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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Hill Bethesda	5215 Cedar Lane Bethesda, MD 20814

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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 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. 42783 Based on record review and interview, it was determined the facility failed to ensure a resident was free of neglect. This was found to be evident for 1 (Resident #165) out of 1 Resident reviewed for neglect during the recertification survey. The findings include: According to the Centers for Medicare and Medicaid Services Activities of Daily Living (ADLs) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. A review of complaint MD00191143 submitted to the Office of Health Care Quality was conducted on 01/14/25 at 7:22 AM. The complaint reported a concern that the facility did not provide Resident #165 ADL care during an entire shift, as a result the resident's was extremely upset because his/her gown and bed linen were soaked in urine. During a record review conducted on 01/14/25 at 8:13 AM revealed a health status note from Licensed Practical Nurse (LPN) # 27 dated 4/15/2023 03:27. The note stated Resident has [Resident gender pronoun] call light on upon arrival. resident complains to be clean up and wants to be clean and change [Resident's gender pronoun] wet bed linens . Night shift (11pm - 7 am) came and met Resident all wet. [Resident's gender pronoun] diaper and bed has been wet all evening shift, this came led to bed soreness. Resident complained to the night shift of not being changed on 3 to 11 shift. The resident was in distress and screaming. writer and aid when in to clean [Resident's gender pronoun] up. During an interview conducted on 01/15/25 at 11:07 AM, the Director of Nursing (DON) stated that he was aware of Resident #165 not receiving ADL care and had provided an in-service to LPN #27 for appropriate documentation into patient chart and reporting any patient concerns to the Director of Nursing or the Assistant Director of Nursing for proper follow up.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 50502 Based on a review of facility-reported incident investigation, record review and interview, it was determined that the facility failed to thoroughly investigate an allegation of abuse. This was evident for 1 (Resident #358) of 11 residents reviewed for abuse during the recertification survey. The findings include: On 1/15/2025 at 3:40 PM, a review of facility-reported incident MD00189545 revealed that on 3/1/2023, Resident #358's family member reported that about 2 weeks prior, Resident #358's Geriatric Nurse Assistant (GNA) hit him/her in the back of the head 5 times. He/she stated that he/she did not report the incident at the time because he/she did not want to get anyone in trouble. On 1/15/2025 at 4:03 PM, a review of Resident #358's medical record indicated a BIMS score of 10 of 15, moderate impairment (Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities.) Further review of the facility's investigation revealed that Resident #358 was interviewed, and he/she denied being hit by the GNA or any member of staff. Other staff members were interviewed and denied knowledge of abuse. Other residents were also interviewed and denied being abused or witnessed any form of abuse. An interview with the assigned GNAs denied any bruising or discoloration. The employee was placed on administrative leave, however, the facility failed to obtain statement from the perpetrator. On 1/16/2025 at 7:55 AM, in an interview with the Director of Nursing (DON), he stated that he helped the Nursing Home Administrator (NHA) conduct the self-report investigations. He explained that for allegations of abuse, the facility removed the alleged staff from the schedule and determined if the staff could come back to work depending on the result of the investigation. He said that they did head-to-toe assessment of the resident, notified the doctor, the family, the Social Worker was involved and reported the incident to the law enforcement. He added that the facility conducted staff and resident interviews, obtained a statement from the perpetrator, reviewed the employee file and conducted an abuse in-service for the staff members. On 1/16/2025 at 8:05 AM, the NHA was made aware that there was no evidence that a statement from the perpetrator was obtained.