STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215253	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Cold Spring	4700 Harford Road Baltimore, MD 21214

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44441 Based on medical record reviews, staff interviews and observations, it was determined that the facility failed to accommodate resident's need and preferences. This was evident for 1 (R#33) of 5 residents reviewed for personal property during the survey. The findings include: On 3/8/24 at 1:02 PM review of the investigative report of a facility reported incident MD00200936 revealed that Resident #33 reported to the unit manager that s/he lost $57 dollars left on their bedside table. This incident was investigated by the facility and was not substantiated. The facility report had that Resident #33 was provided a key to their nightstand for safekeeping of their belongings. In an interview with Resident #33 on 3/11/24 at 12:29 PM, the resident was asked about the incident. S/he stated that the money was left on their table before they fell asleep, was gone before they woke up, Resident was asked why s/he left the money on the bedside table. Resident #33 explained that their nightstand did not have a lock. Resident stated further that the facility administrator was yet to provide a key for the nightstand which they promised. He/she proceeded to show the surveyor the nightstand which did not have a lock or key on it, only a circular dark cylinder. On 3/11/24 at 1:16 PM, the administrator was asked about the incident and whether the resident was provided a key to lock their nightstand as stated in the investigative report. He said he could not recall but would double check. On 3/11/24 at 2:27 PM the administrator came back to report that there was a circular hole in the resident's nightstand for a cylinder but there was no lock to provide him a key. He said that he asked the maintenance guy to place a lock in the resident's nightstand. He was made aware that this was a concern.

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

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

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 48168 Based on interview and record review it was determined that the facility failed to ensure the amount of the surety bond was comparable to the amount of the resident funds entrusted to the facility. This was evident during a review of Personal Funds during the recertification survey. The findings include: On 3/07/24 at 8:42 AM during an interview with the Nursing Home Administrator (NHA) and the Corporate Accounts Receivable Manager (Staff #33), Staff #33 indicated that resident's personal funds were kept in separate accounts and that the facility had a surety bond to cover the total amount of residents' personal funds. The surveyor asked for a list of residents who had personal fund accounts, the total amount of resident personal funds held by the facility, and for a copy of the surety bond. On 3/07/24 at 12:55 PM a review of the document titled Trial Balance which indicated an as of 03/07/24 date, revealed a list of 75 residents and their corresponding account balances which totaled $172,021.92. A review of the surety bond revealed the Bond Amount: $170,000.00 with an effective date of February 26, 2024. Therefore, the surety bond was insufficient to cover the total balance of the current resident funds amount. On 3/07/24 at 1:08 PM the NHA was interviewed to review the amount of the surety bond compared to the current total of residents' personal funds. The NHA confirmed that the surety bond did not cover the total amount of the funds being held by the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on interview and record reviews it was determined that the facility failed to maintain safe, clean, comfortable and homelike environment. This was evident on 2 of 4 nursing units reviewed during both the Infection Control facility task and the Resident Council facility task. The findings include: On 3/8/24 at 10:39 AM an abbreviated tour of the environment was conducted with the maintenance director (staff #10). In the 3A central bathing room he confirmed some trash, and a broom was in a dirty nonfunctioning electronic jet tub, One of the 3 shower stalls was without a light, and in another shower stall, water was puddled in 2 areas. In the stall with the inoperable bathing tub were several holes punctured through the wallboard into the hollowness behind the wallboard. The wall on the left side upon entering the bathing room was shown to have a approximate 4 foot by 5 foot unfinished repair with noted white spackle and some scrapes and dings into the unpainted spackle. The maintenance director was unaware of the concerns and acknowledged that the concerns were not documented in the maintenance book. In resident #33's room there was damage to the bottom of the outer bathroom wall close to the A-bed. The wall appeared to have caved in with pieces of the wall missing. The resident indicated that the wall had been like that since resident #33's admission to the facility approximately 2 1/2 year ago. The inside of the bathroom door veneer