STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215240	A. Building B. Wing	03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moran Nursing and Rehabilitation Center	25701 Shady Lane Southwest Westernport, MD 21562

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45139 Based on observations and interview it was determined that the facility failed to maintain a clean and sanitary environment as evidenced by ceiling tile discolored with black and fuzzy white substance. This was evident for 1 combination shower/bathrooms of 2 observed during a survey. The findings include: On 3/04/25 at 2:47 PM an observation of the 3rd floor shower/bathroom was made with Nurse Staff #5. An observation of one ceiling tile in stall #1 revealed that 1/4 of that tile's surface was covered with a black and fuzzy white substance. On 3/04/25 at 2:55 PM the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the above observation. The NHA reported that there had been recent repairs for a leaking pipe in stall #1 and maybe the tile had not been replaced after the repair. On 3/04/25 at 2:58 PM the Maintenance Director joined the observation in the 3rd floor shower/bathroom. He reported that the ceiling title had been replaced after the repair of the pipe leak. He reported that the current concern with the black and fuzzy white substance on the tile had not been reported to him by the staff. On 3/07/25 at 10:30 AM the above concerns were discussed with the NHA. No additional information was provided prior to the survey team before the end of survey.

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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(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. 30428 Based on observation, interview, review of facility reported incidents and facility policy, it was determined that the facility failed to treat a vulnerable resident with respect and free from verbal and physical abuse. This was evident during a recert/complaint survey and investigation review of 2 of 11 facility reported incidents involving alleged abuse (R #407). The findings include: 1. Review of the facility reported incident documented as occurring on 9/05/23 between Resident #407 and GNA #17 revealed an allegation where Resident #407 reported to the day shift on 9/06/23 that during care on the night of 9/05/23, GNA #17 was rough while providing care and felt like GNA #17 was not listening to the residents' needs. The nurse immediately reported the allegation to the then Administrator and an investigation was initiated. According to the facility investigation it was not reported that Resident #407 verbalized to the day nurse that she felt that she was abused the night before. However, according to a statement acquired from the nightshift nurse during the facilities investigation, the night shift nurse, LPN #34 stated that Resident #407 only said that GNA #17 was 'rude.' Therefore, he did not report 'abuse to anyone.' LPN #34 was interviewed on 3/10/25 at 10:30 AM, though he did not recall the incident he was able to verbalize how to recognize abuse and the steps to take when you see it, or a resident verbalizes to you any concerns related to abuse. During the investigation, the facility social worker, staff #18 conducted interviews with the alert and oriented residents regarding the care that GNA #17 provided during the night of 9/05/23. Interview with Resident #23 by Staff #18 documented that s/he felt that GNA #17 was 'not listening to [him/her]' and was insisting that they pull themselves up in bed despite having shoulder pain. Interview with Resident #28 verbalized that although they had no trouble that night, s/he has had trouble with this GNA #17 before. The resident continued that the GNA will sit on her phone in the shower room, and the resident will struggle with [his/her] robe and GNA #17 will just sit there. Resident #2 verbalized that s/he feels they have to 'manage' and cue GNA #17 with everything, and that she can be rough with care because she wants to get over it even when Resident #2 states things like whoa that's a little rough. Resident #11 stated that GNA #17 will argue and refuse to help. Resident #18 stated that GNA #17 is rough when changing and providing care, pushes and keeps doing so even when she is being rough.