STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215241	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Nursing Home Operator, LLC	1601 East Belvedere Avenue Baltimore, MD 21239

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on observation and an interview with Residents and staff, it was determined that the facility failed to maintain Residents' dignity as evidenced by 1) residents (Resident #14, #96, #30, #56) not being served meals at same time, and 2) Staff availability during the dining process to provide sufficient cueing, prompting, serving, and assisting residents to eat. This was evident for 1 of 2 dining observations performed at the main dining room with 5 large dining tables and 1 small dining table. The findings include: On 04/30/25 at 12:27 PM, an observation was made in the main dining room. Residents #14,# 96, #30, and #56 at table #1, were served their meals in the dining room [ROOM NUMBER] minutes after other residents were served their meals. Geriatric Nursing Assistant (GNA) staff # 28 sat at table #4, where she/he assisted Residents who sat at that table and socialized but did not offer assistance to residents at other tables. Resident # 19, with left-sided body weakness, sat in a wheelchair, seated at Table #6. He/she attempted to eat with the right hand, but the food was not cut, and he/she ate ham and other food with his/her fingers. Resident #19 was not offered assistance to cut food. Additionally, a dietary staff # 29 served hot food, but gave minimal attention to the residents and made no conversation with the residents at the table. The sound of the television in the dining room was completely turned down during the entire mealtime. During an interview with dietary staff # 29 on 04/30/25 at 12:53 PM, it was revealed that most times he/she serves food alone in the dining room, setting up the hot food. Residents join from different floors as hot food was available only in the main dining room. Reviewed with Unit Manager, staff # 30, and Director of Nursing (DON) and both of them acknowledged the findings, on 04/30/25 at 3:25 PM. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/01/25 at 12:10 PM, the Facility administrator showed the surveyor that changes and improvements were made. The surveyor subsequently witnessed meals being served at same time and staff assisting residents.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 49304 Based on interviews with facility staff and review of medical records, it was determined that the facility failed to complete a significant change Minimum Data Set (MDS) assessment within 14 days of a resident's discontinuation from hospice services. This was evident for 1 (Resident # 30) of 47 residents reviewed during the facility's recertification/complaint survey. The findings include: The MDS is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be completed to ensure each resident receives the care they need. A Significant Change in Status Assessment (SCSA) is required when a resident enrolls in a hospice program or a resident receiving hospice services discontinues those services. On 4/24/25 at 10:01 AM review of Resident #30's medical record revealed the resident was admitted to the facility in June 2016. On 5/2/25 at 12:02 PM in an interview with the Regional Clinical Services Manager (RCSM #12) she stated that Resident #30 was admitted to hospice on 5/24/23 and discharged from hospice on 8/28/23. On 5/2/25 at 12:52 PM a review of Resident #30's medical record revealed a SCSA completed on 5/31/23. However further review failed to reveal a SCSA was completed within 14 days of the resident discontinuing hospice services. There were no further SCSAs completed for this resident after 5/31/23. On 5/2/25 at 1:21 PM in an interview with MDS Coordinator #13 she stated a significant change assessment needed to be completed when a resident was admitted or discharged from hospice. During the interview, MDS Coordinator #13 stated Resident #30 was admitted to hospice on 5/24/23 and the SCSA was completed 5/31/23. However, after looking at her computer, MDS Coordinator #13 stated she did not see a SCSA from when Resident #30 was discharged from hospice. Additionally, the Regional Resident Assessment Coordinator #16 present during the interview, also looked in her computer and verified and confirmed that one was not completed.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on a review of Minimum Data Set (MDS) Assessment documentation and an interview with facility staff, it was determined that the facility failed to complete discharge resident assessments as required. This finding was evident for 1 (Resident # 65) of 33 residents reviewed during the resident assessment task during the recertification/complaint survey. The findings included: The MDS is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. Each assessment must be encoded within seven days and transmitted within fourteen days of the assessment being performed. On 05/01/25 at 11:44 AM, medical record review revealed that the resident # 65 was admitted for short-term rehab services to the facility on [DATE] and was discharged from the facility on 1/2/2025, in stable condition. Further review of the clinical record of resident #65 revealed no evidence that a discharge assessment was completed as required. On 05/01/25 at 01:14 PM, interviewed MDS staff # 13 and it was validated that assessment was missed. On 05/01/25 at 1:30 PM, DON also validated that the Resident's discharge assessment was missing.