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45733 Based on observation, interview and medical record review it was determined that the facility failed to provide an invitation to residents for care plan meetings, failed to provide residents with care plan meetings and failed to revise resident care plans. This was found to be evident in 5 (Resident #1, #58, #62, #158 and #164) out of 10 Residents reviewed for care plan timing and revision. The findings include: Care Plan meetings are meetings with a team of care providers (attending physician, a registered nurse, nursing assistant dietary services, resident, and the resident ' s representative if applicable) to ensure the plan is continually adjusted to meet the changing needs or concerns of residents. Care Plan meetings are to be held quarterly. BIMS uses a scoring system that is a number between 0 and 15 that indicates a resident's cognitive health in a long-term care facility. The BIMS score is used to help identify early signs of cognitive decline and the need for further evaluation. Scores: 13-15: Intact cognition, 8-12: Moderate cognitive impairment & 0-7: Severe cognitive impairment. 1) In interview on 01/07/25 at 04:40 PM, Resident #1 stated I don't know what care plan was for? Record review, 01/13/25 at 02:48 PM, revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses of encephalopathy and cognitive function decline. A cognitive evaluation on 10/21/24 by Social Worker #2 with the BIMS score showed 10, indicating moderate cognitive impairment . Further record review found no social worker's care plan conference invitation nor conference notes. During an interview, on 01/16/25 at 09:49 AM, Social Worker Staff #2 stated that she worked in the facility for over [AGE] years. She reported that upon admission Resident #1 had a case worker from the Adult Protection Service following the Resident's care. Staff #2 was able to contact the case worker by phone for financial concerns but not for care-plan meetings. Staff #2 could not explain why she never sent out a care-plan meeting invites to this Resident and the case worker. Interview, on 01/16/25 at 09:59 AM, the Administrator was made aware of the above findings and agreed that there was a deficient practice. 49815 2) On 1/8/2025 at 11:08 AM the surveyor interviewed Resident #62 who stated that he/she does not recall attending care plan meetings recently. The surveyor conducted a review of Resident #62's medical record on 1/14/2025 at 9:30 AM. The review of the medical record revealed that there was one care plan meeting note in the progress notes of Resident #62's medical record for the past year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Nursing Home Administrator (NHA) at 8:30 AM on 1/15/2025 the surveyor conveyed to the NHA that there was only one care plan meeting note in Resident #62's medical record. The NHA provided the surveyor with the plan of care progress note and an attendance sheet dated 8/8/2024 which indicated that the care plan was discussed with Resident, responsible party and the interdisciplinary team. The surveyor asked the NHA for additional care plan meeting documentation for Resident #62 over the past year and the NHA stated to the surveyor that there was not any additional documentation of care meetings for the past year for Resident #62. 3) During an interview on 1/9/2025 at 8:15 AM Resident #58 stated to the surveyor that he/she has never been invited to a care plan meeting and that this was the first time that he/she heard about a care plan meeting. The surveyor reviewed Resident #58's medical record on 1/13/2025 at 9:15 AM. There was no documentation that a care plan invitation was provided, or a care plan meeting was held for Resident #58 for August 2024. The surveyor interviewed the Nursing Home Administrator (NHA) at 1:30 PM on 1/13/2025 and the NHA provided the surveyor with copies of progress notes detailing care plan meetings that were held 5/20/2024 and 10/29/2024 for Resident #58. The NHA was unable to provide a progress note for the care plan meeting or that a care plan meeting was held or that an invitation was provided for the month of August 2024 for Resident #58. The progress notes for May 2024 and October 2024 indicated the following: discussed plan of care with patient & daughter. In a follow-up interview with the NHA at 11:30 AM on 1/13/2025 he stated that these were the only 2 care plan meetings that were held for Resident #58 during the past year which were documented in the progress notes and that there was no documentation for invitations to care plan meetings for additional care plan meetings that were held during the past year. An Arteriovenous (AV) Fistula is a surgical connection made between an artery and a vein typically located in the arm in preparation for dialysis by a vascular specialist. AV Fistulas are the preferred vascular access for long-term dialysis. With an AV Fistula, blood flows from the artery directly into the vein, increasing the blood pressure and the amount of blood flow through the vein. The increased flow and pressure cause the veins to enlarge. The enlarged veins will be capable of