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48168 Based on records review and interviews, it was determined that the facility failed to ensure allegations of abuse were reported within the mandated time frame. This was evident for 3 (Resident #38, #25, #64) of 6 residents reviewed for abuse. The findings include: 1.)On 3/06/25 at 11:56 AM a review of the facility reported incident (FRI) #MD00214156 was conducted. The report described an allegation that a Geriatric Nursing Assistant (GNA #3) was observed to have forcefully pushed Resident #25 into his/her wheelchair. Further review revealed that the incident was witnessed by the facility social worker (SW #18) and that the incident occurred in the resident dining room on 1/30/25 at 12:15 PM. A review of the facility investigation file revealed that the Nursing Home Administrator (NHA) first reported the incident to the Office of Health Care Quality on 1/30/25 at 4:48 PM. On 3/10/25 at 9:34 AM an interview with the NHA and the Director of Nursing was conducted. The NHA acknowledged that the incident was reported more than 4 hours after it occurred and confirmed the deficiency of the late report. No further information was provided regarding the timeliness of the report. 48470 2.) Resident #38 was admitted to the facility in the 3rd quarter of 2024. A quick look into the resident's medical record indicated intact cognition and that a Facility Reported Incident (FRI) for abuse, related to MD00210264, was investigated by the facility. Resident #38 was interviewed on 3/4/25 at 10:16 AM. During the interview, the resident confirmed the incident and reported that it happened a long time ago. On 3/7/25 at 12:34 PM, the investigation packet for the FRI related to MD00210264 was reviewed. The review revealed that the allegation of abuse was first reported to Geriatric Nursing Assistant (GNA #41) on 9/26/24 at 8 AM. The Abuse coordinator was the Nursing Home Administrator (NHA) and was notified on the same day at 8:30 AM. Further review of the investigation packet revealed that the initial report was sent to the State Agency on the same day (9/26/24), however, the time stamp on the email confirmation indicated that the report was not sent until 5:23 PM. The NHA was interviewed on 3/7/25 at 1:42 PM. During the interview, the NHA was asked if she knew the mandated time frame for reporting allegations of abuse. The NHS stated, I do now! And indicated that it was two hours regardless of if there was serious injury. The NHA confirmed that the initial report for the FRI related to MD00210264 was reported late. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51900 3.) Review of Facility Reported Incident (FRI) #00209595 revealed that on 9/08/24 at 10:00 PM, Resident #64's representative informed facility Nurse #40 of an abuse allegation. The representative reported that on 9/07/24, the Geriatric Nursing Assistant (GNA) was fast and rough when applying a cream and slapped the resident's hand when the resident grabbed the handrail. Nurse #40 notified the Director of Nursing (DON) and the Nursing Home Administrator (NHA) at 10:45 PM on 9/08/24. The facility reported the allegation to the Office of HealthCare Quality (OHCQ) on 9/09/24 at 1:20 PM. Review of the facility policy and procedure titled Abuse, Neglect, Exploitation, or Mistreatment revealed the following: * Report Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury. Report to the Administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. On 3/05/25 at 3:38 PM, the surveyor interviewed the NHA and the DON. The surveyor asked how the facility handled allegations of abuse. They responded that the staff are instructed to notify either the NHA or the DON immediately. The surveyor then asked when they would notify the regulatory agency and they replied, As soon as we know about it. Surveyor then reviewed the concern that this allegation was reported more than two hours after the facility staff was made aware of it. On 3/06/25 at 1:00 PM, the NHA reported they had no additional information to provide regarding this concerns.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 51900 Based on records review and interviews, it was determined that the facility failed to ensure allegations of abuse are thoroughly investigated. This was evident for 3 (Resident #38, #25, #64) of 6 residents reviewed for abuse. The findings include: 1.)A review of Facility Reported Incident (FRI) #00209595 revealed that on 9/08/24 at 10:00 PM, Resident #64's representative informed facility Nurse #40 of an abuse allegation. The representative reported that on 9/07/24, the Geriatric Nursing Assistant (GNA) was fast and rough when applying a cream and slapped the resident's hand when the resident grabbed the handrail. Nurse #40 notified the Director of Nursing (DON) and the Nursing Home Administrator (NHA) at 10:45 PM on 9/08/2024. Further review of the FRI documentation revealed that the facility had identified the alleged abuser as Geriatric Nursing Assistant (GNA #39) as evidenced by a hand-written letter which explained his/her account of the events on 9/07/24. The letter was signed and dated by GNA #39 on 9/08/24. A review of the facility policy