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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. 49304 Based on review of the medical record and interviews with facility staff, it was determined that the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (Resident #2) of 47 residents reviewed during the facility's recertificaiton/complaint survey. The findings include: The MDS is a federally mandated assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. MDS assessments need to be accurate to ensure each resident receives the care they need. According to CMS's (Centers for Medicare & Medicaid Services) Resident Assessment Instrument (RAI) Version 3.0 Manual, the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. The Coding Instructions in CMS's RAI Version 3.0 Manual are as follows: - Code 06, Independent: if the resident completes the activity by themselves with no assistance from a helper. - Code 05, Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening containers or requires setup of hygiene item(s) or assistive device(s). - Code 04, Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity. Code 04, Supervision or touching assistance: if the resident requires only verbal cueing to complete the activity safely. - Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. - Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity. On 4/24/25 at 10:40 AM a review of Resident #2's medical record revealed that the most recent quarterly MDS was completed on 4/17/25. Section GG 0130: Self-Care- A5. is where residents are coded for Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. This MDS assessment had Resident #2 coded as Code 05, Setup or clean-up assistance meaning that a helper assists only prior to or following the activity [eating], but not during the activity [eating]. On 4/24/25 at 10:46 AM a review of Resident #2's medical record revealed the following diagnoses: - unspecified dementia, unspecified severity, with other behavioral disturbance - mood disorder due to known physiological condition - vascular dementia - major depressive disorder, recurrent, mild - mild cognitive impairment of uncertain or unknown etiology On 4/25/25 at 8:22 AM in an interview with Resident #2's family member, s/he stated the resident is eating and losing weight, even though they have someone feeding him/her. During the interview the family member stated that when s/he last came up there [to the facility] on 4/19/25, they had someone feeding her. On 4/30/25 at 1:35 PM Resident #2's care plan revealed a problem of imbalanced nutrition with a goal for the resident to meet estimated nutritional needs through oral intake. One of the approaches documented to meet this goal was, Dietary: Additional directions 1:1 assistance created on 3/6/25 by the Registered Dietician (RD #7). An interview was conducted with RD #7 on 4/30/25 at 2:02 PM. During the interview when asked to clarify Dietary: Additional directions 1:1 assistance in Resident #2's care plan, she stated that the staff must pick up the utensils for him/her and s/he actually needs to be fed by the staff. The Unit Manager (UM #18) was interviewed on 4/30/25 at 9:00 AM. During the interview when asked if there was a list of residents who needed feeding assistance, she provided the surveyor with a list. A review of the list revealed Resident #2's name documented. UM #18 was interviewed on 5/1/25 at 11:45 AM. During the interview when asked about the level of assistance Resident #2 needed, she stated that s/he needs someone to actually hold the utensil and feed him/her. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 12:01 PM the surveyor requested evidence used to make the determination to code Resident #2 as set up/clean up assistance on the most recent (4/17/25) quarterly MDS assessment. On 5/1/25 at 12:30 PM MDS Coordinator #13 provided documentation, GG Consolidation Review dated 4/17/25. Review of the document revealed Question 4 is written as follows: Facility clinicians established resident's 'usual baseline performance' from information obtained during the 3-day lookback period from the following sources (check all that apply). Further review of the document revealed the box for Other (specify below) checked and documentation typed into the field below. The other sources listed: direct observation; interview with nursing staff; interview with resident/family; PT direct observation as documented in PT evaluation, daily note, progress note, recertification, and/or discharge summary; OT direct observation as documented in OT evaluation, daily note, progress note, recertification, and/or discharge summary; and SLP direct observation as documented in SLP evaluation, daily note, progress note, recertification, and/or discharge summary were not checked. On 5/2/25 at 1:32 PM in an interview with the MDS Coordinator #13 she verified and confirmed that for the April 2025 MDS, the only documentation she used to make the determination to code Resident #2 as set up/clean up assistance was from the GNA's (Geriatric Nursing Assistants') documentation.