delivering the amount of blood flow necessary to provide adequate treatment for hemodialysis. A permacath or permanent catheter for dialysis is a flexible tube that is used to treat kidney disease with dialysis. It is inserted into a blood vessel in the neck or upper chest and threaded to the right side of the heart. The catheter has two tubes inside, one for blood to the dialysis machine and one for the blood return. The cuff under the skin keeps the catheter in place. Permacaths are used for short term dialysis or until an AV Fistula can be created. On 1/9/2025 at 8:15 AM the surveyor observed Resident #58 in the Resident room with an AV fistula to the right upper arm. The surveyor reviewed the medical record of Resident #58 on 1/13/2025 at 9:15 AM. The review of the medical record revealed that Resident #58 had a current care plan for a permacath for dialysis. Further review of the current physician orders revealed that Resident #58 had current orders for an AV Fistula for dialysis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor interviewed the Director of Nursing (DON) on 1/15/2025 at 10:45 AM and reviewed Resident #58's current care plan and physician orders for dialysis. The surveyor conveyed to the DON that the care plan indicated that the Resident had a permacath but the physician orders indicated that the Resident had an AV Fistula. The Director of Nursing acknowledged that the Resident #58 had an AV Fistula for dialysis and no longer had a permacath for dialysis. On 1/16/2025 at 8:30 AM the DON provided the surveyor with a revised care plan for dialysis which indicated that Resident #58 had an AV Fistula. 51491 4) During a review of Resident Medical Records on 1/08/25 at 03:54 PM it was discovered that Resident #158 had been a resident in the facility since May 2022. Resident #158 had several medical conditions and was dependent on staff for care, including eating, transferring, and mobility. It was found that the Resident had not had quarterly Care Plan Meetings on regular basis. The only documented Care Plan Meeting was held on 7/15/2024. During an interview with Social Service Designee #2 on 1/15/25 at 10:54 AM, she confirmed that they are behind on Care Plan Meetings and that Social Worker Designee #29 handles Residents #158 and #164. During an interview with Social Worker Designee #29 on 1/15/25 at 11:13 AM, she confirmed that Care Plan Meetings are not up to date. She reported that the Care Plan Meetings are documented in the Resident's Medical Records, and she maintains the attendance sheets for Care Plan meetings. During an interview with the Nursing Home Administrator (NHA) on 1/15/25 at 12:30 PM, the NHA provided a signoff sheet for a Care Plan meeting for Resident #158 dated 7/15/24. The signoff sheet included the Dietician, Social worker Designee, Unit Manager, and Activities. He confirmed there were no additional attendance sheets or documentation of Care Plan Meetings. The NHA advised he was aware of the late status of Care Plan meetings. The Attendance sheet provided for the Care Plan Meeting for 07/15/24 included the son, dietician, unit manager activities and Social Services, no other documented Care Plan Meetings for Resident #158 were provided. 5) During a Review of Resident Medical Records on 1/15/25 at 07:45, it was discovered that Resident #164 had been a resident in the facility from December 2022 until January 2024. The Resident had several medical conditions and was dependent on staff for care. It was found that the Resident had not been given the required quarterly Care Plan Meetings. The Resident had a documented Care Plan Meeting for 3/2/23, no additional meetings were found. During an interview with Social Service Designee #2 on 1/15/25 at 10:54 AM, she confirmed that they were behind on Care Plan Meetings and that Social Worker Designee #29 handles the Residents #158 and #164. During an interview with Social Worker Designee #29 on 1/15/25 at 11:13 AM, she confirmed that Care Plan Meetings were not up to date. She reported that the Care Plan Meetings were documented in the Resident's Medical Records and she maintained the Attendance sheets for Care Plan meetings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Nursing Home Administrator (NHA) on 1/15/25 at 12:30 PM, the NHA had no Attendance Sheets for care plan meetings for Resident #164. He confirmed there were no additional attendance sheets or documentation of Care Plan Meetings. He was made aware of the late status of Care Plan meetings.