STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215236	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Nursing & Rehabilitation Center	1454 Fairfield Loop Road Crownsville, MD 21032

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 14894 Based on resident interview, staff interview, and clinical record review it was determined that the facility staff failed to ensure residents are offered two showers each week. This was evident for 1 (#28) out of 56 residents in the survey sample. The findings include: This surveyor interviewed Resident #28 on 4/16/24 at 11:30 AM. The resident stated he/she gets only bed baths and has not had a shower in two years. Review of Resident #28's clinical record revealed the resident has only received bed baths since 1/1/24. The resident stated a preference for having showers. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed on 4/30/24 at 3:00 PM. They were informed of the resident's statement that showers have not been provided. They replied that the resident was initially admitted to the rehabilitation side and the resident was informed that the resident has to let the facility know when a shower is requested. They said the resident refused showers because of his/her preference. The DON said she asked the resident if he/she wanted a shower and the resident refused. This writer said there was no mention of refusals in the chart. The DON replied that the resident has a care plan that included the resident's right to refuse. The DON agreed that the nursing staff should have been documenting the refusals. She added that the resident would let them know when showers were not desired, and they relied on that. She said she will start asking her staff to document the refusals. She added that she asked the Unit Manager who said that it is the resident's preference to get a shower only when requested.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 14894 Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure residents were offered an opportunity to complete Advance Directives upon admission. This was evident for 3 (#14, #38, #46) out of 9 residents reviewed for Advance Directives. The findings include: 1. Resident #14's clinical record was reviewed on 4/16/24 at 1:50 PM. An Advance Directive was not found in the clinical record nor was there evidence that it had been offered to be completed. 2. Resident #38's clinical record was reviewed on 4/16/24 at 1:58 PM and again on 4/19/24 at 9:30 AM. An Advance Directive was not found in the clinical record nor was there evidence that it had been offered to be completed. 3. Resident #46's clinical record was reviewed on 4/17/24 at 10:20 AM and again on 4/19/24 at 9:15 AM. An Advance Directive was not found in the clinical record nor was there evidence that it had been offered to be completed. The Social Work Director was interviewed on 4/19/24 at 8:36 AM. She said, when a resident is admitted , a Maryland Order for Life Saving Treatment (MOLST) is completed by the primary physician, and she then asks if the resident has an Advance Directive. If they say yes she asks for a copy and if they don't, she gives them a copy to complete. When asked where she documents this, she replied probably in my social worker assessment. She added that in the resident chart the Advance Directive is put in the chart and the physician reviews it when they complete the history and physical. The Social Worker informs the physician of the existence of an Advance Directive, and they review it. The Social Work Director came back into the room on 4/19/24 at 1:04 PM. She said she was unsure about the social work histories that were not completed. She said they have had 5 people in that role so it may have been missed. She said she would look into it and get back to the team. No further evidence was provided that showed the resident and/or responsible party was provided with the opportunity to complete an Advance Directive.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 14894 Based on observation it was determined that the facility nursing staff failed to ensure a resident's medical information was kept private. This was evident for 1 (#59) out of 56 residents that are in the survey sample. The findings include: During the facility task of observing medication administration on 4/25/24 at 9:23 AM, Staff #3 was observed leaving the medication cart to enter a resident's room. Staff #3 locked the cart but left a medication packet on top of the cart. The medication packet had Resident #59's name and a list of their medications on it. The medications were risperidone (treats mental illness), Eliquis (an anti-coagulant), Lasix (diuretic), and potassium chloride (mineral pill). The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were informed of the findings on 4/30/24 at 3:00 PM.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review and interview with staff, it was determined that the facility failed to notify the resident or resident representative in writing of the reason for transfer to the hospital. This was found to be evident for 2 (Resident #69 and Resident #35) of 4 residents reviewed for hospitalization s during the investigative portion of the annual survey. The findings include: On 4/17/24 at 10:15AM, a review of Resident #69's electronic medical record revealed that the resident was transferred to the hospital on 1/17/2024 due to a dislodged foley catheter with bleeding and returned on 1/22/24 for ongoing care. Additional review of the electronic medical record and the physical chart revealed that there was no documentation to indicate that the resident nor his/her representative was notified in writing of the hospital transfer on 1/17/24. On 4/22/24 at 12:42PM, a review of Resident #35's electronic medical record revealed that the resident was transferred to the hospital on 3/13/24 for altered mental status and to rule out a stroke and he/ she returned to the facility on [DATE] for ongoing care. The resident was also transferred to the hospital on 4/14/24 due to hypoxia and was anticipated to return to the facility for ongoing care. Additional