and procedure titled Abuse, Neglect, Exploitation, or Mistreatment (dated 10/1/2020) revealed the following: *In the event an employee is accused of abuse/neglect, that employee will be suspended during the investigation process. *Identify and remove the alleged perpetrator. A review of timecard documentation revealed that GNA #39 worked the entirety of the night shift from 9:57 PM on 9/08/24 until 6:06 AM on 9/09/24 which indicated that s/he was allowed to continue to work with residents after the abuse allegation was made on the evening of 9/08/24. GNA #39 was later suspended via phone at 1:25 PM on 9/09/24. Further review of the facility policy and procedure titled Abuse, Neglect, Exploitation, or Mistreatment (dated 10/1/2020) revealed the following: *Complete prompt, comprehensive and conclusive investigations. *Interview individuals having firsthand knowledge of the incident and write summaries of the interviews. NOTE: Employees/witnesses are not to write out statements. Employee/witnesses will be interviewed by designated facility staff and the interviewer will record all witness accounts in a document, written, dated, and signed by the interviewer. *Depending on the incident, other residents in the facility may be interviewed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor review of the summary report sent to OHCQ included: Residents on GNA #39's assignment were interviewed and had no concerns with GNA #39 or any staff. Further review of facility investigation documentation failed to reveal evidence to support this statement. No documentation was found to indicate which residents were interviewed or which staff conducted the interviews. Additionally, review of a statement by Nurse #40 revealed the resident representative had indicated that s/he had made the allegation earlier in the day on 9/08/24. There was no documentation found to indicate if an interview was conducted with the representative to clarify who the allegation was previously reported to. On 3/05/25 at 3:38 PM, the surveyor interviewed the NHA and the DON. The surveyor asked how the facility handled allegations of abuse. They responded that the staff are instructed to notify either the NHA or the DON immediately, and that if a staff member is suspected of abuse they will be separated from the resident and suspended during the investigation. The surveyor then discussed the concerns that GNA #39 was allowed to continue to work with residents after the allegation of abuse was made and failure to have documentation to support that other residents were interviewed as part of the investigation. On 3/06/25 at 1:00 PM, the NHA reported they had no additional information to provide regarding these concerns. On 3/11/25 at 9:26 AM, the surveyor discussed concerns with the NHA and DON about the failure to protect the residents during an investigation and failure to perform a complete investigation. 48168 2.)On 3/06/25 at 11:56 AM a review of the facility reported incident (FRI) #MD00214156 was conducted. The report described an allegation that a Geriatric Nursing Assistant (GNA #3) was observed to have forcefully pushed Resident #25 into his/her wheelchair. Further review revealed that the incident was witnessed by the facility social worker (SW #18) and that the incident occurred in the resident dining room on 1/30/25 at 12:15 PM during lunch. A review of the facility's investigation file failed to reveal that any other residents were interviewed about the incident even though the facility's description of the incident indicated that there were other residents present when the incident occurred. The facility investigation file also lacked any evidence that facility staff made any attempt to determine if any other residents may have experienced any abuse by the alleged perpetrator. The investigation file also lacked any evidence that abuse training was provided to staff after the incident. On 3/10/25 at 9:34 AM an interview with the NHA and the Director of Nursing (DON) was conducted. They said that no resident interviews or assessments were conducted after the incident. When the NHA and DON were asked if any abuse training was provided to staff after the incident, they said that no training was done at that time. No further evidence was provided to the survey team before the end of the survey. 