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 42783 Based on observation, interview and record review the facility failed to 1) ensure a diet met the need of the resident and 2) provide a resident with a lunch meal to accompany resident on scheduled days of dialysis to an outpatient dialysis center. This was found to be evident in 2 (Resident #58 and #169) out of 5 residents reviewed for food and nutrition services. The findings include: 1) A review of complaint MD00205719 submitted to the Office of Health Care Quality was conducted on 01/16/25 at 7:00 PM. The complaint reported a concern that the facility did not provide Resident #169 the low-fat low residue diet that the Resident's medical condition required. On 01/16/25 at 7:10 PM a review of Resident #169's hospital discharge summary dated 05/02/24 stated a low fiber low insoluble residue diet, avoid all coffee, and dairy. On 01/16/2025 at 7:46 PM review of Resident #169's Physician order showed the following diet orders: order dated 05/02/24 Regular diet Mechanical Soft texture, Regular/Thin consistency; order dated 05/10/24 Regular diet Regular texture, Regular/Thin consistency; and on 05/22/24 Dietary consult eval diet preference one time only for diet for 1 Day. During an interview conducted on 01/17/24 at 7:30 AM, the Registered Dietician (RD) #6 reviewed Resident #169's diet orders and confirmed that the resident was ordered a regular diet mechanical soft. During an interview conducted on 01/17/24 at 7:40AM, Supervisor Registered Nurse (RN) #24 stated that when a resident is admitted to the facility the admitting nurse will review the hospital discharge summary to identify the diet. The nurse will fill out a form called CHB (Carriage Hill Bethesda) Resident Diet Card and will check off the diet, if the diet is not listed then the diet such as low fiber diet is written in the other section. The Diet Card is then sent to the kitchen. The Supervisor also stated that a copy of the diet card was not kept therefore she was unable to verify the diet order that was sent to the kitchen for Resident #169. During an interview conducted on 01/17/24 at 8:33 AM, the Dietary Manager (DM) stated she no longer had Resident #169's CHB diet card sent from nursing on admission. On 01/17/24 at 8:34 AM, the DM, RD and Surveyor reviewed the meal ticket dated 5/23/24. The meal ticket showed that Resident #169 had a Regular/Thin Regular diet with likes: for low fiber, no raw vegetables, no milk and dislikes: no beef or pork but likes bacon. The DM stated that the Resident's family member was unhappy that the Resident had not received the low-fat low residual diet when admitted and requested that the resident have a low-fat diet. The DM further stated that the Resident's family member also advised the DM of the Resident's likes and dislikes. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the continued interview, the DM showed this Surveyor handwritten notes in a composition notebook of likes and dislikes for the Resident. The DM was unable to provide the date of when the Resident's diet order was changed to a low-fat diet and the like and dislikes were added to the Resident meal preferences. The DM also provided a list of likes and dislikes that she received via email from the RD on 05/23/24. 49815 2) The surveyor interviewed Resident #58 on 1/9/2025 at 8:15 AM. Resident #58 stated that he/she goes to an outpatient dialysis center every Monday, Wednesday and Friday and that he/she leaves the facility after breakfast and returns around 4:00 pm. Resident #58 further stated that he/she is not provided with a lunch from the facility to take to dialysis and that the dialysis center does not provide lunch. On 1/13/2025 at 12:55 PM the surveyor observed the food delivery cart in the hallway on nursing unit 2. Resident #58's meal tray was on the food delivery cart with the meal ticket torn in half on the meal tray. The surveyor interviewed Geriatric Nursing Assistant (GNA) #17 who was in the hallway near the food delivery cart. The surveyor asked GNA #17 about Resident #58's meal tray that was observed on the food delivery cart. GNA #17 stated that Resident #58 was out of the facility today at dialysis and that was why Resident #58's lunch tray was on the food delivery cart with the meal ticket torn in half. Review of Resident #58's medical record on 1/13/2025 at 7:30 AM revealed that Resident had a current physician order for Regular diet, double protein and a nutritional care plan to provide and serve diet as ordered. On 1/14/2025 at 11:30 AM the surveyor interviewed Resident #58, and he stated that he/she went to dialysis yesterday and that lunch was not provided. Resident #58 further stated that when he/she returned from dialysis at 4:00 PM, the lunch tray was on the table in his/her room. The surveyor interviewed Resident #58's assigned Registered Nurse (RN) #19 on 1/15/2025 at 8:33 AM and RN #19 stated that the facility does not provide a lunch for Resident to take with him/her on dialysis days which is Monday, Wednesday and Friday. The Nursing Home Administrator (NHA) and