STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215231	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare Center	9211 Stuart Lane Clinton, MD 20735

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on medical record review and interview, the facility failed to make prompt efforts to resolve a resident's grievance and also failed to keep the resident appropriately apprised of the progress toward resolution. This was evident for 1 (#25) of 55 residents reviewed in a complaint survey. The findings include: Review of a complaint MD 00217656, sent to the Maryland's Office of Health Care Quality (OHCQ), on 5/22/25 at 8:00 AM revealed that the complaint was sent by the Ombudsman alleging that the facility failed to promptly resolve resident #25's grievance of reimbursement for a missing prosthetic leg. Review of resident #25's medical record on 5/22/25 at 8:30 AM revealed no evidence that the facility misplaced the resident's prosthetic leg. Interview with the Ombudsman on 5/22/25 at 12:15 PM revealed that resident #25's prosthetic leg was missing since 1/2025. The Ombudsman stated that the resident complained to the facility that his/her prosthetic leg was missing from his/her belongings since 1/2025. The resident received no updates on the location of the prosthetic leg and decided to contact the Ombudsman for assistance in 3/2025. The Ombudsman contacted the facility in 3/2025 about the missing prosthetic leg and received no updates on the location of the prosthetic leg. The Ombudsman sent an email to the facility's social worker director on 4/29/25 about the resident's missing prosthetic leg. The facility provided no updates on the location of the missing prosthetic leg nor solutions for replacing the missing prosthetic leg as of the time of the interview. Interview with the Executive Director on 5/27/25 at 8:30 AM confirmed that the facility was aware of resident #25's missing prosthetic leg. The Executive Director admitted that the resident's prosthetic leg was possibly misplaced as of 11/2024 when the facility was evacuated due to loss of heat. As of the date of the interview, the facility had failed to find the resident's prosthetic leg. The Executive Director also admitted that no efforts were made to reimburse or replace the resident's prosthetic leg until the resident returned from medical treatment. The surveyor pointed out that the resident returned to the facility on 5/22/25. The Executive Director stated that the facility would work on replacing the missing prosthetic leg.

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 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. Based on record review and staff interview; it was determined that the facility failed to protect their residents from verbal abuse from a facility staff member. This was evident for 1 (#46) of 55 residents reviewed during a complaint survey. The findings include: Review of facility reported incident (FRI) MD00217347 on 5/29/25 at 8:00 AM revealed the FRI alleged that Geriatric Nursing Assistant (GNA) #13 verbally abused Resident #46 while providing ADL care. Review of Resident #46's medical record on 5/29/25 at 8:30 AM revealed a care plan for psychosocial well-being. The intervention for this psychosocial well-being was listed as encouragement for communication. The Director of Nursing (DON) provided the surveyor with the facility investigation of the alleged verbal abuse incident. Review of the facility investigation on 5/29/25 at 10:00 AM revealed the incident occurred on 5/2/25. GNA #13 made comments about the number of bowel moments being made by resident #46. The facility investigation determined that the allegation of verbal abuse was unsubstantiated. The facility's investigation also contained a statement from GNA#13 which admitted that GNA#13 told resident #46 that he/she shouldn't be in the facility but in a hospital. The facility investigation also contained a list of nursing staff that received re-education on abuse prohibition. The list of nursing staff did not contain GNA #13. Interview with the DON on 5/29/25 at 11:10 AM revealed that Resident #46's family reported that the resident was upset about the statements made by GNA #13 when she/he was providing ADL care on 5/2/25. The surveyor asked why did the facility consider the allegation of verbal abuse as unsubstantiated? The DON confirmed that GNA #13 admitted to the statements that upset resident #46 but the DON stated that GNA #13 did not mean to hurt the resident's feelings and provided adequate ADL care after the incident. The surveyor pointed out that verbal abuse is based on how the resident feels about the incident and the resident believed that he/she was verbally abused.