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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** 49304 Based on review of medical records and interview with facility staff, it was determined that the facility failed to ensure that residents were provided with summaries of their baseline care plans including a list of their medications. This was evident for 1 (Resident #67) of 47 residents reviewed during the facility's recertification/complaint survey. The findings include: A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and medication list must be given to each resident and/or his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. On 4/28/25 at 9:11 AM, Resident #67's medical record was reviewed. The review revealed the resident was admitted to the facility on [DATE] but failed to reveal a BLCP or any evidence that Resident #67 had been provided with a summary of his/her BLCP along with a summary of his/her medications. On 4/28/25 at 9:17 AM the Director of Nursing (DON) was interviewed. During the interview, she stated that BLCPs are initiated by the admitting nurse and completed by any nurse within 48 hours. Additionally she stated that the nurse is supposed to print them out, sign it, have the resident or RP (responsible party) sign it and then upload it into PCC (electronic medical record) under Documents. When asked who was responsible for providing the resident and/or RP with the copies, the DON said, Nursing. When asked if the process was documented, she stated it should be in a progress note. Finally, when asked who was ultimately responsible for ensuring the completion of this process, the DON stated the Unit Managers (UMs). On 4/28/25 at 11:18 AM the DON was asked to provide evidence that Resident #67 received a BLCP summary including a list of his/her medications following his/her 9/9/23 admission to the facility. On 4/30/25 at 11:12 AM the DON verified and confirmed that there was no BLCP completed for this resident's original admitted .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49304 Based on interview with residents, surveyor observations, interview with facility staff, and review of medical records, it was determined that the facility failed to follow physician orders as evidenced by ensuring a resident's peripherally inserted central catheter (PICC line) dressing was changed as ordered by the physician. This was evident for 1 (Resident #67) of 47 residents reviewed during the facility's recertification/complaint survey. The findings include: A PICC line, or peripherally inserted central catheter, is a long, thin tube inserted into a vein in the arm and threaded up to a larger vein in the chest, near the heart. It provides long-term intravenous access for medications, fluids, blood draws, and other treatments. A PICC line requires careful care and monitoring for complications, including infections and blood clots. Dressings should be changed typically once a week, or sooner if they become wet, dirty, or loose as dressing changes are crucial for infection prevention. On 4/24/25 at 9:44 AM in an interview with Resident #67, s/he stated s/he was getting IV (intravenous) antibiotics. During the interview s/he stated s/he did not know why they left it (dressing) on there looking like that (soiled). Additionally, s/he stated s/he could not remember the last time they took the sticker off and cleaned and changed it but said that it had been a while. The surveyor observed the PICC line dressing with a date of 4/3/25. On 4/24/25 at 9:59 AM Resident #67's nurse, Licensed Practical Nurse (LPN #3) was interviewed. During the interview, she stated that the dressing was supposed to be changed once a week. When asked the date documented on the dressing during a dual observation she stated, it says 4/3/25. When asked if the dressing had been changed weekly, LPN #3 stated no. On 4/24/25 at 11:54 AM review of Resident #67's medical record revealed a physician order to change the catheter site dressing on admission, Q (every) week and PRN (as needed) with transparent dressing, one time a day every Thursday. Further review of the medical record revealed an order for a PICC line dated 4/3/25. Resident #67's PICC line dressing had not been changed since the line was placed on 4/3/25.

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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. 42507 Based on observation, medical record review, and interview, it was determined the facility staff failed to provide adequate care to prevent complications from hand contractures. This was evident for 1 (#83) of 3 residents reviewed for limited range of motion (ROM) during a recertification/complaint survey. The findings include: A contracture is an abnormal shortening of muscle tissue causing the muscle to be resistant to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand. Observation of Resident #83 on 4/25/2025 at 9:15 AM revealed that the resident's left hand was contracted. The resident's fingers were bent inwards and nails pressing into the palm of the resident's hand. When instructed to open their left palm, Resident #83 stated s/he could not do so. The resident did not have a protective device (palm protector/splint) to prevent pressure to their palm, and none was visible in their room. The observation was brought to the attention of Resident #83's nurse, Registered Nurse (RN #23) on 4/25/2025 at 9:17 AM. RN #23 confirmed that Resident #83 was supposed to be wearing a left hand splint. On 4/30/2025 at 10:22 AM, a review of Resident 83's clinical records revealed the resident was initially admitted to the facility in May 2020 and