrator and the Director of Nurses right away on the day the allegation was reported to him/her. The Director of Social Work stated that he/she and the other facility Social Worker initiated an investigation into the allegation of sexual abuse but could not recall the exact day of the allegation. In an interview with the facility Administrator on 01/21/25 at 4:35 PM, the nurse surveyor requested the facility investigative documents into the staff witnessed allegation of sexual abuse that allegedly occurred between Residents #911 and #913 on or around July 12, 2023. In an interview with the facility Administrator, DON, Director of Social Work, and the Corporate Nurse on 01/22/2025 at10:45 AM, the facility Administrator stated a staff nurse documented in Resident #913's medical record an incident between Residents #913 and #911 which occurred on 06/30/23. The time of the note was 3:43 PM. The nursing progress noted the 06/30/23 was Invalid. The facility Administrator stated that the nurse that wrote the progress note can indicate that the progress note is Invalid. The facility Administrator stated that there were no administrative documents or investigative records regarding the alleged resident to resident sexual abuse from 06/30/23. There were no staff or resident witness statements. The local police and the State Survey Agency were not notified either. The facility Administrator and DON stated that the staff were aware of Resident #913's intrusive behaviors through the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN #3 on 01/22/25 at 2:52 PM, LPN #3 stated that s/he was the nurse who reported the allegation of resident-to-resident sexual abuse to the facility administrative staff on 06/30/23. LPN #3 stated that s/he documented the incident in Resident #913's, alleged perpetrator's, medical record. LPN #3 stated that s/he was not aware of how the 06/30/23, 3:43 PM progress note was labeled Invalid. LPN #3 stated s/he was informed by GNA #1 of the alleged sexual abuse between Residents #911 and #913 on 06/30/23. LPN #3 stated that GNA #1 was a new GNA and was observed in a frantic state and could hardly inform her/him of the witnessed incident. LPN #3 stated that after being informed by GNA #1, LPN #3 went immediately to Resident #911's room and separated Resident #911 and #913. LPN #3 also stated that s/he was not asked to formally write a witness statement or was interviewed by any administrative staff regarding the 06/30/23 alleged resident to resident sexual abuse. A review of the facility abuse, neglect, exploitation, or mistreatment policy on 01/22/25 revealed that: 1) the facility's leadership ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, 2) the facility's leadership shall report immediately, but not later than 2 hours, after the allegation received of suspected abuse to the State Survey Agency, 3) the facility's leadership will conduct a prompt investigation of any allegation received of suspected abuse and will implement immediate action to safeguard resident, and 4) the facility's leadership will provide notification to the proper authorities.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 18819 Based on an anonymous complaint, reviews of closed medical records and pertinent administrative policies and records, and staff interview, it was determined that facility administrative staff failed to investigate an allegation of resident to resident sexual abuse when it was reported by staff members. This was evident for 1 (Resident #911) of 6 complaints reviewed during an annual recertification survey. The findings include: Review of anonymous complaint MD00194310 on 01/21/2025 at 1 PM, revealed an allegation that Resident #913 was observed sexually assaulting Resident #911's on or around July 12, 2023. The anonymous complaint also listed allegations that included: the facility administration requiring the licensed nurse to take back their nursing documentation about the incident and the facility did not report the allegation of resident-to-resident sexual abuse to the State Survey Agency. In an interview with the facility Director of Social Work on 01/21/25 at 3:55 PM, the Director of Social Work was asked if there ever was an allegation of sexual abuse regarding Resident #913. The Director of Social Work stated yes. The Director of Social Work then stated that a GNA reported an allegation of sexual abuse regarding Resident's #913 and #911. The Director of Social Work reported that the GNA #1 stated that she/he observed Resident #913 with his/her hands inside Resident #911's brief touching Resident #911's Genitals. The Social Work Director stated that she/he had not heard of this occurring in the past. The Director of Social Work stated she/he informed the facility Administrator and the Director of Nurses right away on the day the allegation was reported to him/her. The Director of Social Work stated that he/she and the other facility Social Worker initiated an investigation into the allegation of sexual abuse but could not recall the exact day of the allegation. In an interview with the facility Administrator on 01/21/25 at 4:35 PM, the nurse surveyor requested the facility investigative documents into the staff witnessed allegation of sexual abuse that allegedly occurred between Residents #911 and #913 on or around July 12, 2023. In an interview with the facility Administrator, DON, Director of Social Work, and the Corporate Nurse on 01/22/2025 at10:45 AM, the facility Administrator stated a staff nurse documented in Resident #913's medical record an incident between Residents #913 and #911 which occurred on 06/30/23. The time of the note was 3:43 PM. The nursing progress noted the 06/30/23 was Invalid. The facility Administrator stated that the nurse that wrote the progress note can indicate that the progress note is Invalid. The facility Administrator stated that there are no administrative documents or investigative records regarding the alleged resident to resident sexual abuse from 06/30/23. There were no staff or resident witness statements. The local police and the State Survey Agency were not notified either. The facility Administrator and DON stated that the staff were aware of Resident #913's intrusive behaviors through the facility. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN #3 on 01/22/25 at 2:52 PM, LPN #3 stated that s/he was the nurse who reported the allegation of resident-to-resident sexual abuse to the facility administrative staff on 06/30/23. LPN #3 stated that s/he documented the incident in Resident #913's, alleged perpetrator's, medical record. LPN #3 stated that s/he is not aware of how the 06/30/23, 3:43 PM progress note was labeled Invalid. LPN #3 stated s/he was informed by GNA #1 of the alleged sexual abuse between Residents #911 and #913 on 06/30/23. LPN #3 stated that GNA #1 was a new GNA and was observed in a frantic state and could hardly inform her/him of the witnessed incident. LPN #3 stated that after being informed by GNA #1, LPN #3 went immediately to Resident #911's room and separated Resident #911 and #913. LPN #3 also stated that s/he was not asked to formally write a witness statement or was interviewed by any administrative staff regarding the 06/30/23 alleged resident to resident sexual abuse. A review of the facility abuse, neglect, exploitation, or mistreatment policy on 01/22/25 revealed that: 1) the facility's leadership ensures that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, 2) the facility's leadership shall report immediately, but not later than 2 hours, after the allegation received of suspected abuse to the State Survey Agency, 3) the facility's leadership will conduct a prompt investigation of any allegation received of suspected abuse and will implement immediate action to safeguard resident, and 4) the facility's leadership will provide notification to the proper authorities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allegany Health Nursing and Rehab	730 Furnace Street Cumberland, MD 21502