was so damaged that there was a 3 x 1 inch opening into the hollow space of the door. There were two screws protruding from the wood door frame. The damage to the door veneer extended two feet up from the floor. The maintenance director confirmed the damage. The maintenance director indicated that there was a contractor on the second floor hired to fix and repair. While in the 3rd floor corridor, an area of handrail was observed to have a busted jagged 2-inch diameter hole in the vertical portion of the railing end cap. Another area in the vertical portion of the hand railing was observed at the approximate halfway point between the two units. The maintenance director was notified of a previous observation by the surveyor in room [ROOM NUMBER], a plastic corner molding strip between the entrance and the toilet room door was broken off approximately 5 inches above the floor leaving a jagged edge. On 3/11/24 at 10:05 AM the maintenance director was on the second floor and toured the 2A central bathing room. The wall covering of the shower stalls was discussed as there were irregular discolorations on the walls in all three shower stalls. He indicated that it was likely discoloration in the topcoat of the wall finish. He acknowledged the identified concern in room [ROOM NUMBER]. On 3/12/23 at 3:45 PM, the environmental concerns that were confirmed by the maintenance director were reviewed with the nursing home administrator. He was informed of the top of the wood nightstand in room [ROOM NUMBER] window bed was observed to have ragged edges around the top into the veneer. Additionally, the door to the wardrobe was sloping preventing the door from closing properly.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 45733 Based on the review of facility self-report investigation records, observation, and interview, the facility staff failed to provide a safe/secure storage space for resident's personal belongings. This was evident for 1 (Resident #279) out of 16 residents reviewed for facility self-reported incidents. The findings include: Record review, on 03/04/24 at 9:20 AM, revealed that Resident #279 had complained on 07/25/23 to the Staff #12 who filled out a Resident Concern Form. In this complaint, the resident stated that he/she expected to be reimbursed $2,332 for missing or damaged items. Further review of the facility self-report investigation of the resident's allegation found that it could not be clarified whether and how the resident's personal belongings went missing or were damaged. Observation, on 3/4/24 at 12:20 PM, of a storage room for residents' personal belongings on the second floor across from the nursing station found the following: multiple large black trash bags on the floor and multiple boxes stocked in piles holding residents' belongings. Some of the boxes were open and some of them did not have clear name labels and the whole area was difficult to access. During interview, on 3/4/24 at 12:25 PM, the DoN reported that the administrator, the environmental services workers, and she herself had keys to the storage room. The DoN could not provide a safe storage space policy and there were no security cameras to safeguard the storage space. In addition, the DoN confirmed that there is no process in place to track how items were brought in and out of the storage room.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47200 Based on medical record review and interview, it was determined that the facility staff failed to timely report an allegation of abuse/harassment and resident elopement to the State Agency, the Office of Health Care Quality, immediately but not later than 2 hours after the allegation is made. This was evident for 2 (Resident #279 and Resident 392) out of 2 residents reviewed for elopement and abuse during survey. The findings include: 1. On 3/4/24 at 12:46PM the surveyor reviewed the facility's self-report form sent to the Office of Health Care Quality for an incident which occurred on 1/26/22 regarding Resident #92. The self-report form indicated Staff #59, Executive Director, Nursing Home Administrator, received a call on 1/26/22 at approximately 5:45PM from the hospital regarding the resident having been found by EMS walking in the facility neighborhood and was brought to the emergency room . The surveyor noted the time on the self report form dated 1/26/22 was documented as 8:17PM, and it was documented that local law enforcement was contacted at 8:17PM. On 3/4/24 at 12:46PM the surveyor began review of the facility's complete investigation file which included documentation on the incident investigation form which included the following information: 4. Description of incident: On 1/26/22 executive director was notified @ 5:45pm that resident was in the ER. On 3/6/24 at 10:39AM the surveyor reviewed the medical record of Resident #92 which revealed a plan of care note documented by Staff #58, Registered Nurse on 1/26/22 at 6:00PM regarding the resident having left the building unsupervised. On 3/7/24 at 1:23PM the surveyor conducted several interviews of facility staff, including the Director of Nursing who confirmed understanding of reporting