readmitted in July 2024 with medical diagnoses that include but not limited to Unspecified Dementia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left dominant side, and Contracture left wrist. On 4/30/2025 at 10:38 AM, a review of physician orders revealed the following active orders for Resident #83 dated 7/12/2023: Splint Order: Left resting hand splint On daily after AM care and Off after lunch following 2-3 hours of wear as tolerated. every day shift Apply Splint - provide hand hygiene and PROM of digits AND every evening shift Remove Splint and provide skin check. On 4/30/2025 at 10:50 AM, a review of Resident #83's April 2025 Treatment Administration Record (TAR) revealed that the nursing staff signed off on the day (7a-3p) shift that a left resting hand splint was applied every day including 4/24/2025 through 4/30/2025. However, it was inconsistent with surveyor observation on 4/25/2025 at 9:15 AM where no left resting hand splint was observed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/2025 at 11:45 AM another surveyor conducted a follow up observation and interview of Resident #83: Resident was observed lying in bed watching TV, his/her left arm was contracted and lying unsupported at his/her side with no splints on. Resident was asked if s/he could move the left arm and s/he was able to move it slightly. Resident was asked if s/he had a splint for the left arm and s/he said yes that it was in the drawer; S/he asked the surveyor to look in the drawer. The surveyor looked and could not find it. S/he was asked if the staff put the splint on him/her daily and s/he said not really. Resident was asked if s/he had it on yesterday, or the day before and s/he said no. On 4/30/2025 at 12:27 PM, surveyor conducted an interview with the Rehab Director (Staff #10). Staff #10 stated that Resident #83 has a left grip splint ordered to be worn during the day since July 2023 to minimize further contracture and reduce resident's report of pain. On 5/1/2025 at 10:01 AM, surveyor made a third (3rd) observation of Resident #83 in their room and accompanied by the Interim Unit Manager (UM #21). Resident #83 was observed in bed and had no left resting hand splint in place. When asked where the splint was, the resident stated, I don't know. when asked if staff had been applying the splint on his/her left hand, the resident shook their head and said No. UM #21 searched resident's room and could not find the left hand splint. UM #21 then left the resident's room and said she was going to follow up with rehab department (OT) to get another splint for the resident. On 5/1/2025 at 10:12 AM, Surveyor reviewed with UM #10, Resident #83's TAR for April 2025 that revealed staff signature that they were applying the splint on day shift inconsistent with surveyors observations on 4/25/2025 and 4/30/2025 when 2 different surveyor's made observations of the resident and s/he did not have the left resting hand splint on. UM #10 stated that she was going to address that with staff. On 5/1/2025 at 1:07 PM in an interview with the Director of Nursing (DON), surveyor reviewed observations made on 4/25/2025, 4/30/2025, and 5/1/2025 of resident not having the left resting hand splint applied as per orders. DON stated that GNAs (Geriatric Nursing Assistants) on the floor told her the splint was removed and taken out of the resident's room by OT (Occupational Therapy) but they could not tell her (DON) the exact date that OT took the splint out of the resident's room. However, surveyor reviewed resident's TAR for April 2025 that revealed staff documentation that they were applying the splint including the days that surveyors did not see the splint on the resident's left hand and/or in their room. DON stated she was going to follow up with OT regarding when they removed the splint from the resident's room.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42507 Based on observation, medical record review, and interview, it was determined the facility staff failed to 1) label oxygen tubing and humidifier bottle when changed, and 2) equip a resident with an incentive spirometer to address their respiratory needs per physicians order. This was evident for 2 (#45, #67) of 3 residents reviewed for respiratory care during a recertification/complaint survey. The findings include: Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider. An incentive spirometer is a simple, plastic medical device that exercises your lungs. Your healthcare provider may recommend that you use an incentive spirometer after an illness, surgery or an injury to your chest or abdomen. An incentive spirometer helps prevent lung infections by expanding your lungs, strengthening your lungs, keeping your lungs inflated and clearing mucus and other secretions. You may have low oxygen levels after surgery or a serious illness, and an incentive spirometer helps you achieve a normal oxygen level. 