the Director of Nursing (DON) were notified by the surveyor on 1/15/2025 at 8:40 AM that Resident #58 does not receive a lunch meal to take with him/her on scheduled dialysis days and that the outpatient dialysis center does not provide a lunch meal for the Resident. The Director of Nursing stated that he would check on this. On follow-up interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) at 10:30 AM on 1/15/2025 they stated that Resident #58's daughter use to provide a lunch meal for Resident #58 on scheduled dialysis days. The surveyor conveyed to the DON and the NHA that Resident #58 stated that he/she was not provided a lunch and does not eat lunch at the dialysis center. No additional information was provided by the NHA or DON at the time of the exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 48393 Based on observations, clinical record reviews and interviews, it was determined that the facility failed to ensure that medical records maintained for residents reflect an accurate representation of the care and services provided across all disciplines and failed to ensure the accuracy of the Medical Orders for Life-Sustaining Treatment (MOLST) order form. This was evident for 8 (Resident #94, #158, #166, #255, #256, #455, #1 and #10) out of 74 residents sampled during the annual survey. The findings include: 1) On 01/14/2025 at 12:38 PM, the Director of Nursing (DON) stated that the activities staff keeps activity logs for residents under the plan of care (POC) Task section in Point Click Care (PCC), the electronic health record. On 01/14/25 at 1:19 PM, a review of the POC Task documentation provided by the facility administrator showed that Resident #94 participated in activities for two days, 11/18 and 11/19, in November 2024. December 2024 and January 2025 activity documentation was requested, however no further POC Task documentation of activities for Resident #94 was provided. On 01/15/2025 at 9:44 AM, an interview conducted with the Activities Director (AD) #21 confirmed that Resident #94's activity participation is documented in PCC under the POC Task section. The AD #21 stated that there was no documentation in PCC for Resident #94's December 2024 or January 2025 activity participation. The AD further stated that some participation notes are kept on paper in separate notebooks and that she would provide the notes for review. During a follow up interview with the AD #21 on 01/15/25 at 09:57AM, the AD #21 provided three notebooks to the surveyor for review and stated, These are the notes I keep of who attended activities. I don't have much in here for Resident #94. On 01/15/2025 at 10:04 AM, an interview conducted with the Activities Assistant #20 revealed that Resident #94 attends activities 1-2 times a week and that she keeps record of his/her attendance in a separate notebook in the office and in PCC. On 01/15/25 at 10:30 AM, Activities Assistant #20 reviewed the notebook pages together with the surveyor. There was no evidence to support that Resident #94 attends activities in the facility according to his/her care plan. At the time of exit conference, the facility did not provide any additional evidence to show that Resident #94's clinical record reflected an accurate representation of activities provided in the facility. 2) On 01/14/25 at 09:01 AM, a review of resident #255's clinical record revealed no data found for completed bathe/shower tasks in point click care (PCC), the electronic health record, for the last 14 days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/14/2025 at 9:38 AM, the surveyor requested documents from the facility related to Resident #255's completed bathe/shower tasks. On 01/14/2025 at 11:44 AM, the Director of Nursing (DON) provided skin sheet documents which revealed that Resident #255 received a shower in the facility on 1/1/25, 1/4/25, 1/8/25, and 1/11/25. On 01/14/2025 at 1:07 PM, an interview conducted with the DON revealed that resident showers are documented on skin sheets and also in PCC. The DON stated that Resident #255's shower documentation from PCC would be provided for review. On 01/14/2025 at 1:35 PM, a subsequent review of Resident #255's shower documentation from PCC was conducted. The review revealed that Resident #255 received showers in the facility on 1/6/25, 1/9/25, and 1/11/25. On 01/14/2025 at 01:59 PM, a follow up interview with the DON confirmed that shower dates on Resident #255's skin sheet documentation from the binder did not match the dates on shower documentation entered in PCC. The DON stated that Resident #255's shower days recently changed due to a room change assignment. The DON further stated that his expectation for shower documentation is that nursing staff documents bathe/ shower tasks accurately on both skin sheets and in PCC for every resident. 