48470 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #38 was admitted to the facility in the 3rd quarter of 2024. A quick look into the resident's medical record indicated intact cognition and that a Facility Reported Incident (FRI) for abuse, related to MD00210264, was investigated by the facility. Resident #38 was interviewed on 3/4/25 at 10:16 AM. During the interview, the resident confirmed the incident and reported that it happened a long time ago. On 3/7/25 at 12:34 PM, the investigation packet for the FRI related to MD00210264 was reviewed. The review revealed that the allegation was first reported to Geriatric Nursing Assistant (GNA #41), who then reported it to the Registered Nurse (RN #42) supervisor. The investigation packet also contained a written document dated 9/26/24, of the interview with Resident #38, #42 (roommate), and #29. The interview documentation was not signed by the named residents nor the staff who conducted the interview. There was no other documentation to indicate other residents, aside from the 3 mentioned, were interviewed or assessed. On 3/7/24 at 1:42 PM, the Nursing Home Administrator (NHA) was interviewed about the incident. The NHA reported that the written document was probably done by the Director of Nursing (DON). Later at 1:51 PM, the DON joined the interview and was asked if she was the one that conducted the resident interviews, she answered, No and indicated that the written document must have been done by RN #42. Both staff were asked if there were other residents interviewed or assessed regarding the allegation, and both indicated that they were not sure. The NHA reported that usually an interview would have been conducted on all the residents assigned to an alleged perpetrator. The DON reported that RN #42 was on leave but would check her office for documents to see if other residents were interviewed. On 3/10/25 at 11 AM, RN #42 approached the surveyor to discuss the FRI related to MD00210264. RN #42 confirmed that she was the one that wrote the documentation for the interviews with Residents #38, #42 and #29. RN #42 also reported that she did interview other residents assigned to the alleged perpetrator but failed to document them. RN #42 indicated that she should have documented her interviews. On 3/11/25 at 9:28 AM, the concern of not completing a thorough investigation by failing to have credible evidence that all residents assigned to an alleged perpetrator was interviewed or assessed, was discussed with the NHA and DON. Both staff verbalized understanding and acknowledged the concern.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48470 Based on records review and interviews, it was determined that the facility failed to ensure comprehensive assessments were coded accurately. This was evident for 1 (Resident #8) of 7 residents reviewed for accidents. The findings include: Resident #8 had been residing in the facility since 2022. A quick look into the resident's medical record indicated that a Facility Reported Incident (FRI) related to MD00210606 for unwitnessed fall with fracture was submitted in October of 2024. Resident #8 was interviewed on 3/3/25 at 11:07 AM. During the interview, the resident reported the most recent fall had resulted in an injury and had to wear a shoulder sling for a while. On 3/7/25 at 10:01 AM, Resident #8's medical record was reviewed. The review revealed care plans related to falls and indicated that Resident #8 also had a fall on February 15 of 2024. 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. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. A subsequent review of Resident #8's medical record on 3/7/25 at 11:03 AM, revealed an MDS assessment was conducted with an Assessment Reference Date (ARD) of 3/5/24. Section J, item J1800 asked the question, Has the resident had any falls since admission/entry or reentry or prior assessment, whichever is more recent? to witch Resident #8 was coded as No. The Registered Nurse Assessment coordinator (RN #16) was interviewed on 3/7/25 at 11:10 AM. During the interview, RN #16 reported that she completed Section J of the MDS with an ARD of 3/5/24. RN #16 was asked what time period she looked at to answer item J1800. RN #16 reviewed Resident #8's record and indicated that the period would be between 3/5/24 and a day after the ARD of the previous assessment, which would have been 12/8/23. RN #16 continued to review Resident #8's medical record and confirmed that the resident had a fall on 2/15/24. RN #16 reported that the resident was not coded for that fall and stated, It looks like I missed it. RN #16 indicated that she would do a modification of the assessment to reflect the fall in the 3/5/24 MDS assessment. The concern with accurately coding MDS assessment was discussed with the Director of Nursing (DON) on 3/7/25 at 1:23 PM. The DON acknowledged the concern and indicated that RN #16 had already informed her of the identified error.