1) On 4/24/2025 at 9:25 AM, during initial pool screening, surveyor observed Resident #45 in bed with their eyes closed. The resident was wearing a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) that was connected to a humidifier (water) bottle connected to an oxygen concentrator set at 3LPM (liters per minute). The LPM oxygen flow rate of 3 indicates that 3 liters of oxygen should flow into the resident's nose in 1 minute. There was no date/time noted on both the oxygen tubing and humidifier bottle. On 4/24/2025 at 9:30 AM, Resident #45's nurse, Licensed Practical Nurse (LPN #20) observed and verified that the oxygen tubing and the humidifier bottle were not labeled with date/time. In an interview LPN #20 stated that the expectation was for the humidifier bottle and oxygen tubing to be labeled with date/time they were hung/changed. She added that she was going to change both the humidifier bottle and oxygen tubing so as to label them. During a review of Resident #45's medical record conducted on 4/25/2025 at12:28 PM, surveyor noted an active physician order dated 4/23/2025 for: Oxygen via Nasal Cannula at 3LPM every shift. There were additional orders dated 4/23/2025 for Change Oxygen tubing every week. Initial and date tubing every night shift every Wed, and Change Humidifier Bottle Q week and PRN. Initial and date bottle, every night shift every Wed AND as needed. On 4/25/2025 at 12:46 PM, review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for April 2025 revealed staff documentation that the humidifier bottle and oxygen tubing were changed on 4/23/2025. However, when surveyor observed the humidifier bottle and Oxygen tubing on 4/24/2025, there was no date/time and/or initial to indicate that the humidifier bottle and oxygen tubing had been changed as per physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/2025 at 10:39 AM, in an interview with the Director of Nursing (DON), surveyor reviewed resident's orders for Oxygen, staff documentation on the MAR/TAR, and surveyor's observations on 4/24/2025 regarding resident's Oxygen tubing and humidifier bottle not labeled as per physician orders. No other information was provided. 49304 2) On 4/24/25 at 10:03 AM in an interview with Resident #67 s/he stated s/he needed an incentive spirometer. During the interview, s/he stated every time s/he asks a staff such as nurses or Geriatric Nursing Assistants (GNAs) for one, they say it is on order. S/he stated that one nurse did not know what an incentive spirometer was or what it was used for. Additionally, Resident #67 stated s/he has a lot of mucus and worries s/he is going to choke on it since s/he hardly gets out of bed. S/he also stated that s/he has had pneumonia twice, and most recently, this year. The surveyor did not observe an incentive spirometer in Resident #67's room. On 4/24/25 at 11:57 AM review of Resident #67's medical record revealed a physician order for incentive spirometer 10 times per hour while awake every shift for atelectasis that was ordered on 1/31/25. On 4/29/25 at 8:15 AM during a second observation, no incentive spirometer was noted to be in Resident #67's room and stated s/he still had been asking the nurse or GNA every day and not received one. Licensed Practical Nurse (LPN #24) was interviewed on 4/29/25 at 8:25 AM. During the interview, LPN #24 stated that Resident #67's respiratory treatments included an incentive spirometer, oxygen therapy, and BiPAP (bilevel positive airway pressure) at night. When asked if the resident had the incentive spirometer at his/her bedside, LPN #24 stated she had not been in his/her room yet. When asked if she does bedside rounds with the off going (11 PM - 7AM) nurse, she stated yes. On 4/29/25 at 8:31 AM LPN #24 and the surveyor walked from the nurse's station to Resident #67's room. LPN #24 told Resident #67 that she wanted to see if s/he had his/her breathing machine, the incentive spirometer. Resident #67 said, No, I have been asking every day for the past 3 weeks and still do not have one. LPN #24 looked around the resident's room, and with permission from Resident #67, his/her drawers and was unable to find an incentive spirometer. LPN #24 stated, Let me go get one for you. On 4/29/25 at 8:33 AM LPN #24 asked the Unit Manager (UM #18), Do you know where the incentive spirometers are? UM #18 stated we have to get it from central supply, from Central Supply Clerk #6. On 4/29/25 at 8:35 AM during an interview with LPN #24 when asked if residents should have ordered equipment at their bedside, she stated of course they should have the necessary equipment at their bedside. When asked why the incentive spirometer was not at Resident #67's bedside, LPN #24 stated after going through the resident's orders, if she saw s/he did not have it, she would have gotten it, but that had not happened yet because she had just started her shift. When asked what time her shift started, LPN #24 stated 7:00 AM. The UM #18 brought several incentive spirometers to the unit. LPN #24 and the surveyor walked back down to Resident #67's room and she gave an incentive spirometer to the resident. Resident #67 stated s/he was supposed to have already had one and had been asking for so long.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 44441 Based on interviews with residents and staff and medical record reviews, it was determined the facility failed to ensure that residents were given pain medications timely and consistent with professional standards of practice. This was evident for 2 (#237, #37) of 4 residents reviewed for pain management during a recertification/complaint survey. The findings include: 1) On 4/24/25 at 11:10 AM during the initial tour of the facility, Resident #237 told the surveyor that s/he was not sure if their pain medication was ordered as needed or scheduled because they were not getting it on time. Review of the Physicians' order on 4/28/25 at 11:59 AM had orders written as: 4/19/25: Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) *Controlled Drug* Give 2 tablet by mouth at bedtime for Back pain. 4/20/25: Acetaminophen Oral Tablet 500 MG (Acetaminophen), Give 1 tablet by mouth at bedtime for pain Do not exceed 3 gm in 24 hours. On 4/28/25 at 1:50 PM a review of the facilities medication administration policy had under #5 that medication passes must be started no more than (1) hour before, and