review of the electronic medical record and physical chart revealed that there was no documentation to indicate that Resident #35 nor his/her representative had been notified in writing of the hospital transfers on 3/13/24 or 4/14/24. During an interview conducted on 4/24/24 at 7:55AM with the Director of Nursing (DON), the Surveyor informed the DON of the concern that there was no documentation to indicate that Resident #69 and/or his/her representative, Resident #35 and /or his/her representative, nor the Ombudsman had received notification of transfer in writing for their hospitalization s. The Surveyor requested copies of these documents. On 4/24/24 at 9:00 AM, the Social Worker gave the Surveyor a copy of a Transfer/ Discharge Notification form for Resident #69's transfer on 1/17/24 and Resident #35's transfer on 4/14/24, however, the Social Worker stated that she did not provide the resident's, resident representatives, nor the Ombudsman with a copy of the Transfer/Discharge Notice. According to the facility's Discharge Notification Policy, reviewed on 4/25/24 at 1:45PM, the Surveyor discovered that Social Services staff are charged with ensuring that systems are in place to provide written notification of transfer or discharge to the patient/resident and, if known, a family member or legal representative prior to the patient/resident transfer and the LTC Ombudsman. A copy of the transfer/discharge notice must be included in the resident's record.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure baseline care plans were developed for the residents. This was evident for 1 (#28) out of 6 residents reviewed for care plans. The findings include: A review of Resident #28's clinical record revealed the resident was admitted on [DATE] and had care plan conferences on 8/1/23 and 10/26/23. A baseline care plan that should have been created within 48 hours of admission was not in the clinical record nor was there a comprehensive care plan within 48 hours of admission. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed on 04/30/24 at 03:00 PM. They were informed of the absence of a baseline care plan. An explanation was not provided and a baseline care plan was not shown to this surveyor prior to exit.

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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** 14894 Based on clinical record review and staff interview, it was determined that the facility failed to conduct and document timely care plan meetings for residents. This was evident for 4 (#46, #4, #69 and #21) out of 6 residents reviewed for care planning. The findings include: 1. A review of Resident #46's clinical record on 4/17/24 revealed that the resident had a care plan conference on admission but not since. There was no evidence that the resident and/or responsible party were invited to a meeting. The Social Work Director was interviewed on 4/17/24 at 9:58 AM. She said the resident had a meeting on admission but not since. She said she could not find any invitations to a care plan meeting. She returned on 4/19/24 with a copy of a care plan conference report. It only showed a care plan invite by phone on 10/5/23. The resident should have had care plan meetings on or before 1/3/24 and 4/3/24. A review of Resident #4's clinical record on 4/25/24 revealed that the last care plan conference was held on 9/14/23. There should have been one held on or before 12/15/23 and another one before 3/15/24. There was no evidence that these care plan conferences were held. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 4/30/24 at 2:52 PM. This surveyor informed them that two care plan conferences were not in the resident's clinical record and, therefore, it was unclear if they were held. The DON did not provide an answer other than to ask for clarification as to what I was referring to. 49148 2. A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. This helps to evaluate the effectiveness of the resident's care. Interdisciplinary team (IDT) is a team of medical professionals that provide specific patient centered care to the residents within a facility. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. Assessments are held on admission, annually, quarterly, and if there was a significant change of condition. During an interview conducted with Resident #69 on 4/17/24 at 7:44 AM, the resident informed the Surveyor that he did not have 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	On 4/19/24 at 8:40 AM, Surveyors conducted an interview with the facility's Social Worker. The Social Worker was asked to explain the care plan process. The Social Worker informed the Surveyors that she is responsible for setting up resident's care plan meetings. Care plan meetings are held soon after MDS assessments are completed. She informs the resident, resident representative (if known), and the IDT of the date, time, and location of the meeting. After the meeting, she writes a care conference note in the resident's electronic medical record. A review of Resident #69's electronic medical record on 4/19/24 at 12:21 PM revealed that the resident's MDS history reflected an entry assessment completed on 12/28/2023, an admission assessment completed on 12/31/2024, a discharge assessment completed on 1/17/2024, an entry assessment completed on 1/22/2024, and a quarterly assessment completed on 2/03/2024. During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/23/24 at 10:31 AM, the Surveyor shared the concern for timeliness of care plan meetings. The Surveyors were informed that the Social Worker should work with all the residents in a timely manner regarding their specific care plan meetings. During review of Resident #69's electronic and paper medical record on 4/23/24 at 11:07 AM, the Surveyor discovered that there was no documentation to indicate any care plan meetings nor care conference notes. On 4/25/24 at 1:00 PM, the Administrator was asked to provide the Surveyor with documentation of Resident #69's care plan meetings. At 1:40 PM, the Administrator provided the Surveyor with a copy of a care conference note dated 1/09/2024, updated 4/25/2024. There was no other documentation of a care plan meeting nor care conference note after the MDS quarterly assessment on 2/03/2024. 