3) On 01/14/25 at 09:01 AM, a review of Resident #256's clinical record in point click care (PCC) revealed no documented evidence to support his/her participation in an activities program. On 01/14/2025 at 9:38 AM, the surveyor requested documents from the facility related to Resident #256's activity participation in the facility for November 2024, December 2024 and January 2025. However, no further PCC documentation of activities for Resident #256 was provided. On 01/15/2025 at 9:44 AM, an interview conducted with the Activities Director (AD) #21 revealed that residents' activity participation is documented in PCC under the Task section. The AD #21 confirmed that there was no documentation in PCC for Resident #256's activity participation for requested months of November 2024, December 2024 or January 2025. The AD stated that some participation notes are kept on paper in separate notebooks and that she would provide the notebooks for review. During a follow up interview with the AD #21 on 01/15/2025 at 09:57AM, the AD #21 provided three notebooks to the surveyor for review and stated, These are the notes I keep of what residents attended activities but I don't have much in here for Resident #256. On 01/15/2025 at 10:04 AM, an interview conducted with the Activities Assistant #20 revealed that Resident #256 refuses to get out of bed for activities but that he/she receives the newspaper daily according to his likes and preferences. AD #20 further stated that she keeps record of his/her 1:1 room visits in a separate notebook and also documents in PCC. Multiple observations were conducted of Resident #256 reading the newspaper daily in his/her room throughout the annual survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER Carriage Hill Bethesda		STREET ADDRESS, CITY, STATE, ZIP CODE 5215 Cedar Lane Bethesda, MD 20814	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/15/25 at 10:30 AM, Activities Assistant #20 reviewed the notebook pages together with the surveyor. There was no documented evidence of Resident #256's newspaper reading activities. There were also no documented incidences of Resident #256's refusals to attend activity offerings in the facility. At the time of exit conference, the facility did not provide any additional evidence to show that Resident #256's clinical record in PCC reflected an accurate representation of the resident's current activity participation status in the facility. 50502 4) Atorvastatin Calcium is a drug used to lower the amount of cholesterol in the blood and to prevent stroke, heart attack, and chest pain. On 1/16/2022 at 9:11 AM, a review of complaint MD00187193 dated 1/3/2023 indicated that Resident #166 did not receive his/her medication on January 1, 2023. On 1/16/2025 at 10:25 AM, a review of the physician orders revealed that Resident #166 was on ATORVASTATIN CALCIUM 40MG TABLET Give 1 tablet by mouth in the evening for cholesterol -Start Date: 12/28/2022 - Date discontinued: 01/30/2023. Further review of the Medication Administration Record (MAR) revealed that Resident #166 did not receive the Atorvastatin dose from December 28, 2022, to January 6, 2023. On 1/16/25 at 11:28 AM, during an interview with the Assistant Director of Nursing (ADON), she described the process on how the facility made sure that the residents received their medications. She said that they checked the MAR for blank spaces that indicated that the nurse did not sign and immediately called the attention of the assigned nurse. The ADON reviewed the MAR in front of the surveyor and confirmed that Resident #166 did not receive the Atorvastatin dose for 10 days. On 1/16/25 at 12:30 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were made aware of the concern. 51491 5) During a Medical Record Review of Resident #455 on 1/09/25 at 03:48 PM it was discovered his/her care plan identified him/her as being at risk for skin breakdown due to generalized weakness, being mobility impaired, and having incontinence. The doctor ordered an air mattress for his/her bed for wound healing/prevention and to check the functioning and placement of the air mattress every shift. During an observation on 01/10/25 at 07:59 AM Resident #455 was seen lying in bed on a standard mattress, not an air mattress. During an observation on 01/13/25 at 09:10 AM Resident #455 was seen lying in bed on a standard mattress, not an air mattress. During a Medical Review of the Task Administration Record (TAR) on 1/13/25 at 10:35 AM, it was discovered that the order for monitoring of the Air Mattress was signed off as completed for 10 shifts, from night shift 1/09/25 to night shift 1/12/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/13/24 at 10:40 with the Director of Nursing (DON), he stated that the expectations are for the air mattress to be set up within 24 hours after ordered and agreed the resident should have had an air mattress. 