completed no more than one (1) hour after the scheduled time Further Review of the medication Administration Audit Report for the month of April on 4/29/25 at 9:27 AM revealed different days when scheduled medications including pain medications were given more than 2 hours late. Some of the dates include: 4/20/25 the lidocaine patch scheduled for 9:00 AM was given at 12:12 PM 4/21/25 Lidocaine patch scheduled for removal at 8:00PM, was removed at 11:40PM 4/22/25 Lido Patch scheduled for removal on 8:59PM, was removed at 01:14AM 4/23/25 Lidocaine patch scheduled for 9am was given at 12:16 PM 4/23/25 Hydrocodone-Acetaminophen oral tab 5-325 scheduled for 9:00PM was given at 01:14 AM On 4/29/25 at 11:25 AM Staff #18 a unit manager was asked about medication (MED) pass hours, and she said that medications are expected to be given an hour before the time scheduled and an hour afterward, she confirmed that there are days when med pass are late due to interruptions from residents or staffing issues. On 4/29/25 at 12:57 PM the Director of Nursing (DON) was made aware of the concern. She stated that they are working with the nurses by providing education to adhere to med pass hours. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42507 2) During an initial pool screen of Resident #37 on 4/24/2025 at 9:10 AM, the resident stated that s/he was always having bilateral leg pain and the staff did not give them pain medications on time. Resident #37 further stated that sometimes s/he has waited for about an hour for the nurse to bring their pain medication. Review of Resident #37's clinical records on 4/29/2025 at 10:42 AM revealed the resident was admitted to the facility in May 2014 with medical diagnoses that include but not limited to Chronic pain, Unilateral primary Osteoarthritis left hip, Pain in right leg, Pain in left leg, other Muscle spasm, Peripheral vascular disease, Type 2 Diabetes. On 4/29/2025 at 10:58 AM, a review of physician orders as of 1/1/2025 revealed the following orders: - Acetaminophen tab 325MG: Give 2 tablets orally every 6 hours as needed for pain 1-5 use caution with APAP total daily dose greater than 3,000MG, start date 2/21/2025. - Tramadol HCl Oral Tablet 50 MG (Tramadol HCl): Give 1 tablet by mouth every 6 hours as needed for Pain, start date 3/28/2025. [Of note: this PRN (as needed) order has no parameters for administration] There were also discontinued orders for: - Acetaminophen tab 325MG: Give 2 tablets orally every 6 hours as needed for pain 1-4 use caution with APAP total daily dose greater than 3,000MG, start date 1/18/2019 and discontinued on 2/21/2025; and - Hydrocodone-Acetaminophen Tablet 7.5-325 mg : Give 1 tablet by mouth every 6 hours as needed for pain 6-10, start date 12/13/2024 and discontinued on 2/21/2025. On 4/29/2025 at 11:16 AM, record review revealed that Resident # 37's pain was not managed consistently: A review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2025 was completed. Staff documentation revealed that the resident was given: - Acetaminophen 325 mg (2 tabs) for pain outside ordered parameters (pain 1-4) on the following dates: 1/22/2025 at 17:02 (5:02 PM) for pain score of 6; 1/26/2025 at 20:15 (8:15 PM) for pain score of 8. - Hydrocodone-Acetaminophen 7.5-325 mg (pain 6-10) was given outside ordered parameters on the following dates: 1/13/2025 at 20:48 (8:48 PM) for pain score of 4; 1/19/2025 at 21:27 (9:27 PM) for pain score of 4; 1/24/2025 at 21:00 (9:00 PM) for pain score of 5; and 1/30/2025 at 12:56 PM for pain score of 5. A review of Resident #37's MAR and TAR for April 2025 revealed that the resident received: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- PRN Acetaminophen 325 mg (2 tabs) for pain outside ordered parameters (pain 1-5) on the following dates: 4/1/2025 at 2020 (8:20 PM) for pain score of 0; 4/24/2025 at 13:47 (1:47 PM) for pain score of 9. - PRN Tramadol 50 mg was ordered and given multiple times (27 times) without parameters and pain assessment (no pain score indicated). Moreso, Resident #37 had no non-pharmacological (use of non-chemical methods to reduce pain without medications) interventions for pain management put in place. On 4/30/2025 at 8:10 AM, Resident #37's Medication Administration Audit Report for January 2025 reviewed to see actual times that medications were given revealed that some of the residents meds (including pain meds) were given late on multiple days: - All meds scheduled to be given on 1/1/2025 at 8:00 AM were given after 10:00 AM including pain meds such as Meloxicam and lidocaine patches. - Lidocaine patches scheduled on 1/2/2025 at 20:00 (8:00 PM) were given at 02:17 (2:17 AM) on 1/3/2025 including cyclobenzaprine and gabapentin scheduled at 22:00 (10:00 PM) were also given 02:17 (2:17 AM) on 1/3/2025. - Meloxicam and lidocaine patches scheduled on 1/6/2025 at 8:00 AM and 9:00 AM were given at 11:31 AM and 11:30 AM respectively. All other meds scheduled on 1/6/2025 to be given at 8:00 AM were given at 11:30 AM. - Meloxicam and lidocaine patch scheduled on 1/7/2025 at 8:00 AM were given at 11:50 AM. - Calc Antacid Chew, Gabapentin, Cyclobenzaprine, and ProHeal Liquid protein scheduled on 1/14/2025 at 14:00 (2:00 PM) were all given at 16:36 (4:36 PM) - Meloxicam scheduled on 1/23/2025 at 8:00 AM was given at 12:23 PM. On 4/30/2025 at 10:05 AM, in an interview with the Director of Nursing (DON), she stated that they were aware of residents' concerns with delays in getting their meds. DON stated that they were in the process of working with staff in relation to time management. Surveyor reviewed Resident 37's meds that were given late in January 2025. Surveyor also reviewed with the DON the MAR and TAR for January and April 2025 regarding staff not following ordered parameters for PRN pain med administration. DON stated the meds should be given base on the doctor's orders. Surveyor reviewed resident's Tramadol that was ordered PRN without parameters. DON stated they had identified that and were in the process of fixing it. On 4/30/2025 at 10:08 AM In a follow up interview with the Regional Clinical Services Manager, Staff #12 (in the presence of the DON), she stated that they have identified the above issues regarding staff administration of meds and were currently working on staff education to fix those issues.