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30428 Based on record review and interviews it was determined the facility staff failed to 1.) ensure resident care was supervised 24 hours per day by licensed nursing staff and failing to ensure medications were administered as ordered by the physician and 2.) ensure physician order for weekly blood sugar check was performed. This was evident for 1 (#MD00214955) of 12 complaints and 1 of 5 (#8) residents reviewed for unnecessary medications reviewed during the survey. The findings included: 1a. Review of the medical record for Resident #68 on [DATE] at 7:36 AM revealed admission to the facility for care and treatment related to alcohol dependence with alcohol induced persistent dementia, heart failure, history of traumatic brain injury and depression. A review of the medication administration record (MAR) revealed that on [DATE] Resident #68 was ordered Ativan for generalized anxiety disorder to be administered at 8:00 PM, in addition to; Eliquis for atrial fibrillation, Imodium, an antidiarrheal, Lopressor, blood pressure medication, Wellbutrin for depression and Zyprexa for delusions. All the medications were noted as Late Administration: Charted Late comment: late charting between 2:09 AM and 2:18 AM by agency Licensed Practical Nurse (LPN #8). 1b. Review of the medical record for Resident #409 on [DATE] at 8:00 AM revealed admission to the facility on the evening of [DATE] for potential admission to hospice. Physician orders included Xanax, enteral feeding via gastrostomy tube and wound care orders for multiple right and left leg arterial wounds, stage 3 and 4 ischium and sacral wound respectively and assessment for the need of Morphine that were not completed. According to Resident #409's medication administration record s/he had blood pressure medication and sleep medication, intravenous antibiotics and antianxiety medication due at 8:00 PM on [DATE] that were not signed off according to the MAR. Resident #409 was also ordered for the administration of morphine as needed every 6 hours, however, there is no documentation or progress notes that the resident was assessed for pain for the appropriate administration of the morphine. There is one progress note that Resident #409 was found unresponsive by agency LPN #14 at 4:45 AM on [DATE] and was pronounced deceased at that time. According to facility reported incident #MD00214915, agency LPN #68 and agency LPN #409 were reported to have left the facility during the night of [DATE] into the morning of [DATE] for an extended period leaving the facility without nursing coverage and subsequent care to the residents. This was confirmed by the facility DON and NHA during interview on [DATE] at 10:00 AM. The identified concern related to the failure of the staff to provide care to the residents identified in this citation were reviewed with the facility DON and NHA on [DATE] and again during the exit conference on [DATE]. 31982 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.)During an interview on [DATE] at 2:26 PM, Resident #2 indicated to a surveyor that s/he felt unsafe. When asked to explain, s/he reported that agency staff who worked overnight 2 weekends ago left the building unattended, to get food. The resident added that no medications were given that evening. s/he was uncertain of the credentials of the staff involved. Review of an anonymous complaint on [DATE] alleged that 2 agency LPN's (Licensed Practical Nurses) left the facility for approximately ,d+[DATE] hours during the night shift on [DATE] to purchase food from a convenience store. The agency LPNs were the only licensed nurses in the facility that night. 1) The absence of the Agency LPNs left the facility resident's and Geriatric Nursing Assistants without supervision of a licensed nurse, and 2) a medication pass was missed. This information was confirmed in an interview with anonymous complainant #37 on [DATE] at 2:08 PM. Review of the staffing schedule for [DATE] revealed there were 73 residents in the facility on that date, 4 GNAs (Geriatric Nursing Assistants) were working from 10 PM [DATE] - 6 AM [DATE], the 2 LPNs scheduled for night shift called out and Staff #14 and #15, agency LPNs were added to the schedule in their place. Review of the agency staff timesheets revealed that Staff #14 worked from 8:17 PM on [DATE] - 8:26 AM [DATE], and Staff #15 worked from 8:15 PM on [DATE] - 8:26 AM on [DATE]. Each timesheet indicated a 30-minute break was taken but did not specify the time of the break. In an interview on [DATE] at 9:14 AM Staff #19 a GNA confirmed she worked on the 3rd floor from 10 PM - 2 AM on [DATE]-[DATE]. When asked if she recalled any issues with staffing that night, she indicated she did. She stated that around 12:00 midnight, the LPN working on the 3rd floor said she was going downstairs. Staff #19 assumed it was for a break. She indicated that after approximately 45 minutes she walked downstairs because the LPN