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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 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51678

Based on observation, interview, record review, and policy review, the facility failed to revise residents care plan to include the use of a geriatric chair and lap trays for one of 22 sampled residents (Resident (R) 44). This failure placed the resident at risk for unmet care needs, safety risks, and increased anxiety related to devices that were considered restraints.

Findings include:

Review of the facility's policy titled, Care Plan Process, Person Centered Care, dated 05/05/23 revealed The facility will develop and implement a baseline and comprehensive care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Person-centered care includes trying to understand what each resident is communicating, verbally and nonverbally, identifying what is important to each resident with regard to daily routines and preferred activities, and understanding the resident's life before coming to reside in the nursing home. The Interdisciplinary Team (IDT) will review effectiveness and revise the person-centered care plan after each assessment. This includes both the comprehensive and quarterly assessments.

Review of R44's undated Face Sheet, located in the resident's Electronic Medical Record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE].

Review R44's admission Minimum Data Set (MDS,) with an assessment reference date (ARD) of 11/26/24 and located under the Resident Assessment Instrument (RAI) tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact.

Review of R44's care plan located under the RAI tab last revised on 01/14/25 revealed no problem, goal, or interventions for the use of the geriatric chair which prevented her from rising and the lap tray over her wheelchair. The use of a geriatric chair nor the use of a lap tray was identified in any area of the resident's care plan.

Observation on 01/20/25 at 3:31 PM of R44 revealed she was seated in a geriatric chair by the nurse's station. She had an overbed table positioned over her lap and the geriatric chair was in a reclined position. She tried to get out of the geriatric chair by trying to sit up and swing her legs over the side of the chair, staff would place her legs back in the chair and gently have her sit back in the chair.

Observation on 01/21/25 at 3:00 PM revealed R44 was seated in a wheelchair with a black padded tray over the front of the wheelchair. She appeared agitated and was trying to move the tray off. Staff were intervening to keep the tray down, so she was unable to get out of the wheelchair.