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 49304 Based on interview with residents, review of medical records, and interviews with facility staff, it was determined that the facility staff failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner. This was evident for 1 (Resident #67) of 47 residents reviewed during the facility's recertification/complaint survey. The findings include: Resident #67 was interviewed on 4/24/25 at 10:06 AM. During the interview s/he stated s/he was missing some teeth, and it was causing him/her pain and discomfort. Resident #67 opened his/her mouth to show the surveyor. The surveyor observed several missing and/or jagged teeth. Additionally, s/he stated that x-rays were taken, but s/he had not heard anything after that and was waiting for a follow up appointment with the dentist. On 4/29/25 at 8:05 AM review of Resident #67's medical record revealed the following dental notes: - 2/10/25 Dentist Note: The Tooth Grid of the dental note revealed the resident had 9 missing teeth, 2 non-restorable teeth, 3 fractured teeth, and 6 teeth with retained roots. Additionally, in the Recommended Treatment section it was documented: Extractions teeth 19 and #30. Furthermore, in the Actions Required by Nursing Home Staff section it stated, need responsible party to give consent for extraction, please obtain signature on Consent for Extraction form (CFE), and please consult [dental group's name] scheduling for date of extraction appointment once CFE signed. Finally, in the Recall section it listed CFE needed: 2/11/25 and X-ray: 2/11/25. - 4/1/25 Dentist Note: Called to notify patient extraction will be rescheduled due to needing images prior. - 4/2/25 Dentist Note: Pt has broken teeth that are sharp and causing discomfort. Recommending FMX (full mouth x-ray) due to pt inability to isolate which teeth are of concern. Pt is describing referred pain. FMX will be taken and will review and phase out extractions PRN. Reviewed risks and benefits of extraction with pt. - 4/7/25 Dental Hygienist Note: FMX taken which patient tolerated, patient has pain on retained roots, request dentist return to evaluate images. Dentist #27 had noted x-rays: 2/11/25 however x-rays were obtained almost 2 months later. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 8:54 AM in an interview with Unit Secretary (US #25) she stated Resident #67 was not on the list to be seen by the dentist, but after surveyor intervention stated she could email [dental group]. During the interview, when asked if there was a consent on file for Resident #67, US #25 looked through the resident's chart and stated there was not one in his/her chart, but she remembered there was one flagged. She stated they (dental group) sent one on April 25th and she could look to see if it was thinned from the resident's chart. UM #18 said if they just sent it on 4/25/25, it would not have been thinned from the chart. US #25 stated that after a consent is filled out, she sends it to [dental group] and files it in the resident's chart. US #25 was unable to provide a copy of a signed consent for Resident #67 that was requested by the dentist almost 3 months prior. Obtaining a copy of a signed consent was listed in the dentist's note in the Actions Required by Nursing Home Staff section of her 2/10/25 visit. On 4/29/25 at 11:08 AM the Director of Nursing (DON) provided the surveyor with an email from [dental group's] Staff #26. In the email, [dental group's] Staff #26 had written [Resident #67] due for a dental visit again in August and Hygienist in June, asked if the resident was experiencing any issues, and noted that Dentist #27 would be back on 5/28/25. On 4/29/25 at 11:11 AM in an interview with [dental group's] Staff #26, when asked if the dentist had seen Resident #67's x-rays, she stated the dentist had not seen the x-rays because she is not due to be back to the facility until the end of May. During the interview, she stated we only know what the facility tells us. It has to come from the facility. Additionally, she stated she only recently heard from the facility that they wanted the dentist to come back out and see this resident. When asked what date the facility made the request for Resident #67 to be seen by the dentist for follow up, [dental group's] Staff #26 stated that the request came to us today (after surveyor intervention). She stated the dentist gets booked out very quickly and so that is when we rely on the facility to communicate if a resident is having pain, an infection or anything else that warrants the resident to be seen more quickly. During the interview, [dental group's] Staff #26 stated, US #25 did not say in her email that she needed an earlier date for Resident #67, she just asked when the dentist was coming back to the facility. On 4/30/25 at 8:51 AM after surveyor intervention, US #25 provided the surveyor documentation that Resident #67 was now on the list to be seen by the dentist on 5/6/25.