had not returned, and she found that the 2nd floor nurse was also missing. Staff #19 indicated that she called the DON (Director of Nursing). The DON was sick at the time and indicated that she would call the Administrator. Staff #19 was asked if the LPN's said anything upon their return. She stated, they called me to let them in - had [NAME] bags. Staff #19 thought they went to the [NAME] store in Kaiser WV because it was closest to the facility. When asked how long it took to go to that [NAME] store, she stated, probably 40 minutes there and back, they didn't come back till about 1:40 AM. She confirmed when asked that neither the Administrator nor other licensed nursing staff came to the facility that night. An interview was conducted with the Administrator and the DON on [DATE] at 9:40 AM. They were asked if there were issues regarding the agency LPNs who worked on the night of [DATE]. The Administrator confirmed that the 2 regularly scheduled LPNs called out, she posted the need for coverage on the agency's website. She indicated that everyone was in an uproar because the 2 LPNs arrived late, about 8:15 PM - 8:30 PM. When asked if there were any complaints from residents the DON indicated that she believed about ,d+[DATE] residents complained they didn't get their medications. She indicated that a review of the MAR (Medication Administration Record) revealed that some medications were not signed off. The DON indicated that she had been sick and was off from [DATE] until working remotely on [DATE] and was back in the facility on [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked if there was anything else that happened that night the Administrator stated, I got a report that the LPNs took an excessively long break. She added that the agency uses Geotracking and according to the Geotracker, they took a 40-minute break outside of the geofence. When asked where they were during that time, she stated I'm assuming they went to lunch. She added, staff are allowed to leave the property for lunch break. When asked if they left at the same time she stated, that's what I hear. When asked if she talked to them about it she stated yes, they said we're here now, and it was about 1:00 AM. She was asked to provide the surveyor with the Geotracking information for Staff #14 and #15 from [DATE]. None was provided prior to the end of the survey. She confirmed there were no licensed staff in the building while they were gone. When asked if the Agency staff received an orientation to the facility, she indicated that the staff from that agency are not oriented to the facility, but they get report from the off going nurse. She indicated the facility is working on a binder of information for agency staff to reference. When asked why there was no RN in the building, the DON indicated she did not know. When asked what action was taken after this incident, the Administrator indicated she reported the incident to the staffing agency, placed Staff #14 and #15 on a do not return status and reported the incident to the Medical Director. The Administrator confirmed that only the 4 GNAs were in the facility providing care for the residents during the time Staff #14 and #15 left. The Administrator indicated she did not report the incident to the state agency, did not report Staff #14 and #15 to the Maryland Board of Nursing, and did not speak to the GNAs to verify the events on [DATE] night shift. When asked if the allegations were investigated the DON indicated that after she returned to the facility she completed an audit to identify which residents missed medications that night. She indicated that there were many things not signed off including medications, behavior assessments, and treatments. Review of the audit sheet identified that on the 2nd floor medications were late for 8 residents, medications were missed for 6 residents and 6 residents filed grievances regarding medications not given or given late. On the 3rd floor medications were missed for 5 residents. In another interview on [DATE] at 2:19 PM the DON was asked what was put into place after the audit. She indicated that the Medical Director was notified and asked staff to monitor for any ill effects related to the residents not receiving their medications as prescribed. Some of the resident representatives were called and informed of the findings. She confirmed, however, that as of the interview date, not all representatives of the residents affected had been called. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215240	A. Building B. Wing	03/11/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted with the agency LPN, Staff #14 on [DATE] at 2:33 PM. When asked about the events on [DATE] she stated, I got there super late, everything was closed, I didn't have any food thought we could get food really quick and come back. She confirmed that Staff #15 left the facility with her and stated, we came right back, everything was fine. She indicated that they left the facility at approximately 12:30 PM and believed they returned about 1:00 AM. She confirmed they went to a [NAME] store but did not know where it was located. When asked who was the charge nurse that night she stated, There was no nurse supervisor, it was just me and the other nurse there. She stated what could have really gone wrong? If I didn't get anything to eat I couldn't have continued my shift anyway, I had just driven 4 hours to get there. She indicated that there were med techs working but she was told that she had to sign off the narcotics that were administered by the med tech because they can't sign them off. She was unable to identify who told her this. Further review of the staffing schedule revealed that a Certified Medication Assistant (CMA) was included on the evening shift schedule, it did not identify her actual working hours. An interview was conducted on [DATE] at 3:05 PM with Staff #38 a CMA/GNA. She indicated that she has worked in the facility for about 5 years. She indicated she worked her normal shift of 2:30 PM - 11:00 PM on the 3rd floor on [DATE]. She indicated that the agency LPN was running late, an RN (Registered Nurse) was working until the agency LPN arrived to relieve her at around 8:30 or 9:00 PM, and the RN gave the agency LPN report. When asked if she was able to administer all medications she stated No, I can't give narc's (narcotics) or insulin, the nurse has to do that part. She indicated the narcotics were stored in a separate locked section and the nurse had the key to the locked narcotics box. When asked if she ever administered narcotics and had the nurse sign them off as administered she stated, No. She further indicated that CMAs did not work overnight, that it was her responsibility to administer the medications except the narcotics and insulin until 11:00 PM. After 11:00 PM it was the responsibility of the night shift nurse to administer all medications. When asked how the nurses would know which medications they needed to administer she indicated they looked at the MAR (Medication Administration Record) in the computer. She indicated she had never seen Staff #14 or #15 before. When asked if the agency LPNs said anything about needing to get food she stated No, they didn't say anything. Cross reference F-725. 48470 3.) Resident #8 had been residing in the facility since 2022. A quick review of the residence's medical record indicated that the resident was taking insulin for diabetes management. Diabetes is a disease that occurs when your blood glucose, also called blood sugar, is too high. Insulin is a hormone that helps glucose get into your cells to be used for energy. If you have diabetes, your body doesn't make enough or any insulin or doesn't use insulin properly. Glucose then stays in your blood and doesn't reach your cells. Diabetes raises the risk of damage to the eyes, kidneys, nerves, and heart. Insulin monitoring is essential for effective diabetes management. On [DATE] at 8:58 AM, Resident #8's medical records were reviewed and revealed an order that started on [DATE], to check the blood sugar (BS) every Wednesday at 6 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent review of Resident #8 medical record on [DATE] at 10:06 AM, revealed that the order to check the resident's BS were being signed by the nurses on the electronic Medication Administration Record (eMAR) as done but no actual value for the resident's BS were being documented. The resident's vitals report was reviewed and revealed an area to document blood sugar. Since the start date of the order for BS check on [DATE], only one value was documented in this report on [DATE]. An interview was conducted with the Licensed Practical Nurse (LPN #43) assigned to Resident #8's care on [DATE] at 10:37 AM. During the interview, the order for BS check was reviewed with LPN #43 and she indicated that the order was scheduled early in the day so the night shift nurse would have performed it. LPN #43 was asked if she knew where the values for BS checks were documented. LPN #43 reviewed Resident #8's electronic health record and reported that she did not see any value for BS checks. LPN #43 proceeded to review the order and indicated that she would revise it to include an area on the eMAR to document the blood sugar value. On [DATE] at 11:23 AM, Resident #8's progress notes were reviewed and revealed an entry on [DATE] at 11:08 AM by LPN #43 that read: Residents blood sugar 159 @ this time. Weekly order for accuchecks updated to reflect area