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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. Based on review of facility documents and staff interview it was determined the facility failed to report an allegation of abuse immediately but not later than 2 hours after an allegation was made. This was evident for 1 (#21) of 19 residents reviewed for abuse during a complaint survey. The findings include: On 5/22/25 at 1:09 PM, a review facility reported incident, MD00205036, which alleged that Resident #21 sustained a scratch to his/her face during an altercation with Resident #2, resulting in Resident #21 being transferred to the hospital emergency department for further evaluation. The facility's investigation documented the incident had occurred on 4/3/24 at 6:30 PM. The facility's investigation did not include documentation as to when the incident was sent to OHCQ or when the final report was sent. The above concern was discussed with the Director of Nurses (DON) on 5/22/25 at approximately 1:30 PM and the surveyor requested email confirmation of when facility report sent to state office. On 5/22/25 at 2:18 PM, the DON reported to the surveyor that email confirmations of when above facility reported incident was sent to OHCQ were permanently deleted and no longer available for the DON to provide to the surveyor.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on medical record review and interview with facility staff and the review of a facility reported incident (FRI), it was determined that the facility staff failed to 1. thoroughly investigate an injury (bruising) of unknown origin and 2. failed to thoroughly investigate allegations of abuse. This was evident during the review of 2 of 19 facility reported incidents. Residents (#20 and #21) The findings include: 1. Review of the facility reported incident #MD208608 on 6/2/25 at 12:57 PM revealed a concern related to a new discoloration observed around Resident #20's right upper eye lid. Secondary to Resident #20's diagnosed intellectual disabilities s/he was unable to give a verifiable account of what happened to cause this newly identified injury. According to an electronic medical record review, Resident #20 is also diagnosed with muscle weakness and lack of coordination. Further review at this time of the facility investigation report revealed that the facility determined that the allegation of abuse was 'unsubstantiated' after reviewing all documents and witness statements. A comparative review was completed on 6/3/25 at 12:00 PM of the staff schedules from 8/7, 8/8 and 8/9/24 to the staff that were interviewed. There were 8 identified staff that marked 'no' for all 3 questions related to the investigation into the alleged abuse of Resident #20, including 1. Did you work with [Resident #20] on 8/7, 8/8 or 8/9, that were assigned to work with Resident #20 according to the scheduled assignments provided to the surveyor by the DON on 6/3/25. Surveyor interviewed the unit manager staff LPN #16 on 6/4/25 at 8:28 AM regarding the interviews that she conducted on 8/12/24. She was asked about her process in determining who to interview during an investigation and she stated that she will look at the schedule as to who was assigned to the resident. The statements from the FRI for Resident #20 were reviewed concurrently at this time with staff #16. The concern that there were multiple staff assigned to Resident #20 between 8/7-8/9 that marked 'no' when in fact they did care for Resident #20 was discussed. She was then asked if she reviewed the acquired statements and interviews and she stated 'yes.' At this time the actual schedules of the staff for 8/7-8/9 were reviewed. The concern that there were staff assigned to Resident #20 whose statements stated 'no' regarding caring for Resident #20 during that same time frame was reviewed and shown to staff #16. Staff #16 was also asked if it was standard practice to interview yourself for an abuse investigation as she had completed an interview and signed her name as the witness and name/title of the person taking the statement, she had no response. The conclusion into the facility allegation of abuse of Resident #20 was that Resident #20 bumped his/her eye on the radiator that was located next to his/her bed as this resident, according to the investigation, nodded his/her head yes/no when asked specific questions, although the statements gathered were false and not verified. This concern was reviewed at this time with staff #16 and was previously reviewed with the facility DON on 6/3/25 and again during exit on 6/5/25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 5/22/25 at 1:09 PM, a review of the facility's investigation file for self-report MD00204541, which was an allegation of abuse related to a resident-to-resident altercation, was conducted. The initial self-report documented that on 4/3/24, staff heard a noise coming from the 2nd floor dining room and found Resident #21, and Resident #2 involved in an altercation in the dining room and separated the 2 residents. Resident #21 sustained a scratch to his/her left face, caused by Resident #2 during the altercation, 911 was called, and Resident #21 was transferred to the ER (emergency room) for evaluation of the scratch on his/her left face. The self-report further documented that Resident #21 returned to the facility after having a CT (computed tomography) scan (medical imaging procedure) and no abnormalities were seen and documented that after reviewing all documents, including statements, the allegation was substantiated The self-report documented the incident occurred on 4/3/24 at 6:30 PM, however there was no documentation found in the self-report to indicate the name of the staff who first became aware of the incident. The self-report indicated that Resident #21 and Resident #2 were not able to accurately describe what happened or caused the altercation and no one witnessed the altercation, however when staff arrived in the dining room, staff observed Resident #21 holding Resident #2's wheelchair and a scratch was visible on Resident #21's left face. Continued review of the facility's investigation revealed the facility failed to thoroughly