time frames. At this time the surveyor shared concerns and requested documentation of the time the self report was submitted. Upon surveyor's review on 3/8/24 of the Medication Administration Audit Report for 1/26/22 the following information was revealed: 1.) behavior monitoring by the nurse for wandering every shift which was scheduled to occur at 3:00PM on 1/26/22 had no documentation or staff sign off present, 2.) the following nursing care for the resident scheduled to occur on 1/26/22 at 3:00PM was documented by Staff #, Licensed Practical Nurse (LPN,) on 1/27/22 at approximately 11:04PM, approximately 32 hours after their 3-11 shift on 1/26/22 began: vital signs task, turn and reposition every 2 hours, pain level, barrier cream application, pressure reducing wheel chair cushion while out of bed, wander guard to right ankle, check for placement, and wander guard for elopement risk every shift, 3.) medications and nursing care scheduled to be given on the 3-11 shift on 1/26/22 at 4:30PM, 5:00PM, 5:30PM, 8:00PM, 9:00PM, and 10:00PM, were documented as administered by Staff #, LPN, on 1/27/22 at approximately 1:13AM. On 3/8/24 at 11:38AM the Director of Nursing informed surveyors that there was no documentation during the 3-11pm shift on 1/26/22. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/8/24 at approximately 10:40AM the facility provided copies of emails to the surveyor. Upon surveyor review of the initial self report email, it was noted the email provided was sent on 1/26/22 at 9:55PM with the initial self-report to the Office of Health Care Quality being made approximately 4 hours and 10 minutes after the Staff #59 was notified of the resident's elopement via a phone call from the hospital. 45733 2. Review on 03/01/24 at 9:55 AM, of the facility's self-report file found that an initial self-report (MD00195727) was sent, on 8/18/23 at 1:59 PM, to the State Agency. Further review revealed that the local police were notified and arrived on 08/18/23 at 10:40 AM, which indicated that the incident had occurred before 10:40 AM and that facility staff were already aware of the allegation prior to 10:40 AM. During an interview, on 03/01/24 at 2:19 PM, the Director of Nursing (DoN) stated that the resident's family sent a formal email notification about the harassing texts to the facility in the morning of 08/18/23. The DoN was unable to provide the exact time of the email. The DoN confirmed that the police were at the facility on 08/18/23 at 10:40 AM; however, the initial self-report was not sent to the State agency until 08/18/23 at 1:59 PM, 3 hours and 19 minutes later.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42507 Based on review of facility reported incident investigations and interview and record review, it was determined the facility failed to thoroughly investigate allegations of: 1.) misappropriation of resident property, and 2.) elopement. This was evident 2 out of 4 residents reviewed for personal property (Resident #116 and Resident #99) and 1 out of 2 residents reviewed for elopement (Resident #92) during the facility's recertification/complaint survey. The findings include: 1) On 2/26/2024 at 11:05 AM, review of Facility Reported Incident (FRI), MD00196890, revealed that Resident #116 reported on 9/12/2023 missing a $100 bill from a pair of joggers. The facility initiated an investigation and did not determine misappropriation of property. Further review of the facility investigation report of the incident revealed that there were witness statements from staff and the resident's roommate. However, review of interview statements dated 9/19/2023 did not indicate the titles nor identify the persons completing the forms. The interview statement of the resident's roommate was not signed. There were no statements from other residents and/or any education/sign-in sheet of education provided to staff post the incident. The investigation was not thorough. On 2/26/2024 at 12:25 PM, in an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA), Surveyor informed them that the investigation was not thorough as interview statements were incomplete and did not identify the persons completing the interviews, no statements from other residents, no staff training/signed in sheets on file. No additional information was provided. 2) On 2/27/2024 at 8:10 AM, review of Facility Reported Incident (FRI), MD00192501, revealed Resident #99 alleged that their belongings went missing including clothes, identification card, bank card which had been stopped, masonic ring and necklace, and sneakers. Further review of the facility investigation report of the incident noted resident and staff interviews. There were written statements dated 5/18/2023. However, most of the statements did not indicate the titles/identify the persons writing the statement. There was no interview statement of other residents on file and/or no evidence of staff training after the incident included in the investigations. The investigation was not thorough. On 2/27/2024 at 10:10 AM, an interview was completed with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). Both the DON and NHA were informed that the investigation of the above allegation was not thorough: Most of the written statements did not identify/have the titles of the persons writing the statements, no evidence of resident's roommate and/or any other residents' interviews on file. No new information was provided. 