During an interview on 01/21/25 at 3:00 PM, Licensed Practical Nurse (LPN) 1 and LPN2 stated they had not noticed she did not have pedals. They agreed her feet were just dangling down.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER Allegany Health Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 730 Furnace Street Cumberland, MD 21502	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	They agreed R44 was at risk for falls and that is why she is kept in the geriatric chair or the wheelchair with a lap tray. During an interview on 01/23/25 at 11:55 AM, Registered Nurse (RN) 1 and RN2 stated they were MDS nurses. RN1 stated she had not revised R44's care plan for the use of restrictive devices and neither were aware R44 had been placed in a geriatric chair and used a lap tray when in a wheelchair. Both RN1 and RN2 verified the use of a geriatric chair and/or the use of lap trays were not part of R44's plan of care. RN1 and RN2 confirmed the resident was placed in a geriatric chair on 11/23/24 after a fall. Interview on 01/23/25 at 12:36 PM with the DON and Administrator revealed they had not considered the geriatric chair with overbed table and a wheelchair with the lap tray as restraints. They agreed there had been no assessment or care planning completed to ensure safety with the use of those devices.

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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 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a facility-reported incident, a closed medical record and all pertinent information and staff interview, it was determined that the facility staff failed to identify a newly admitted Resident who was admitted without clear physician's order for end-of-life care and failed to follow the facility policy to initiate Cardiopulmonary Resuscitation (CPR). This was evident for 1 (Resident #902) of 11 facility-reported incidents reviewed during an annual recertification survey. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of [DATE]. The findings include: Review of facility-reported incident (FRI) MD00174662 on [DATE] revealed allegations that Resident #902 was admitted to the facility from the community on [DATE] at 1:15 PM. Resident #902 was being evaluated in the emergency room earlier in the day. On [DATE], Resident #902 was assessed by his/her physician and deemed incapable of understanding any information and that a third party should make the decisions for Resident #902. Reviews of the facility investigation and Resident #902's closed medical record revealed that on [DATE] at 1:30 AM, Resident #902 was observed lying on a floor mat by the bed with nonskid socks on. Resident #902 was assessed by the nursing staff with no evidence of injury and placed back in bed. At 3:40 AM on [DATE], a GNA staff member alerted LPN #4 that Resident #902 had changes in his/her breathing pattern. LPN #4 assessed Resident #902 and notified RN #5 that Resident #902's eyes were observed rolled back into his/her head and Resident #902 was not breathing. LPN #4 alerted 911/EMS and applied oxygen by non-rebreather mask to Resident #902. No other life-sustaining procedures were started at this time. In an interview with LPN #4 on [DATE] at 11:30 AM, LPN4 stated that s/he was alerted by a staff member that Resident #902 was not breathing well and also had trouble finding a pulse. LPN #4 stated that s/he notified 911/EMS and the RN supervisor (RN #5). LPN #4 stated that s/he asked RN #5 what to do. LPN #4 stated that s/he and RN #5 both looked at Resident #902's medical record and could not find a completed MOLST form. LPN #4 stated s/he then asked RN #5 what should they do and RN #5 stated to wait for 911/EMS to arrive. LPN #4 then stated that s/he stayed with Resident #902 until 911/EMS arrived. LPN #4 stated that CPR was not performed on Resident #902 and that 911/EMS pronounced Resident #902 at that time. LPN #4 stated that s/he has had education in the past regarding CPR/MOLST forms and what staff should do if a resident does not have a completed MOLST form and codes. LPN #4 stated that if s/he identified a resident now without any vital signs and without a completed MOLST form, that s/he would start CPR immediately. (continued on next page)