investigate the resident-to-resident altercation. The facility's investigation included 6 Witness Statement forms which were completed by staff. On the forms, the Name And Title Of The Witness, the Name/Title Of Person Taking the Statement, and the Date of Occurrence, were printed on the forms with a space for the witness to fill in the information, followed the heading Summary of Statement', and the questions 1. Were you present during the altercation with both residents?, 2. Did you work with this resident today?, 3. Did you suspect any concerns with the two residents in question? If yes, who did you report to? What was going on?, and 4. If you heard a noise in the dining room, were residents separated?. Following each question, the potential response of Yes and No was printed Review of the witness statements revealed that 6 of the 6 staff documented the date the incident occurred was 4/4/24, which contradicted the facility's self-report which documented the resident-to-resident altercation occurred on 4/3/34. In response to the question, were you present during the altercation with both residents, 6 of 6 staff circled the response no, indicating the staff member had not witnessed the altercation. In response to the question . If you heard a noise in the dining room, were residents separated?, 5 of 6 staff circled no, and 1 staff did not answer the question. All of the witness statements documented that none of the employees were present during the alteration. with both residents. There were no statements from the staff heard the noise coming from the 2nd floor dining room, the staff who responded to the noise in the dining room or the staff that separated the residents and determined an altercation between Resident #21 and Resident #2 had occurred. The facilities investigation included Abuse Questionnaire forms that asked residents Has staff, a resident or anyone else here abused you, this includes verbal, physical or sexual abuse:? Did you tell staff? Have you seen any resident here being abused? and Did you tell staff?, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's investigation included 2 Abuse Questionnaire forms that indicated 50 residents were interviewed for abuse, however, there the abuse questionnaire forms failed to include any resident names, only room numbers and there was no documentation on the forms to indicate who interviewed the residents. The facility's investigation included 12 Weekly Comprehensive Head to Toe Skin Assessment Report forms which had a space to document the resident's name, room number, the employee name, the date, a place to check whether the skin was normal or abnormal, and the statement if abnormal, record site of affected area(s) followed by an outline of the back and front person to document any skin irregularities. Review of the Skin Assessment Report forms revealed the resident's name, and his/her room number were handwritten on each of the assessment forms. The statement, No Skin Issues was handwritten on 11 of the 12 assessment forms included with the facility's investigation, and one form had no documentation to indicate the status of a resident's skin. There was no date documented on 10 of the 12 assessments to indicate when the assessment had been completed, and the name of the employee(s) that completed the skin assessments was not documented on 12 of the 12 assessments A skin assessment form for the scratch on Resident #21's left face was not found with the facility's investigation. Review of Resident #21's medical record revealed, on 4/3/24 at 7:31 PM in a Skin Grid Non-Pressure note, the nurse documented Resident #21 had a new non-pressure wound, and documented the wound was a scratch to left face that was red, moist grainy, optimal granulation with no exudate. The area to document the size of the wound was blank. Continued review of the facility's self-report and the resident's medical record medical record failed to reveal documentation of the size, depth and width of the scratch on Resident #21's left face which warranted a transfer to the hospital emergency room. The above concerns were discussed with the Director of Nurses (DON) on 5/22/25 at 3:05 PM and the DON acknowledged the concerns at that time.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, it was determined that facility staff failed to notify a resident in writing of a pending discharge and failed to ensure that the discharge was documented in the medical record. This was evident for 1 (#27) of 1 resident reviewed for discharges. The findings include: On 5/21/25 at 1:10 PM a review of complaint #MD00213157 revealed the complainant alleged Resident #27 had not received appropriate notice of the facility's intent to discharge him/her. A medical record review for Resident #27 on 5/27/25 at 1:31 PM revealed in the progress notes that the resident was discharged from the facility, however, there was no written notice of discharge. In Addition, staff failed to document discussion with the resident regarding discharge planning, the resident's input regarding the discharge, and the reason for the discharge. On 5/22/25 at 9:46 AM an interview with Social Worker Designee Staff #23 confirmed she worked with Resident #27 regarding discharge planning. She reported she had discussions with the resident about discharge and the resident was not sure where to go upon discharge. She reported the resident was not asking to be discharged and the reason for the discharge was because the resident's insurance was ending. When asked if she had issued a 30-day discharge letter to the resident she reported that the business office would handle that. An interview with the Business Office Manager on 5/22/25 at 10:19 AM revealed she received a notice from their corporate office Social Worker that the resident's insurance was ending on 12/4/24, however they did not issue a written 30-day notice to the resident. The resident was told verbally and was given the option to appeal. She stated this was the facility's normal practice to not issue a 30-day notice in writing when the resident's insurance was ending. This was reviewed with the Nursing Home Administrator on 6/5/25 at 9:20 AM. She acknowledge the concern.