6) A Medication Regimen Review is a review of all medications the resident is taking to identify any potential side effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. During a Medical Record review of Resident #158 on 1/08/25 at 04:02 PM it was discovered that the Resident was administered medications for bipolar disorder. The Pharmacy had completed a Medication Regimen Review (MRR) and had made recommendations for the doctor to modify medication orders. The MRR was not found in the Resident's Medical Records. During an interview with the Director of Nursing (DON) on 01/10/25 at 08:42 AM he stated the MRRs are not kept in the Resident's Chart, the recommendations are kept in a binder. During an observation on 1/10/25 at 10:23 the DON had provided 2 large, 3-ring binders marked, one binder for the first floor and one binder for the second floor. The binders were labeled Pharmacy Recommendations and inside the binder were the requested MRR's recommendations. The dates of the MRR records consist of records going as far back as 2021. During a Medical Regimen Review of the MRR in the binder on 1/10/25 at 10:44 AM it was discovered that the Pharmacy had made recommendations on 7/09/24 that stated Resident #158 has been on dual antipsychotic therapy without a Gradual Dose Reduction attempt in more than 2 years. For these reasons, please assess and evaluate if he/she is a safe candidate for a trial dose reduction on these agents. The Doctor responded disagreeing and the stated resident needed a Psych Consult. During an interview with the DON on 1/13/25 at 06:38 AM, the facility is not currently adding the MRRs to the Resident's charts. He reported that the Medical Records employee who was downloading them into the Resident's chart is no longer with the facility and the facility has been looking for a replacement to handle the duty. They are looking for someone to scan the MRRs into the Resident's chart. 45733 7) Maryland Medical Orders for Life-Sustaining Treatment (MOLST) order is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. An incapacitated person cannot sign a Medical Orders for Life-Sustaining Treatment (MOLST) form. Instead, a health care agent or surrogate can sign the form on their behalf. BIMS uses a scoring system from 0-15 to assess a nursing home resident's cognitive status. The BIMS score helps to identify early signs of cognitive decline and the need for further evaluation. Scores: 13-15: Intact cognition, 8-12: Moderate cognitive impairment and 0-7: Severe cognitive impairment. During a floor rounding, on 1/7/25 at 12:23 PM, Resident #1 stated, What is Medical Orders for Life-Sustaining Treatment? I like the color of the packaging. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review, on 1/8/25 at 01:03 PM, revealed that Resident #1 was admitted to the facility, on 10/19/24, with diagnoses of encephalopathy, cognitive decline, confusion & paranoia. The resident's stay was authorized for skilled nursing care. Upon admission an initial Brief Interview for Mental Status (BIMS) was done and outcome was 9 which indicated moderate cognitive impairment. Further review of a Psychiatric Consult notes, dated 10/16/24 revealed that this resident was diagnosed with dementia, neurocognitive decline and delirium. However, on 10/21/24, the facility's physician staff #28 completed a MOLST order form marking the resident as a cognitive intact consent party. During the interview, on 01/09/25 at 02:24 PM, the Assistant Director of Nursing staff #1 and the Administrator were made aware of the above findings. Staff #1 agreed that Resident #1 was not reliable in making treatment decisions since the resident was admitted last year in October 2024. Both were informed that there was a concern in regards to the accuracy of the MOLST order. 8) Record review on 01/13/25 at 02:48 PM of Resident #10's admission record revealed that the resident was admitted to the facility on [DATE] with the diagnosis of altered mental status with encephalopathy and cognitive functions decline. Other documents supported that Resident #10's was cognitively impaired through an initial BIMS score of 9 on 9/25/23 as moderate cognitive impairment and a Physician Staff #30's progress notes on 1/10/24 revealed that the resident had dementia. Further review, a MOLST order form was issued on 4-26-23, certification for the basis of these orders: marked the patient of a discussion with and the informed consent. Interview, on 01/13/25 at 03:24 PM, the above findings were reviewed with the Administrator. He agreed that the facility staff failed to maintain accurate MOLST orders on file and that demonstrated it as a deficiency practice concern.