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F 0678 Level of Harm - Actual harm Residents Affected - Few	In an interview with the former Social Work Director on [DATE] at 9:05 AM, the former Social Work Director stated that S/he first visits a newly admitted resident to complete a social history. Also, during the first interview the former Social Work Director stated that S/he speaks to the residents and or the family members about advance directives and reviews the MOLST form. The former Social Work Director stated that if a resident is admitted to the facility without a complete Maryland Order for Life Sustaining Treatment (MOLST) form the resident would be considered a full code in an emergency. The Maryland MOLST form is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The nurse surveyor reviewed the former Social Work Directors' [DATE] 6 PM progress note with him/her. The former Social Work Director was asked why there was nothing documented about a set of advanced directives or a MOLST status in the [DATE] 6 PM progress note. The former Social Work Director stated that s/he could not recall why there was nothing in the [DATE] 6 pm progress note about advance directives or the resident's code status or MOLST form. A review of the facility's Social Services Policies and Procedures on [DATE] revealed a statement that indicated: In the absence of appropriate DNR identification or orders, the Facility Staff will respond to medical emergencies with CPR measures and a full code will be instituted. On [DATE], a total of 18 residents closed and active medical records were audited by the nurse surveyor. In these audits, a completed MOLST form was located. All of the MOLST forms clearly indicated whether or not CPR should be performed if the resident was found in an emergency situation. The Director of Nursing (DON) was interviewed on [DATE]. During the interview, the DON demonstrated and provided Quality Assurance (QA) material that s/he maintained in which the entire nursing staff were educated on [DATE] on ensuring the resident had a completed MOLST form, what to do if the resident is not admitted with a completed MOLST form, and what to do if a resident codes in the facility and does not have a completed MOLST form or physician order for CPR. Also, the facility medical director had given Resident #902's primary care physician education on the timeliness of completing a resident's end of life wishes on the MOLST form and if a resident is admitted without a completed MOLST form the resident will be a full code. An Ad Hoc Quality Assurance Performance Improvement meeting was held on [DATE] regarding the contents of the plan. Data was to be reviewed monthly in QAPI for 3 months. Based on the above actions taken by the facility and verified by the nurse surveyor on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of [DATE].