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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. 42507 Based on a complaint, record review, resident and staff interviews, it was determined the facility failed to develop, prepare, and distribute menus that reflect a resident's nutritional wishes. This was evident for 1 (#37) of 2 residents reviewed for food during a recertification/complaint survey. The findings include: In an interview with Resident #37 on 4/24/2025 at 9:05 AM, the Resident stated that the food served did not match what was on the meal ticket. Resident #37 stated that s/he was allergic to pork but they served her/him pork sausage and bacon. Resident #37 further stated that s/he did not eat corn because of a medical condition but they served her/him corn even though the meal ticket indicated no pork and no corn. Review of Resident #37's clinical records on 4/29/2025 at 10:42 AM revealed the resident had allergies that include but not limited to Corn and Pork. An interview was conducted with the Registered Dietitian (RD #7) on 5/2/2025 at 9:13 AM: Regarding Resident #37's food concerns, RD #7 stated they were aware that the resident was served food items (pork and corn) listed as allergies on the resident's meal ticket. However, RD #7 added that the then Kitchen Manager provided training/in-service to the kitchen staff after the deficient practice was identified. In an interview on 5/2/2025 at 11:15 AM with the Food Service Director /Kitchen Manager (Staff #15), she confirmed to the surveyor that Residents' allergies were listed on their meal tickets. Regarding Resident #37's concerns of being served pork and corn (that the resident was allergic to), Staff #15 stated she was not working in the facility at the time but was made aware by the resident during one of her (Staff #15) routine rounds that s/he (resident) had been served pork sausage and bacon. However, Staff # 15 stated that since working in the facility, Resident #37 has not been served pork sausage, bacon nor corn. In an interview with the Nursing Home Administrator (NHA) on 5/2/2025 at 11:56 AM, surveyor shared the above food concerns. NHA stated that the incident occurred in October 2024 when they had a new Food Service Director (no longer works in facility) and facility was changing systems. NHA stated that in the process of changing systems some residents' diets and allergies were not properly updated. Hence, Resident #37's allergies were not updated and s/he ended up getting pork sausage and bacon. However, NHA added that it was caught in time and Resident #37 did not eat any of the pork sausage and/or bacon. NHA further stated that a Resident Concern Form was written and they might have provided verbal education with the tray line staff. Surveyor requested a copy of the concern form from NHA. On 5/2/2025 at 12:31 PM, surveyor received and reviewed the Resident Concern Form dated 10/17/2024 that revealed: Resident received bacon on her/his breakfast tray. S/he has an allergy to pork and should not have received pork on her/his tray. S/he then requested milk and cereal but it never arrived. Resident stated s/he did not eat the bacon. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Steps taken to investigate/Results of the Investigation dated 10/21/2024: I will educate cooks on education form. I have in-service all team members on tray accuracy. Dietary staff must send resident meal tickets. The findings confirmed that the resident was served pork. However, NHA did not provide proof of staff education (staff sign-in sheet). On 5/2/2025 at 2:17 PM, in a follow up interview with the NHA, she stated that she had looked everywhere but could not find any in-service/sign-in sheet on dietary/kitchen staff education regarding accuracy of the tray line after the above incident and/or as indicated on the Resident Concern Form.

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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** 49409 Based on an observation and facility staff interviews, it was determined that the kitchen failed to store food items, so as to maintain the integrity of the specific item. This was evident during the initial tour of the kitchen, by noting expired food items and undated opened items, observed by the surveyor during the recertification/complaint survey. The findings include: On [DATE] at 8:19 AM observations with the Food Service Director (FSD) revealed the following: In the kitchen dry storage room on at 8: 25 AM, Extra heavy half full one gallon Mayonnaise container without an open date. Several snack cups were on the floor under the storage shelves, Magic cup dessert, (2) vanilla (3) chocolate (2) and wild berry (1). Complete butter milk pan cake mix expired on [DATE]. On [DATE] at 09:32 AM, the walk-in freezer had ice built up on the floor, noted hanging icicles under the condenser. Corn beef, wrapped in plastic wrap, was found in the kitchen fridge without an open date. On [DATE] at 09:06 AM Interview with dietary staff # 33 revealed that kitchen staff date the left over food items after they are opened, and discard after 72 hrs. On [DATE] at 9:30 AM reviewed with Food Service Director all the above findings and he/she validated the findings.