48393 3. Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The MDS contains items that measure physical, psychological and psycho-social functioning. The items in the MDS give a multidimensional view of the patient's functional capacities. BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment. It is a required screening tool used in nursing homes to assess cognition. The resident can score 0 to 15 points on the test. A score of 13 to 15 suggests the patient is cognitively intact, 8 to 12 suggests moderately impaired and 0 to 7 suggests severe impairment. During an interview conducted on 04/16/24 at 11:11 AM, Resident #21 stated that he/she initially had a care plan meeting scheduled for 4/10/24 but it was cancelled because the Social Work Director could not make it. Resident #21 further stated that the care plan meeting was not rescheduled. On 04/19/24 at 7:02 AM, a review of Resident #21's medical record revealed that the resident was admitted to the facility on [DATE] for rehabilitation therapy. A comprehensive MDS assessment dated [DATE] showed Resident #21 had a BIMS Assessment score of 15. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/19/24 at 7:29 AM, continued review of Resident #21's electronic medical record (EMR) revealed no evidence that a care plan meeting was completed. During an interview conducted on 04/19/24 at 08:40 AM, the Social Work Director stated that care plan meetings for residents on the short-term rehabilitation unit are scheduled within 7 days of admission. The Social Work Director confirmed that she is responsible for setting up care plan meetings for short term rehabilitation residents, including Resident #21, and stated that care plan meeting notes are documented in the EMR. The Social Work Director further stated that she completes an additional form titled, care plan meeting summary on paper that includes a list of care plan meeting attendees and keeps it in a binder in her office. During an interview conducted on 04/19/24 at 1:11 PM, the Social Work Director confirmed that the care plan meeting notes were not found in Resident #21's EMR and that the care plan meeting summary was not completed. The Social Worker further stated, I will do the care plan meeting for Resident #21 today. In a follow-up interview conducted on 05/03/24 11:22 AM, the Social Work Director provided documentation to confirm that the care plan meeting for Resident #21 was completed on 4/19/24. The Social Work Director stated, I don't remember telling Resident #21 that the care plan meeting was going to be held on 04/10/24. If I cancelled the care plan meeting, then it may have been because I'm the only Social Worker here. I completed Resident #21's care plan meeting late.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on resident interview, staff interview, observation, and clinical record review it was determined that the facility staff failed to: 1) ensure a resident had the opportunity to participate in an activity program, and 2) provide an ongoing resident-centered activities program to improve or maintain the resident's mental and psychosocial well-being. This was evident for 3 (#28, #46 and #6) out 5 residents reviewed for activities. The findings include: 1. Resident #28 was interviewed on 4/16/24 at 11:47 AM. The resident stated that he/she is okay with never being out of the room but was unclear if ever encouraged to leave. The resident stated he/she likes music. A review of the resident's clinical record revealed that the last note from the Activities Director was in January. This surveyor observed the resident on 4/16/24, 4/18/24, 4/19/24, 4/22/24, 4/23/24, 4/24/24, 4/25/24, 4/26/24, and 4/29/2024. The resident was observed and neither the television nor the radio were on. The Activities Director (Staff #22) was interviewed on 4/25/24 at 1:38 PM. She stated she was backlogged with getting activity department notes uploaded. She said she usually turns the resident's television on once a day. She said she has other activities that she has trialed before with the resident but he/she enjoys them for a short period but later refuses them. She said an activity lasts a short while before refusal. She said she does rounds and sees the resident once a day. She added that the resident had talking books. She said they have a 1:1 cart and staff go around the facility to encourage residents to participate. She provided a list of all the residents with a notation for an activity provided, however the list does not note the time of the activity or the length. The list did not provide an indication of the actual activity to ensure a variety was provided for that day. The Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed on 4/30/24 at 3:00 PM. The concerns were brought to their attention. They asked if the writer interviewed the Activity Director. This writer replied that I did. They offered that there are activity assistants to help the Director and stated that the resident often refuses new activities. The resident will request an activity then get tired of it. This writer mentioned that we have never seen the tv on even though the Activity Director noted that it is a daily activity. In fact, with only 2 or 3 exceptions it is the only activity noted in the clinical record. No times are provided nor is there any mention of what shows were on. They responded by suggesting they had respected resident choice. Resident #46's family member was interviewed on 4/17/24 at 9:51 AM. The family member said the resident was often in bed. Family member did not believe activities were brought to the resident. She has to call ahead and ask staff to get the resident out of bed. The only time they did on their own was for physical therapy. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's clincal record revealed the last activity assessment was on 9/29/23. No evidence in the clinical record of activities being provided. The Activities Director was interviewed on 4/25/24 at 1:41 PM. She said the resident enjoys Catholic mass with a priest like person, music, spiritual visits, and gets up for family. She added that the resident likes the television on and will watch it. She said the resident is aware if the television is turned off. I informed her that the survey team has not seen the resident outside of the room and no one has seen the television on. Activities Director said the daily room packet, done by her, include birthdays, facts, music, bingo, list of religious services, spiritual elder care, bible, social, and evening movies. The Administrator was interviewed on 4/26/24 at 7:50 AM. This surveyor informed him of the missing documentation. He said documents such as those from Activities or Therapy are scanned in by those departments. This surveyor informed him that similar documents had been seen in other charts. He was shown the clinical records for these residents. He acknowledged that he did not see the documents and would look into it. No evidence was provided prior to the exit conference. 49148 2. On 4/15/24 at 11:25 AM, during a tour of the nursing unit, Resident #6 was observed in his/her room, alert, lying in bed. There was a wooden chair at the bedside and one Christmas decoration on the wall and one on the side table. The television, which was shared with another resident, was on at a high volume. The resident had whispered speech, difficulty expressing themself, and no communication devices in the room. The Surveyor made further observations on 4/16/24 at 11:43 AM, 4/18/24 at 1:19 PM, and 4/19/24 at 11:00 AM in Resident #6's room with the resident lying in bed with the television on the same channel each time and at high volume. Review of Resident #6's electronic medical record on 4/25/24 at 8:52 AM, revealed that the resident had diagnoses, including but not limited to, dementia with communication deficit, schizophrenia, major depressive disorder, muscle wasting, and failure to thrive. The resident was dependent on staff, needing extensive assistance with daily care activities and transfers. The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. On 4/25/24 at 9:30 AM, review of Resident #6's Minimum Data Set (MDS) from 3/05/2021 Section F, which included activity preferences, expressed that it was very important to have books and magazines to read, music, animals, and to keep up with the news. The last 2 annual Minimum Data Set (MDS) dated [DATE] and 2/02/2023 revealed that Section F had not been assessed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of Resident #6's electronic medical record revealed an activity progress note written on 1/24/2024 at 2:29 PM by Activity Director #22 which stated that during one-to-one visits activity staff provides Shabbat visits, discuss facility events, and offer animal visitation; the resident enjoys TV land; and staff will continue to offer independent and one-to-one activities of interest and support any engagement. The resident's care plan was revised on 3/17/24 by Activity Director #22 and stated that the resident will demonstrate comfort, acceptance, or enjoyment of activities by the next review date. Further review revealed monthly documentation of activities provided to Resident #6. The last monthly documentation was from 7/01/2023-8/31/2023 and the activities consisted of 8 one-on-one visits (without specification of the duration of visit) about calendar discussion and one resident's rights meeting; one animal therapy session, and a list of television channels. The Surveyor noted a late entry for activities documented from 1/01/2024-3/31/2024 which included 3 one-on-one activities and a list of television channels. The activity documentation failed to reflect the personal activities provided to the resident as well as identification of activities that may interest the resident. On 4/25/24 at 1:00 PM the Surveyor expressed the concern for an activity program that is resident centered and meets the needs of all residents in the facility with the Administrator. During an interview conducted on 4/25/24 at 2:05 PM with the Activity Director #22, the Surveyor was informed that she tries to go to each resident's room everyday to make sure they are doing some type of activity during the day that they enjoy. She stated that she passes out room packets with birthdays, historical facts, and a daily theme; she hands out free newspapers and discusses the headlines with residents; and alternate music and television channels. The Surveyor informed the Activity Director #22 that there was no observation of an activity packet, newspaper, book, or radio speaker for music at the resident's bedside; however, the television has been on the same channel the days the Surveyor observed the resident.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 14894 Based on observation and staff interview it was determined that the facility staff failed to ensure a resident was repositioned. This was evident for 1 (#28) out 56 residents in the survey sample. The findings are: Resident #28 was observed on 4/16/24 at 11:46 AM to be on their back in bed and with their feet up against the footboard of the bed. Resident #28 was observed on 4/18/24 at 1:54 PM lying in bed on their back while being fed lunch. Resident #28 was observed on 4/23/24 at 2:15 PM lying in bed on their back. Resident #28 was observed on 4/24/24 at 12:30 PM lying in bed on their back. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 4/30/24 at 3:00 PM. The findings were presented to them. They said they could not explain why the resident was on his/her back but stated they would investigate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 14894 Based on observation, clinical record review, and staff interview it was determined that the facility failed to: 1) maintain a resident's bed in the low position, maintain a clean floor in a resident's room, ensure a resident's safety fall mats were in place, ensure medication carts were secured at all times when not in use and 2) failed to implement measures to reduce resident safety risks when building doors and patio gates were unlocked during the after hours. This was evident for 2 (#4 and #14) out of 56 sampled residents, 1 random observation of medication carts, and four doors of building entrances/exits observed during the annual survey. The findings include: 1. A care plan is a formal process that includes identifying an issue and/or need that is addressed through a carefully considered plan of action. A review of Resident #4's clinical record revealed that the resident had a care plan to address being at risk for falls. The facility developed an approach which included the intervention that the resident's bed be kept in the low position. Resident #4 was observed to be lying in bed with the bed in the high position on 4/15/25, 4/17/24, and 4/22/24. Resident #4 was observed on 4/23/24 at 2:20 PM to be lying in bed with it at the high position (waist high). Resident #4 was observed on 4/24/24 at 12:54 PM to be lying in bed with it at the high position. Resident #4 was observed on 4/29/24 at 1:20 PM to be lying in bed with it at the high position. Nurse #3 was interviewed on 4/29/24 at 1:25 PM. This surveyor brought her into Resident #4's room and showed her the bed. This surveyor asked if the bed was in the high position, and she replied yes. This surveyor stated that the resident's care plan says the bed should be in the low position. Nurse #3 confirmed but did not lower the bed. Resident #14's room was observed on 4/19/24 at 10:30 AM. A breakfast tray, food containers, and sugar packets were observed to be on the floor on the right side of the bed. This surveyor returned at 11:50 AM on 4/19/24 and the sugar packets were still on the floor. An observation of the Resident #14's room was made on 4/23/24 at 2:10 PM. The call bell was on the floor on the right-side of the bed and the catheter bag was on the floor on the left-side. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was made on 4/26/24 at 1:13 PM. There was food and a food tray on the floor by the right-hand side of the bed and the catheter bag laying on the floor on the left-hand side. This surveyor asked the nurse, Staff #13, to come into the room. She cleaned up the debris but left the resident's fall mat up and against the resident's bed. The Unit Manager, Staff #7, walked by the room at 1:30 PM, looked in (Resident 14's bed and fall mat were visible from the hallway), and then continued walking down the hallway. Staff #7 walked by again at 1:38 PM and again looked into the room but said nothing about the fall mat being up against the resident's bed. This surveyor informed her that the fall mat was upright and against the bed. Staff #7 went into the room at 1:43 PM and talked to nurse (Staff #13). Staff #7 informed the surveyor that the fall mat was up because housekeeping mopped the floor. This surveyor informed her that the food was on the floor not the fall mat. She repeated the assertion that the floor mat was up as a result of the floor being mopped. This surveyor repeated the observation that the fall mat was up before and during the cleaning of the floor. Staff #7 asked Staff #13 to tell the surveyors what happened. Staff #13 said the resident threw the tray and plates on the floor. Staff #13 said she cleaned it up and used a wet towel on the floor. She then said the fall mat had been up and leaning on the bed the whole time. Writer explained the importance of the fall mat to Staff #7, and she told Staff #13 to put the fall mat on the floor. Survey team observed on 4/24/24 at 7:31 AM a medication cart was unlocked; surveyor was able to open all drawers. A nurse, Staff #25, was coming on shift and walking down the hallway at 7:35 AM. She was informed of the unlocked cart. She locked the cart and told the night shift nurse, Staff #5, who was leaving room [ROOM NUMBER] after administering medication. 42828 2. On 4/16/24 at 6:45 AM and at 7:30 AM surveyors entered the facility from the parking lot through an unlocked door, near the main entrance, which directly led to a lounge and resident care areas. Surveyors observed a keypad device attached to the side of the door frame. No alarms were heard and there was no staff present upon entry. An interview held on 4/23/24 at 1:45 PM with an anonymous complainant revealed that the facility's doors are not secured at any hour of the night. The complainant went on to say that the door's keypad does not work and has been broken for approximately 8 months. The complainant stated they do not think that the facility ensures the residents are safe. On 4/24/24 at 5:10 AM, the survey team observed a person drive into the facility's parking lot, park their motor vehicle, and enter the facility through the double doors of the loading dock. Around 5:35 AM the survey team proceeded to enter the building through the unlocked loading dock doors. Once in the building, surveyors noted there were no staff visible at the end of the corridor which spanned approximately 40-50 feet in distance. The service hallway housed the kitchen, laundry, and maintenance departments. The survey team then walked approximately 40 - 50 feet along the service corridor, which at its end, led surveyors to another door. The survey team was able to turn the doorknob and open the unlocked door without incident/alarm and gain access to resident care areas without being acknowledged by staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/24/24 at 5:44 AM with Cook, Staff # 8, which revealed that they recently arrived at work and entered the facility through the loading dock doors without the use of the keypad. Staff #8 confirmed the door was unlocked and they did not have to use a code nor a key/badge to gain access in many months. On 4/24/24 at 6:33 AM the survey team was able to open the gate to the courtyard. The team walked across the courtyard and, without incident/alarm, opened the double doors and walked into the activity rooms. On 4/24/24 at 6:45 AM the surveyors entered the facility through the doors to the left of the loading dock. Once entered, surveyors observed a double door which led to an office space and noted there was a set of unlocked doors on an