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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. Based on record review and staff interview, it was determined that facility staff failed to develop resident-centered comprehensive care plans for their residents. This was evident for 3 (#8, #27, and #53) of 38 residents reviewed for complaints. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Elopement is defined as a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary, would be considered an elopement. 1) On 5/28/25 at 3:46 PM during a review of the facility report incident investigation file for incident #MD00206569 it was revealed that on 6/12/24, facility staff were unable to find Resident #8 and s/he was found the next day at a nearby shopping center parking lot. A review of the resident's statement revealed that s/he had paid someone to push them in their wheelchair to the nearby shopping center, however, due to the resident's physical limitations s/he was unable to get back to the facility. An electronic medical record review on 5/28/25 at 4:17 PM, for Resident #8 revealed under the assessment tab the resident was assessed for elopement risk on admission and quarterly and found to be no risk. A review of the physician's orders revealed the resident had an order dated 10/19/22 that read the resident could go on a leave of absence with supervision. The MDS with the assessment reference date of 5/31/24 revealed the resident had no cognitive impairment and was wheelchair bound. Further review revealed that after the incident on 6/12/24, the elopement risk assessment conducted on 6/21/24, the nurse documented the resident had not eloped in the past. The facility failed to develop a care plan for elopement and implement interventions to ensure this incident does not occur again. On 5/28/25 at 4:17 PM an interview with the Director of Nursing (DON) revealed he failed to recognize the incident on 6/12/25 as an elopement because of the resident cognitive status and failed to ensure that interventions were put into place to prevent further elopements. An interview with the Nursing Home Administrator (NHA) on 5/29/25 at 8:42 AM revealed she failed to recognize this incident as an elopement. 2) A medical record review for Resident #27 on 5/27/25 at 1:31 PM revealed in the progress notes that the resident was discharged from the facility, however, there was no discharge care plan included. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 at 9:46 AM an interview with Social Worker Designee Staff #23 revealed she initiated a care plan for each new admission that was assigned to her. She confirmed that Resident #27 was assigned to her, however, she had no rationale as to why she failed to initiate a discharge care plan for the resident. The concerns were reviewed with the Director of Nursing (DON) on 5/28/25 at 4:37 PM and he acknowledged the concerns. 3) Review of complaint MD00207518 on 6/2/25 at 10:48 AM sent to the Office of Health Care Quality (OHCQ) revealed that Resident #53 was malodorous from the facility nursing staff failing to change the resident and provide ADL care. Review of Resident #55's medical record on 6/2/25 at 11:10 AM reveal no care plan for incontinence. A document dated 6/20/24 titled bowel elimination pattern assessed the resident has being bowel incontinent. MDS assessments dated 6/19/24 and 2/10/25 assessed the resident has being frequently incontinent of bowel and bladder. During an interview with the Director of Nursing (DON) on 6/3/25 at 8:00 AM, the surveyor informed the DON that the facility failed to provide an incontinence care plan for Resident #53.