to record results. On the same day at 11:55 AM, the Director of Nursing (DON) was interviewed in the presence of the Nursing Home Administrator (NHA) and the Corporate Compliance Nurse. During the interview, the concern was discussed that there was no credible evidence that the nurses are performing blood sugar checks on Resident #8. The DON looked up the residences electronic health record and indicated that it was marked weekly as done by the nurses, but no actual values were being recorded. The corporate compliance nurse reported that he would go up to the unit to review the resident's medical record to see if the nurses had documented the BS value somewhere else. The NHA and the DON both agreed that if there was no documented result for BS then it was not done. Both staff acknowledged the concern. On [DATE] at 12:20 PM, the corporate compliance nurse reported that after reviewing Resident #8's medical records, he was also not able to find any result for BS checks other than the [DATE] documentation.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 45139 Based on medical record review and interviews, it was determined that the facility failed to offer the current COVID-19 vaccination or document the refusal for the current COVID vaccine for residents. This was evident in four (Resident #63, # 20, #11, #18) out of five residents reviewed for immunization status. The findings include: On 3/04/25 at 9:00AM a review of immunization records failed to reveal a record that Resident #63, # 20, #11 and #18 had been offered or was educated about the current COVID-19 immunization. In addition, the review failed to reveal documentation that the resident refused the current COVID vaccine On 3/04/25 at 3:39 PM the Infections Preventionist (Staff #2) was interviewed. During the interview she confirmed that Residents #63, #20, #11 and #18 had not been administered the COVID vaccine and there was no documentation that they received COVID vaccine education or declined the vaccine. She confirmed that the residents should be offered the COVID vaccine, and that the facility will start offering the COVID vaccine when they offer the flu vaccine in the fall. On 3/06/25 at 12:35 PM the administrator confirmed that the facility plan going forward is to offer the COVID vaccine when the Flu vaccine is offered. No further information or documentation was provided prior to the end of the survey.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 51900 Based on observations and staff interviews, it was determined that the facility failed to ensure the maintenance of essential kitchen equipment, as evidenced by failure to ensure that the walk-in refrigerator door would routinely close. This was evident for one out of one walk-in refrigerator observed in the kitchen. The findings include: On 3/03/25 at 10:17 AM, during a kitchen tour, the surveyor observed the facility's walk-in refrigerator door was not fully closed, and observed a sign on the door reminding staff to ensure that the door closed completely. The surveyor then interviewed the Certified Dietary Manager (CDM #32) and asked questions about how temperatures are monitored for each of the refrigerators and freezers. She notified the surveyor that the facility staff check the temperatures twice daily, but because the walk-in refrigerator door doesn't always close, they check it more often. While observing the inside of the walk-in refrigerator, with the CDM, the surveyor noted that the door didn't fully close behind them. The CDM (#32) acknowledged that the door didn't appropriately close. The surveyor asked how long this had been an issue and she stated that it has been a while and that the door had been fixed, but that it continued to have difficulties closing all the way. She stated that if a person pushes the door more forcefully, it will close completely. The staff is very aware that they need to closely monitor the door to ensure it has closed. The surveyor, with CDM (#32) present, observed the door fail to close on its own in two out of three attempts. On 3/05/25 at 11:50 AM, the surveyor observed that the walk-in refrigerator door was closed initially but later observed a staff member entering the walk-in and the door didn't close behind her. At 12:08 PM, the surveyor went into the walk-in refrigerator and the door again didn't close. When the surveyor exited the walk-in, the CDM (#32) was standing there and observed the door did not close behind the surveyor. The CDM (#32) confirmed that the door wouldn't always close and that she would reach out to maintenance to adjust the door. On 3/11/25 at 9:26 AM, the surveyor discussed the concern with the Nursing Home Administrator and the Director of Nursing about the refrigerator door not closing.