adjacent wall. The unlocked doors granted direct access to the service hallway of the facility. The service hallway housed the kitchen, laundry, and maintenance departments. The survey team then walked approximately 40 - 50 feet along the service corridor, which at the end of the corridor led surveyors to another door. The survey team was able to open the unlocked door without incident/alarm and gain access to resident care areas without being acknowledged by staff. On 4/24/24 at 6:10 AM surveyors observed the Activities Director enter through the unlocked loading door. At 6:24 AM, the Unit Manager and the Administrator entered the building through loading dock doors and at 6:58 AM a Certified Medication Assistant (CMA) entered the building through the loading dock doors. Surveyors observed multiple staff enter the building through the loading dock doors without use of the keypad and no alarms were heard/seen and no staff positioned to monitor the service corridor. On 4/26/24 at 8:46 AM surveyors conducted an interview with the Maintenance Director who stated he cannot remember when he was told or how he found out that they were not working. He assumed that everyone in the building knew that they (lock/keypad) were not working. He would be surprised if anyone still punches in the codes to enter the building. On 4/26/24 at 9:00 AM surveyors held an interview with the Administrator and informed him that surveyors had been able to enter the facility through multiple doors (each described) during the hours the front entrance was locked. The Administrator stated that January 2024 the magnetic lock on the loading dock door and the doors to the left of them stopped working, were repaired, and stopped working again. He went on to say he received quotes to replace the locks, but they have not been replaced yet. Subsequently, surveyors asked the Administrator what measures were in place since the facility identified the broken locks. The Administrator did not respond to the question. Surveyors also asked about the unlocked patio gate. The Administrator stated the gate should have been locked before they leave each night, by the work crew that currently contracted. He was not aware of the door near the front entrance that was unlocked. When asked if staff was advised not to use the loading dock doors to enter the facility, since the lock was deactivated, All staff should enter by front door during office hours. It is the facility's responsibility to protect its residents from any identified hazards which may pose safety risks.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 14894 Based on resident interview, staff interview, and observation it was determined that the residents are not provided with an adequate and/or varied diet. This was evident for 2 (#30 and #28) out of 56 residents reviewed in the survey sample. The findings include: 1. Resident #30 was interviewed on 4/16/24 at 9:39 AM. The resident stated the food is always cold and they are given only one choice for an entree. They can choose what to have in a salad on Monday, Wednesday, and Friday but sometimes there is no stuff for a salad. Resident #30 was observed to have a bag of 8-12 cups. When asked, the resident stated that the cups in the bag are cups of breakfast cereal that the resident keeps in case of hunger. 2. Resident #28 was interviewed on 4/16/24 at 11:39 AM. The resident stated that food choices are not honored, and the breakfast never changes. Survey team member interviewed the cook (Staff #8) on 4/24/24 at 5:58 AM. Staff stated that they have a standard breakfast menu with some alternatives available. When asked if they have enough food in their food supply, she reported there is not enough food because they have issues with availability of supply/delivery of food items.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on observation and interview with facility staff, it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents who eat the food prepared in the facility's kitchen. The findings include: During an initial tour of the facility's kitchen conducted on [DATE] at 8:30 AM, the Surveyor observed the dry food storage space in a corner of the food preparation area of the kitchen. The Surveyor noted an opened and unlabeled 25lb bag of Sysco sugar, 25lb bag of flour, and 25lb bag of Par Excellence whole grain brown rice stored in large, covered containers setting on the floor. The Surveyor also noted an opened and unlabeled 1 gallon jug of teriyaki sauce, 5lb plastic container of classic mashed potatoes, bottle of soy sauce, 5lb container of creamy peanut butter, and an expired bag of powdered pancake mix wrapped in plastic wrap setting on a shelving unit. During a continued tour of the kitchen, the Surveyor inspected the main walk-in refrigerator. The Surveyor observed a shelving unit containing an opened and unlabeled bag of salad, bag of spinach, 2 onions sliced and wrapped in plastic wrap, package of boiled eggs, bologna lunch meat in plastic wrap, 5lb container of walnut topping, jar of Smuckers grape jelly, 46oz of Sysco Imperial Thickened lemon-flavored water (discard 7 days after opening), 46oz of Sysco Imperial Thickened Apple juice (discard 7 days after opening), plastic container of sour cream which expired [DATE] opened and unlabeled, and a plastic container of low-fat cottage cheese opened [DATE] which expired [DATE]. Another shelving unit contained an opened and unlabeled gallon of coleslaw dressing, gallon of Reliance dill pickles, and gallon of Reliance sweet pickle relish on the top shelf. The Surveyor also observed 4 steel containers consisting of leftover hotdogs, string beans, soup, and grounded meat, all covered in plastic wrap and unlabeled. On [DATE] at 9:30 AM, the Surveyor and the Certified Dietary Manager (CDM) #15 confirmed the unlabeled and expired food items located in the walk in refrigerator. During a tour of the dry food storage conducted on [DATE] at 9:41 AM, the Surveyor and CDM #15 observed an opened and unlabeled 6.5oz package of chicken gravy wrapped in plastic wrap, 10lb package of [NAME] pasta noodles, and dusty box of lasagna noodles located on the bottom shelf. During a tour of the walk-in freezer conducted on [DATE] at 9:50 AM, the Surveyor observed five 3gallon tubs of ice cream opened and unlabeled, 1 package of sliced pepperoni opened and unlabeled, Philly cheesesteak egg rolls opened and unlabeled, and a box with a blue bag of mixed vegetables fully exposed and unlabeled. CDM #15 was immediately made aware of the Surveyor's findings. In an interview conducted on [DATE] at 10:00 AM, CDM #15 informed the Surveyor that he was unsure of the facility's food safety and storage policy, and he would provide the Surveyor with a copy of the policy. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up kitchen tour conducted on [DATE] at 7:45 AM, an interview with [NAME] #8, revealed that leftover meals should be covered and labeled as breakfast, lunch, or dinner, labeled with the date and time, and then stored in the refrigerator up to 3 days. The unlabeled leftover hotdogs, string beans, soup, and ground meat had been discarded. A continued follow up tour of the kitchen revealed that the food items identified by the Surveyor and CDM #15 as opened and unlabeled had not been removed nor discarded from the walk-in refrigerator, walk-in freezer, and dry food storage areas. During a review of the facility's food safety and storage policy food dating rules, received [DATE] at 11:27 AM, the Surveyor discovered that packaged foods should be dated when opened using month, day, and year labeling; the date may not exceed the manufacturer's use by date; and leftovers should be labeled with the contents and dated and with use by date and discarded after 3 days.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on observation, clinical record review and staff interviews, it was determined that the facility failed to: 1) ensure a resident's personal information was not in another resident's clinical record and 2) ensure medical records were complete by voiding an old MOLST when a new MOLST was completed. This was evident for 2 (#13 and #33) of 56 residents sampled during the annual survey. The findings include: 1. A review of Resident #13's clinical record on [DATE] at 11:38 AM revealed Resident #13's Physician Order Report was in the clinical record. Facility nursing staff was informed of the finding. 49148 2. Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped. Palliative or Supportive care focuses on providing relief from pain and other symptoms of a serious illness. During review of Resident #33's paper medical record on [DATE] at 10:40 AM, the Surveyor discovered two MOLST forms. The first completed MOLST was signed and dated [DATE], with orders for no CPR, option B, Palliative and Supportive care. The second completed MOLST was signed and dated [DATE] with orders to attempt CPR. During an interview conducted with the Unit Manager #7 on [DATE] at 10:48 AM, the Surveyor was informed that the nursing staff knows a resident's code status by looking at the MOLST located in the resident's paper medical record. If a resident decides to update their code status, the physician will complete a new MOLST, place it in the paper chart, and the old MOLST should be voided by drawing a diagonal line through the sheet and writing VOID across the page. On [DATE] at 10:55 AM, the Unit Manager #7 confirmed that Resident #33 had two MOLSTs in his/her paper medical record. The Unit Manager stated she would make sure to update the resident's paper medical record with the most current MOLST and VOID the other. On [DATE] at 1:59 PM, during an interview with the Director of Nursing (DON), the Surveyor was informed that Resident #33's paper medical record had been updated with the most current MOLST form dated [DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on observation and staff interview it was determined that the facility staff failed to ensure proper infection control practices were followed. This was evident for 3 random observations made during annual survey. The findings include: 1. During observation of the medication administration on 4/25/24 at 9:08 AM Staff #1 (certified medication aide) did not wash hands or use hand sanitizer prior to administering the medications and she administered Ocusoft eyelid cleanse wipes without gloves. 2. On the second day of medication administration this surveyor observed that the nurse (Staff #14) walked into room [ROOM NUMBER] on 4/29/24 at 9:06 AM and washed her hands in the bathroom sink. There was a poster on the door instructing nursing staff and visitors to use hand sanitizer before entering the room. She did not use hand sanitizer. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 4/30/24 at 3:00 PM. The findings were presented to them. ADON stated reeducation for staff on med administration was needed. This Surveyor explained infection control procedures to DON for enhanced barrier precautions entrance during medication administration. 3. Surveyor entered Resident #14's room on 4/23/24 at 2:10 PM and observed the resident's catheter bag was on the floor on the left side of the bed. This Surveyor entered the room on 4/26/24 at 1:13 AM and observed the resident's catheter bag on the floor on the left side of the bed. Nurse #13 and Nurse #7 both entered the room between 1:22 PM and 1:43 PM and neither raised the catheter bag off of the floor.