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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** [NAME] ' s example: Harm Based on record review and interview, it was determined that the facility failed to ensure that adequate supervision to prevent accidents/hazards was provided 1) during care which resulted in a fall causing harm to Resident #55. This was evident for 1 of 38 residents reviewed for complaints. The findings include: Review of complaint intake MD00212102 on 6/3/25 at 10:30am revealed that resident #55 ' s family alleged that the facility neglected to provide adequate supervision to the resident. This lack of supervision resulted in the resident having a fall incident. Review of resident #55 ' s medical record revealed a care plan that stated that the resident had ADL self-care performance deficit due to his/her immobility as of 7/3/2017. The care plan ' s interventions for the resident ' s self-care performance deficit was to have staff provide assistance with ADL care. Further review of resident #55 ' s medical record revealed an MDS assessment (Section GG) dated 10/11/24 which assessed the resident as being dependent on staff for ADL care and bed mobility which included being rolled from left to right from a lying position. On 6/4/25 at 11:00am, the DON provided the surveyor with a copy of the November 2024 GNA Kardex for resident #55. Review of the GNA Kardex for November 2024 revealed that the resident was totally dependent on nursing staff for toileting hygiene and being rolled from left to right on 11/20/24 (the day of the fall incident). Also, the resident required two person assistance for both toileting hygiene and being rolled from left to right on 11/20/24. Further review of resident #55's medical record revealed a change in condition document dated 11/20/24 which reported that the resident had a fall incident at approximately 2:30pm. The change in condition stated that GNA #18 was providing ADL care for the resident when the fall incident occurred. GNA #18 was turning the resident when he/she slid off the bed onto the floor. Another change in condition document dated 11/20/24 at 5:47pm stated that the resident complained of pain in both legs after the fall incident. The facility transferred the resident to the local hospital for further evaluation. Interview with the Director of Nursing (DON) on 6/4/25 at 9:30am confirmed that resident #55 had a fall incident on 11/20/24 that resulted in the resident being transferred to the local hospital for evaluation. The DON also confirmed that the facility did not report the fall incident because facility nursing staff witnessed the fall incident. The DON provided the surveyor with the fall incident investigation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility fall investigation on 6/4/25 at 10:00am revealed that the fall investigation contained two witness statements from GNA #18 and RN Unit Manager #19, a copy of the resident ' s care plan, and a copy of the change in condition documents from 11/20/24. The witness statement from GNA #18 dated 11/20/24 stated that he/she was providing ADL care and asked resident #55 to assist him/her in turning the resident to his/her left side. GNA #18 was standing on the resident ' s right side and turning the resident to his/her left side when the resident slid from the bed to the floor. GNA #18 stated that he/she lowered the bed and called for help to assess the resident. The witness statement from RN Unit Manager #19 stated that GNA #18 was re-educated on how to call for help at all times during resident care. On 6/4/25 at 10:12am, the surveyor interviewed GNA #18. During the surveyor interview, GNA #18 confirmed that he/she witnessed resident #55 fall from his/her bed on 11/20/24 when GNA #18 was turning resident #55 onto his/her left side during ADL care. GNA #18 also confirmed that he/she raised the height of the resident ' s bed to his/her waist, which was at least 30 inches from the floor, to make changing the resident easier for the GNA. GNA #18 stated he/she asked the resident to use the upper bed rails (enablers) to assist with turning the resident to his/her left side. GNA #18 then stated that he/she witnessed the resident continue to roll toward the left side with the resident ' s legs sliding off the bed. GNA #18 stated that he/she tried to stop the resident from rolling off the bed but he/she was unable to stop the resident because the resident was a big person. GNA #18 then stated that he/she called for help and RN Unit Manager #19 came into the resident ' s room to assess and assist with the resident after the fall. GNA #18 then stated that RN Unit Manager #19 assessed the resident for damage. The resident complained of pain to his/her knee. GNA #18 and another staff member used the hoyer lift to transfer the resident from the floor to the bed. GNA #18 stated that he/she was later educated on how to roll a resident and that the resident was a 2 person assist. Surveyor interview with RN Unit Manger #19 on 6/4/25 at 12:10pm confirmed that resident #55 was known to require 2 person assistance when the resident needed to be turned. RN Unit Manager #19 stated, the resident is heavy .and needs to have two people assisting .when the resident needs to be turned. The other person can stop the resident from falling off the bed . Interview with MDS Coordinator #20 on 6/4/25 at 2:49pm confirmed that the resident required two personal assistance for toileting hygiene, personal hygiene and rolling left to right. On 6/4/2025 at 10:05am, the DON provided the surveyor with the emergency room report from the local hospital for resident #55 ' s visit on 11/20/24. Review of the emergency room report from the local hospital revealed that the resident was sent to the local hospital after a fall on 11/20/24 and complaining of pain to the left hip. The local hospital assessed the resident and found that the resident had a fracture to the left leg. The surveyor informed the Executive Director and the DON on 6/5/25 at 9:30am of the deficient practice of failing to provide adequate supervision that caused harm to resident #55 on 11/20/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215231	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clinton Healthcare Center	9211 Stuart Lane Clinton, MD 20735