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a facility-reported incident, a closed medical record and all pertinent information, and staff interviews, it was determined the facility staff failed to provide adequate supervision and follow the resident's plan of care to: 1) prevent a fractured humerus during a transfer, and 2) to prevent a cognitively and functionally impaired resident from sliding out of bed onto the floor and receiving bilateral fractured hips. This was evident for 2 (Residents #909, #906) out of 11 facility-reported incidents resulting in harm to both residents reviewed during the survey. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 07/11/23. The findings include: 1) A review of the facility-reported incident MD00178281 was reviewed on 01/23/2025 at 1 PM. The facility's investigation revealed that on 05/14/22 at 9:30 PM Resident #906 had fallen out of bed during care and that subsequent assessments and X-rays determined that Resident #906 had suffered bilateral femoral neck fractures. Resident #906 had been admitted to the facility on [DATE] with cognitive impairment and was totally dependent upon the staff for all aspects of his/her care needs. The facility investigation indicated that on 05/14/22 GNA #5 entered Resident #906's room to provide incontinence care. The investigation indicated that GNA #5 informed staff that S/he turned Resident #906 onto his/her left side, away from him/her, and then Resident #906 rolled out of bed. GNA #5 then informed the nurse. A review of Resident #906's activities of daily living care plan on 01/23/25 revealed nursing interventions dated 06/11/21 that instructed staff members to use two staff members when performing for bed mobility (turning and repositioning) for Resident #906. In an interview with GNA #5 on 01/24/25 at 5:15 PM, GNA #5 stated that prior to the start of Resident #906's bed bath on 07/09/24, GNA #5 stated S/he obtained all the equipment and clean linen supplies to provide Resident #906's bed bath. GNA #5 stated that S/he then raised Resident #906's bed up to his/her hip level. During the bed bath, GNA #5 stated that S/he turned Resident #906 away from him/her, onto Resident 906's left side, which placed Resident #906 closer to the edge of the bed away from him/her. GNA #5 stated that this was when S/he realized that S/he needed more incontinent wipes. GNA #5 stated that S/he then turned away from Resident #906 lying in bed to ask another staff member if they could bring him/her more incontinent wipes. GNA #5 stated that this is when Resident #906 jerked up and rolled out of bed onto the floor. After the Resident #906's fall, GNA #5 stated that other staff members had informed him/her that Resident #906 was a one-staff member assist for baths. GNA #5 stated that S/he had reviewed Resident #906's plan of care that day but could not say why S/he performed the bed bath by himself/herself. The facility administrator and director of nurses were made aware of the findings at the exit conference on 01/24/25 at 6 PM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2) The facility's investigation of the reported incident MD00194149 was reviewed on 01/23/2025 at 10:00 AM. The facility's investigation revealed that on 07/09/23 Resident #909 was being transferred by 2 GNA's to a shower chair during the evening shift when they heard a pop and called the floor nurses for assistance. Resident #909 was sent to the local emergency room via 911 for evaluation. The 2 GNA's were suspended pending the investigation. Resident #909 was scheduled for a shower on 07/09/23. Resident #909 was admitted to the facility on [DATE] with a history of a fractured hip, dementia, and metabolic encephalopathy. Resident #909 is alert to person only and has a BIM's score of 7. Resident #909 was scheduled for a shower on 07/09/23. A review of the facility investigation revealed that GNA #3 requested assistance from GNA #4 to transfer Resident #909 from the bed to the shower chair. GNA #3 and GNA #4 stated that they each got under one arm of Resident #909 and were transferring him/her to the shower chair when they heard a popping sound. GNA #3 and GNA #4 then lowered #909 to the floor. While GNA #3 stayed with Resident #909, GNA #4 alerted the nurse to the incident. Upon assessment by the nurse, Resident #909 was noted to have an abnormal range of motion in the left arm. Resident #909's physician and family were notified of the incident and orders to transfer Resident #909 to the emergency room for eval and treat. The hospital obtained an X-ray of Resident #909's left arm which revealed a fracture of the left humerus with osteopenia/osteoporosis. Resident #909 was sent back to the facility with an order for a splint to the left arm until seen by an Orthopedic physician for a possible cast. The Medical Director and Resident #909's family were made aware of plan of care and both were in agreement. The facility investigation determined that Resident #909 obtained a fracture to his/her left humerus as a result of GNA #3 and GNA #4 failure to follow the plan of care for Resident #909. Both GNA #3 and GNA #4 received counseling and were educated on checking a resident's profile for safe transfer status and plan of care. The facility staff were educated to review a residents' profile for safe transfer status and plan of care. All resident care plans were reviewed and updated. A review of Resident #909's admission fall and injury prevention care plan dated 07/20/21 revealed a nursing intervention that indicated to transfer Resident #909 by the use of lifting device as ordered. In a telephone interview with GNA #3 on 01/24/25 at 3:43 PM, GNA #3 stated that S/he recalled the incident with Resident #909. GNA #3 stated that Resident #909 was to receive a shower that day had asked GNA #4 for assistance transferring Resident #909 from the bed to the shower chair. GNA #3 stated S/he thought Resident #909 was a 2-person assist for transfers. GNA #3 stated that during the transfer both S/he and GNA #4 grabbed Resident #909 under each arm. GNA #3 stated S/he was on the left side of Resident #909 during the transfer. GNA #3 stated that we heard a snap and immediately stopped the transfer and lowered Resident #909 to the ground. When asked, GNA #3 stated that S/he had transferred Resident #909 under his/her arms frequently in the past. GNA #3 stated that S/he had not reviewed Resident #909's plan of care for transfers. GNA #3 stated that after the incident S/he then learned that Resident #909 was to be a Hoyer transferred. GNA #3 stated that S/he was not aware that Resident #909's care plan had been changed regarding transfer status to a Hoyer lift. GNA #3 stated that S/he received education after the incident to check a resident's transfer status prior to the transfer. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with GNA #4 on 01/24/25 at 3:52 PM, GNA #4 stated that S/he recalled the incident and that GNA #3 had asked for assistance to get Resident #909 out of bed. GNA #4 stated that S/he was not assigned to Resident #909 on 07/09/23. GNA #4 stated that S/he did not review Resident #909's care plan regarding transfer status prior to assisting GNA #3. GNA #3 stated that S/he was standing on Resident #909's right side before the transfer. GNA #4 stated both S/he and GNA #3 grabbed Resident #909 under the arms and lifted the resident up from the bed and this was when they heard Resident #909's arm snap. GNA #4 then stated to GNA #3 they needed to lower Resident #909 down. GNA #4 stated that S/he went and got the nurse. GNA #4 stated that S/he and GNA #3 were suspended after the incident. GNA #4 stated that S/he received education on how to determine a resident's transfer status. The Director of Nursing (DON) was interviewed on 01/24/25. During the interview, the DON demonstrated and provided Quality Assurance (QA) material that s/he maintained in which the entire nursing staff were educated on 07/11/23 on how to access a resident's care plan and correctly identify the number of staff needed to provide care to each resident. The QA plan was to be reviewed monthly in QAPI for 3 months. Based on the above actions taken by the facility and verified by the nurse surveyor on site, it was determined that the facility's deficient practice was past noncompliance with a compliance date of 07/11/23.