47200 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 3/4/24 at 12:46PM the surveyor reviewed the facility's initial self-report form sent to the Office of Health Care Quality for an incident which occurred on 1/26/22 regarding Resident #92's elopement from the facility. The self-report form indicated that Staff #59, Executive Director, Nursing Home Administrator, received a call from the hospital regarding the resident having been found by EMS walking in the facility neighborhood and was brought to the emergency room . On 3/4/24 at 12:46PM the surveyor reviewed the facility's final self-report form dated 2/2/22 which noted the date/time of the incident occurrence was 1/26/22 at 2:18PM. The form additionally reported: After video surveillance and maintenance check of wander guard system; it was determined that Resident #92 had a functional wander guard in place (was checked prior to and after the incident and found to be functional.) There was a noted equipment malfunction of the system at the main entrance which resulted in no alarm sounding as Resident #92 exited the facility. On 3/4/24 the surveyor reviewed the facility's incident investigation form. Documentation on the form under section 8c revealed a place to document if a protective device was ordered, which was checked no, and a place to document if the protective device was in place at the time of the incident, which was checked as n/a. Further review of the form revealed the following: Resident left unattended on 1/26/22 at approximately 2:15PM. Despite the fact that resident's wander guard was intact and functional, entrance door to facility did not alarm. Upon further surveyor review of the complete investigation file on 3/4/24, no documentation could be found to support what the initially determined equipment malfunction was, what repairs were made by facility maintenance on 1/26/22, and who made those repairs. An invoice was present for work performed by a contractor on 1/28/22. Additionally, no evidence was found in the facility's complete investigation file to confirm the resident had a functional wanderguard on at the time of elopement, and no evidence was present to confirm there was no alarm sounding as the resident exited the facility. No documentation of interviews of maintenance staff, other staff, residents, or other persons was present in the facility's complete investigation file, with the exception of documented interviews of nursing staff and one additional interview with a staff member whose position was not identified on the interview documentation. No times were found documented for interviews conducted. No written and signed statements were present in the facility's complete investigation file. No documentation or information regarding checks for function having been performed on the wander guard system or facility entrance doors prior to the elopement was included in the facility's complete investigation file. The surveyor noted the final self report dated 2/2/22 indicated there was video surveillance. No documentation was present of when and who reviewed the video surveillance or the video surveillance itself. No hospital reports for Resident #92 were present in the complete investigation file. The surveyor noted there was no documentation from the resident's medical record present regarding nursing care that was to occur during the time of elopement. On 3/6/24 at 11:00AM the surveyor inquired to Staff #11, Regional Corporate Nurse, as to why the facility's complete investigation failed to include any hospital records or reports for Resident #92. Staff #11 acknowledged understanding of the surveyor's concern and further offered: I can get hospital records. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/7/24 at 11:05AM, the surveyor communicated concerns regarding the facility's investigation to the following facility staff: Administrator, Director of Nursing, Staff #54; Corporate Director of Operations, and Staff #11, Regional Corporate Nurse. Staff #54, Corporate Director of Operations, reported to surveyors that the facility does not have any camera footage of the incident, and there was no audio capability. On 3/7/24 at 1:23PM the surveyor was provided with copies of emails from Staff #57, Corporate Director of Facility Maintenance and Safety Operations, who reported that on 1/26/22 they received a call notifying them around 6pm and they reported to the facility to check the wander guard system. The surveyor noted that in an email dated 1/27/22, Staff #57 communicated the following information: Wander guard system still seems to be working OK. The surveyor was additionally provided with a signed statement dated 3/7/24 by Staff #57 detailing the equipment issue found on 1/26/22 and actions that were taken on 1/26/22 in response to that equipment issue. Upon surveyor's review on 3/8/24 of the Medication Administration