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 42828 Based on observations, interviews, and record review, it was determined that the facility failed to ensure the call light system was available, functional and operational for all residents. This was evident for 6 residents (Resident #15, #33, #8, #18, #22, and #36) out of 76 residents screened during the initial phase of the recertification survey. The findings include: The Brief Interview for Mental Status (BIMS) assessment is a 15-point cognitive screening used to screen and identify the cognitive condition of residents. It's a structured evaluation aimed at evaluating aspects of cognition in elderly patients. The BIMS score interpretation is, 0 - 7: Severe cognitive impact, 8 - 12: Moderate impairment, 13 - 15: Intact cognitive response. On 04/15/2024 11:18 AM surveyors toured the unit and entered Resident #15's room. Surveyors observed that Resident # 15 was laying in bed, the call light device was unplugged from the wall with the activation button resting on the bedside table out of the resident's reach. Surveyors did not observe any other call device within resident reach or in their room. Resident #15 has a BIMS of 9 out of 15 on the most resent assessment. Surveyors interviewed the resident who stated that the call device was not working, and it was always broken. Resident #15 also stated that if he/she needed assistance, he/she would yell at anyone passing by his/her room. Upon exit of Resident #15's room, surveyors interviewed Geriatric Nursing Assistant, Staff# 11, who stated that the call light system for Resident #15 had not been working since 4/12/2024. On 4/15/2024 at 11:17 AM surveyors conducted an interview with Resident #138 who stated that his call light device was not working for a number of weeks and it was under repair. However, he/she had not at any time been given any alternate call device to notify staff when he/she needed assistance. Surveyors did not observe any other call device within resident reach or in their room. On 04/15/2024 at 11:33 AM Surveyors conducted a review of the maintenance log for the unit which revealed: Resident #15's call light device was not working on 3/29/2024 and repaired on 4/1/2024. During the record review, Staff #7 documented the repair request for Resident #15's call light device into the Maintenance Request Log, dated 4/15/2024. Further observations on 04/16/2024 at 09:45 AM revealed that Resident #8 did not have an operable call light device available. Surveyors pressed the call light device which revealed no light illuminated or sound on the outside of the resident room. Subsequently, during interview with Resident # 8, he/she stated I stopped using the call bell months ago. They (staff) do not respond to it. Surveyors did not observe any other call device within resident reach or in their room. On 4/16/2024 at 10:30 AM surveyors interviewed the Unit Manager, Staff #7, who stated that the call light device in Resident # 15's room was under repair. Surveyors then asked Staff #7 if there was another means of calling for staff help that the resident may use. Staff #7 replied that nurses give the resident's hand bells when their call lights are under repair. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During tour of the facility on 04/16/2024 at 10:31 AM surveyors interviewed Resident # 18 who stated that he/she had moved to this room three weeks ago and the call light device was not working during their entire stay in that room. The resident allowed the surveyors to activate the call light by pressing the button on the device. Surveyors observed that the light above the resident's door (on the hallway-side) did not illuminate, nor was there any sound of a call bell noted. Surveyors inspected the resident's shared bathroom which revealed there was no call light device available. Surveyors did not observe any additional call light devices in the resident's room. On 4/16/2024 at 10:32 AM surveyors observed Staff #7 attempting to reset the call light device on the wall behind Resident 18's bed however, Staff #7 was not successful in activating the call light. Upon exit of the room, surveyors and Staff #7 inspected the residents' bathroom and Staff #7 confirmed no call light device was available. Staff #7 stated that the Maintenace Director was aware and was to install a call device. On 4/16/2024 at 10:40 AM surveyors conducted an interview with Resident #22. When asked if nursing staff responds when he/she presses the call light device, Resident #22 stated that does not work. Resident #22 further stated that when he/she needs help, he/she would call a family member on the phone and instruct said family member to call the front desk to request for nursing staff to come to his/her room. Surveyors inspected the call light device and pressed the activation button which failed to illuminate above the resident's door (on the hallway-side) and no audible sound was noted. Surveyors did not observe any additional call light devices in the resident's room. On 04/16/2024 at 11:21 AM surveyors inspected the call device in Resident #36's room which revealed upon pressing the call device's activation button, no light or sound noted on the outside of the resident's room. Surveyors did not observe any additional call light devices in the resident's room. On 5/3/2024 at 10 AM further review of the maintenance request logs with dates of entry ranging from 2/21/2024 through 5/02/2024 revealed that there were no maintenance requests entered into the logbook for Residents #8, #18, #22, and #36 call light devices for repair. In addition, there was no entry for a request to repair Resident #18's call light nor to install a call light device in Resident #18's shared in-room bathroom. On 4/17/2024 at 11:40 AM surveyors conducted an interview with the Maintenace Director. The Maintenance Director stated that the call light system has been repaired several times during his employment there as a maintenance staff and as a Maintenance Director. The process in place for staff to notify him of any building concerns is to place the concerns or repair requests into the Maintenance Logbook located at the nurses' station on each unit. He confirmed that he was not aware of the missing call light device in Resident #18's bathroom before 4/17/2024. He also made it known that the facility's protocol was that when a call light is under repair in a resident's room, hand bells were to be provided to the resident. The maintenance Director also stated that on 4/9/2024 his department started weekly audits of all call light devices for functionality. On 4/26/2024 at 7:30 AM surveyors conducted an interview with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) and revealed the multiple surveyor observations of faulty call light devices and the lack of alternative devices/methods observed for residents' use.