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 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. Based on observation during tour and interview with facility staff, it was determined that the facility staff failed to ensure that the facility stock medications and supplies were maintained in a secure fashion. This was found evident during one of the random tours completed during the complaint survey on 1 of 3 units. The findings include: During the tour of the facility on 5/28/25 around 10:20 AM of the back hall that connects 3 East and 3 West, fully accessible to residents, the survey team identified an open room filled with boxes and contractor equipment. Upon closer inspection and observation, inside the numerous unorganized boxes were multiple bags of bottles and random bottles laying in the boxes of the following medications: Vitamin D 1250 milligram (mg) capsules Aspirin 81 mg Deep Sea premium nasal Spray Ferrous Sulfate 325 mg supplement Zinc 50 mg Acetaminophen extra strength 500 mg Stress Formula high potency dietary supplement Cranberry Dietary supplement Melatonin 3mg supplement Iron Tablets 325 mg supplement, Elemental Ferrous 65mg Multiple cases of Jevity 1.0 Calorie-supplemental gastrostomy tube feeding Additionally, there were multiple boxes of the following medical supplies found: Assure Platinum glucose test strips Magellan brand hypodermic safety needles Within the room there was also an unsecured contractor ladder and large spools of wire that were in use intermittently by the contractors for the repairs currently being completed in the facility. (continued on next page)

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	215231	A. Building B. Wing	06/05/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:30 AM on 5/28/25 one of the contractors was interviewed regarding their access to the room. They stated that it was unlocked by 'someone' that morning at approximately 8:15 AM and the room has stayed open since then. A tour was completed with the facility Nursing Home Administrator (NHA) on 5/28/25 at 11:40 AM to show her the concerns that were observed by the survey team. She was shown the plethora of medications that were accessible in addition to the boxes of needles and unsecured contractor equipment. Staff #21 who was identified as the central supply employee who unlocked the door this morning, was interviewed at 1:06 PM on 5/28/25. He stated that 'yes' there are supplies in there and he goes in throughout the day to get what's needed and it is usually locked but was left open for the contractors. The concern about the unsecured medication was reviewed with the facility NHA on 5/28/25 and again during exit on 6/5/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215231	A. Building B. Wing	06/05/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined the facility staff failed to maintain a medical record in the most accurate form. This was evident for 1 (#47) of 17 facility reported incidents reviewed and 1 (#35) of 38 residents reviewed for complaints. The findings include: 1) A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. resident records. Resident #47 was admitted to the facility on [DATE]. Resident #47's closed record was reviewed on [DATE] which revealed a MOLST form was completed on [DATE] by CRNP#1. The front page of the MOLST form did not indicate what Resident #47's wishes for life sustaining care. (Full Code, No CPR) In an interview with CRNP#1 on [DATE] at 2 PM, CRNP#1 reviewed Resident #47's [DATE] MOLST form and stated that s/he did not realize that s/he had not completed the first page after speaking with Resident #47 on [DATE]. 2) A review of Resident #35's medical record on [DATE] at 9:10 AM revealed 2 progress notes written by Staff Developer #24 on [DATE]. She made a late entry note for [DATE] and [DATE], documenting Resident #35 had refused his/her shower, the resident was educated, and the resident representative and physician were notified. This indicated that the refusal, education, and notifications occurred on [DATE] and [DATE]. A review of the Geriatric Nursing Assistant (GNA) documentation there was no refusal documented for the shower, but that a bed bath was given. On [DATE] at 10:35 AM an interview with Staff Developer #24, revealed she was the Unit Manager for the unit that Resident #35 resided when these notes were created. She reported she was auditing showers and when she found the resident refused and the assigned nurse had not made a note she would create a progress note. She reported that the showers were refused on [DATE] and [DATE] based on the shower sheets, however the education and notifications occurred on another date which may have not been on [DATE] when she wrote the note. The concerns were reviewed with the Director of Nursing (DON) on [DATE] at 9:01 AM and agreed that the progress notes did not accurately reflect what had occurred.