Audit Report for 1/26/22 the following information was revealed: 1.) behavior monitoring by the nurse for wandering every shift which was scheduled to occur at 3:00PM on 1/26/22 had no documentation or staff sign off present, 2.) the following nursing care for the resident scheduled to occur on 1/26/22 at 3:00PM was documented by Staff #, Licensed Practical Nurse (LPN,) on 1/27/22 at approximately 11:04PM, approximately 32 hours after their 3-11 shift on 1/26/22 began: vital signs task, turn and reposition every 2 hours, pain level, barrier cream application, pressure reducing wheel chair cushion while out of bed, wander guard to right ankle, check for placement, and wander guard for elopement risk every shift, 3.) medications and nursing care scheduled to be given on the 3-11 shift on 1/26/22 at 4:30PM, 5:00PM, 5:30PM, 8:00PM, 9:00PM, and 10:00PM, were documented as administered by Staff #, LPN, on 1/27/22 at approximately 1:13AM. On 3/8/24 at 10:40AM the surveyor shared their concerns as to the dates/times on the Medication Administration Audit Report to the Director of Nursing, Administrator, Staff #54, Corporate Director of Operations, and Staff #11, Regional Corporate Nurse. No further clarification of the dates/times of care/medication sign off was provided at this time. On 3/8/24 at 11:38AM the Director of Nursing informed surveyors that there was no documentation during the 3-11pm shift on 1/26/22. They further reported that later, on 1/27/22 staff input documentation for 1/26/22. They further stated: When they realized he was gone, they should have began documenting from that point on and I talked to IT and they should have back dated the documentation to to 1/26/22 when they input it on 1/27/22. They didn't backdate it. The surveyor further inquired to the DON if they would expect for staff to backdate documentation if it had not been performed, to which they replied: No, but from the time they realized they should have began documenting.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 45733 Based on record review and interview, facility staff failed to provide correct notice to pay for (or to have paid under Medicare or Medicaid) a stay at the facility and to provide sufficient skilled rehabilitation treatment, and to assure the safe discharge of a resident. This was evident for 1 (Resident #282) out of 1 resident reviewed for proper notice of stay and safe discharge during the survey. The findings include: Review on 3/12/24 at 11:00 AM, of Resident #282's closed record found that the resident was a skilled admission on 6/20/23 to the facility and Physician Staff #35 ordered the skilled rehabilitation therapy four times per week for 12 weeks including allowing time for caregiver education and discharge planning and dialysis treatments. Further review found that the resident's discharge was improperly planned, as evidenced by: a) Review on 3/12/24 at 1:23 PM, of social service notes, dated 7/11/23 at 5:11 PM, revealed that social worker staff #36 issued the Notice of Medicare Non-Coverage (NOMNC) to Resident #282 to be effective on 7/13/23. It meant that the resident was liable to pay for his/her stay at the facility starting on 07/14/23 or had to accept to be discharged . However, there was no basis for Staff #36 to issue this non-coverage letter as the resident was still receiving skilled rehabilitation treatment, had not achieved the treatment goals, and no discharge arrangements were in place. During interview, on 03/13/24 at 03:01 PM, the administrator agreed that the social worker staff #36 should not have issued the NOMNC. The administrator added that the staff #36 had been terminated for making multiple errors, including issuing the NOMNC notice on 7/11/23 at 5:11 PM to Resident #282. b) Further review revealed that on 7/14/23 at 16:14 PM, Staff #36 called Resident #282's caretaker to inform the caretaker of the resident's scheduled discharge today. However, at that time, Staff #36 had not secured a place at a suitable outpatient dialysis center for the resident nor had she arranged home health services to be in place on 7/14/23. The reason that the resident was ultimately not discharged on this day, was because the resident's caretaker advocated against the unplanned and unsafe discharge. During interview, on 03/13/24 03:01 PM, the Administrator agreed that Resident #282's caregiver needed education, Staff #36 needed to secure a suitable outpatient dialysis center, and home health service had to be in place on the day of the resident's discharge. The administrator agreed that social and rehabilitation services failed to follow safe discharge requirements. c) Review on 3/12/24 at 2:00 PM, of physical service progress notes, dated 7/10/23, revealed that Physical Therapy (PT) Staff #37 documented that Resident #282 was deteriorating and needed more assistance using the stairs. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed that on 07/13/23, only 2 days later, Staff #37 abruptly ended skilled rehabilitation services for the resident. There were no other PT treatments after 7/13/23, without Staff #37 indicating that the resident had returned to his/her functional level that he/she had prior to the admission of this facility. In addition, Staff #37 did not obtain a discharge order for rehabilitative services until 7/19/23, 6 days later. During interview on 03/13/24 03:01 PM, the Administrator agreed that Resident #282 could have continued skilled rehabilitation treatments.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on observation, medical record review, and interview, it was determined the facility staff failed to failed to assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, and ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 3 (Resident #128, #93, #291) of 5 residents reviewed for MDS accuracy, and 1 (Resident #89) of 10 residents reviewed for pressure ulcers. The findings include: The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. 1) On 2/27/24 at 10:22 AM, the surveyor reviewed Resident #128's medical record. The review revealed that the resident was discharged to home on 11/27/23. However, Resident #128's MDS assessment dated [DATE] coded the resident's discharge status as a short-term general hospital. During an interview with the Director of Nursing (DON) on 2/27/24 at 10:51 AM, the DON confirmed that Resident #128 was discharged home. The surveyor shared inaccurate MDS coding for Resident #128. The DON validated it. 2) During this recertification survey from 2/21/24 to 3/14/24, the Residents Assessment task was triggered for Resident #93's MDS record over 120 days old. The surveyor reviewed Resident #93's medical record on 2/28/24 at 2:01 PM. The review revealed that the resident's census and progress note documented that he/she was discharged on [DATE]. However, further review of Resident #93's MDS revealed that the most MDS assessment for the resident was on 10/27/23. No additional assessment was documented, indicating his/her discharge. During an interview with the DON on 2/28/24 at 2:10 PM, she stated that the MDS coordinator needed to update upon the discharge. The surveyor shared the above concerns about the missed MDS assessment, and the DON validated the above concerns. 44441 3) On 3/12/24 at 9:45 AM review of a complaint incident MD00197189 medical records revealed that Resident #291 had a medical diagnosis of Hemiplegia, a one-sided paralysis and Hemiparesis, a partial paralysis or muscle weakness to one side of the body. This was because of a medical condition which affected resident's right dominant side. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the care plan with a creation date of 10/4/22 on 3/12/24 at 10:41 AM documented that resident had an impaired mobility related to (r/t) a medical condition as evidenced by a right sided weakness. A second care plan created on 10/19/22 also had self-care deficit r/t right hemiparesis as evidenced by weakness and impaired balance'. . Further review on 3/12/24 at 10:15 AM of the quarterly Minimum Data Set (MDS) a comprehensive assessment tool with an Annual Reference Date (ARD) of 8/7/23 documented a functional limitation in Range of Motion (ROM)- secondary to impairment on one side of the upper and lower extremities. However, a review of the annul MDS with an ARD of 10/16/23 documented under section GG that resident had No impairment to the upper and lower extremities. On 3/13/24 08:10 AM the Director of Nursing (DON) was asked if she knew Resident #291 and what she recalled about residents' physical condition. She stated that the resident had a right sided paralysis, requiring a Hoyer lift, and a 2 person assist. The DON was made aware of the MDS discrepancies. 48168 4) On 3/05/24 at 12:30 PM a review of Resident #89's medical record revealed a wound and skin note dated 12/18/23 that indicated the presence of a pressure ulcer on the resident's right lower buttock, and another wound and skin note dated 2/20/24 that also indicated the resident had a pressure ulcer on his/her right lower buttock. On 3/05/24 at 1:03 PM a review of Resident #89's medical record revealed an MDS assessment completed on 1/22/24 that indicated that the resident did not have any pressure ulcers (Section M). The surveyor asked the Director of Nursing (DON) for a copy of Section M of the MDS completed on 1/22/24, and copies of the wound and skin notes dated 12/18/23 and 2/20/24. On 3/06/24 at 10:34 AM in an interview with the DON, the surveyor asked to speak to the facility's MDS nurse, but the DON stated that the facility does not have an MDS nurse, and that the MDS role was covered by several corporate MDS nurses who covered multiple facilities. Resident #89's MDS assessment and wound and skin documentation was reviewed with the DON who confirmed that the MDS assessment did not capture the presence of the resident's pressure ulcer and was therefore deficient.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42507 2) On 2/23/2024 at 9:00 AM, in an interview with Resident #57, the resident stated that s/he had facility acquired right buttocks bed sores and a right leg wound. Resident #57 further stated that the wounds were improving, and dressings changed daily. During a review of Resident #57's medical record conducted on 2/29/2024 at 8:45 AM, surveyor noted active physician orders dated 2/6/2024 for right buttock and right calf wounds to Cleanse with NSS (normal saline solution). Apply Calcium Alginate with Medi-honey cover with a border gauze daily, every day shift for wound care. On 2/29/2024 at 11:35 AM, a review of Resident #57's care plan was completed: A Plan of Care was developed for Resident #57 for Actual impaired skin integrity to right lower calf and bilateral buttocks r/t declined mobility as evidenced by pressure injury created on 2/5/2024 with revision on 2/5/2024. The interventions included but were not limited to: Monitor dressing at least every shift to ensure it is intact and adhering. However, the plan of care approaches did not include any interventions for daily wound care and/or dressing changes as indicated in the physician's order and Treatment Administration Record. On 3/1/2024 at 12:25 PM, a review of nurses' progress notes revealed the following documentation dated 2/6/2024 at 10:40 AM: Skin/Wound Note: Resident had initial visit with Wound MD today for Right lateral shin wound and right buttock wound. Etiology for both wounds are pressure. Both wounds will be treated with calcium alginate with Medi-honey daily. On 3/4/2024 at 10:10 AM, an interview was completed with the 2 A Unit Manager (UM #7). UM #7 confirmed that Resident #57 had pressure ulcers on their buttocks and right calf that were first noted on 2/1/2024. Surveyor reviewed Resident #57's care plan with UM #7. UM #7 verified and confirmed that the care plan was not comprehensive or resident centered and had no interventions for wound care dressing changes. She stated that she was going to work on fixing it. Surveyor reviewed Resident #57's care plan with the Director of Nursing (DON) during an interview on 3/4/2024 at 12:45 PM. DON stated that Unit Managers were responsible for initiating, revising/updating, and resolving residents' care plans. DON verified and confirmed that there was not adequate focus, goal, or interventions on the care plan for pressure ulcer/wound care for Resident #57. She stated that the expectation was that Resident #57's care plan should address wound assessment, turn/reposition every 2 hours, dressing changes, type of dressing, and how often the dressing should be changed. An interview was completed with the wound nurse, Licensed Practical Nurse (LPN #39) on 3/4/2024 at 1:05 PM. Regarding Care plans, LPN #39 stated she updates care plan in relation to wounds. Surveyor reviewed Resident #57's current care plan with LPN #39 who verified and confirmed that the care plan did not address the ordered treatments and dressing changes. LPN #39 stated that she was going to update the resident's care plan to include dressing changes and put actual treatments in. 48168 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 2/21/24 at 12:40 PM a record review revealed that hospice care notes were in the Resident #47's paper chart. On 3/05/24 at 2:10 PM a review of Resident #47's electronic medical record revealed an order to begin hospice services on 5/18/23. A further review revealed that the resident's plan of care did not contain a problem for hospice care. On 3/06/24 at 11:12 AM in an interview with the DON, she was asked to provide evidence that the care plan reflected that Resident #47 was receiving hospice care. The DON said that she would look into it. On 3/06/24 at 2:11 PM the DON was interviewed and she confirmed that there was no problem for hospice care in the Resident #47's facility care plan and there should have been. 4) On 2/23/24 at 11:44 AM a review of Resident #89's medical records revealed a Skin and Wound note dated 2/20/24 which indicated that the resident had a pressure ulcer. On 3/05/24 at 1:03 PM a review of Resident #89's care plan revealed that the care plan did not include a problem for the resident's pressure ulcer. On 3/05/24 at 2:28 PM in an interview with the Director of Nursing (DON), she reviewed Resident #89's care plan and skin and wound notes and confirmed that the resident's care plan did not contain a problem for the pressure ulcer and should have. The DON acknowledged that this was a regulatory deficiency. 5) In an interview with Resident #101 on 2/21/24 at 10:42 AM the resident explained that he/she was hospitalized recently and had a suprapubic catheter placed. A review of Resident #101's medical record revealed documentation that the resident had a suprapubic catheter placed on 2/02/24. A review of the resident's care plan revealed that the suprapubic catheter was not listed. On 3/04/24 at 1:18 PM in an interview with the wound care nurse (LPN #39), she stated that she assessed, cared for, and tracked Resident #101's suprapubic site since it was a surgical wound. When asked if she had access to enter problems on Resident #101's care plan, she said yes, and that she updated the plan of care for any resident she treated. The surveyor reviewed the resident's current care plan with the wound nurse who confirmed that the care plan did not address the suprapubic catheter. LPN #39 said that she would update the resident's care plan. 6) On 2/28/24 at 12:01 PM a review of MD00178503 and Resident #91's medical record revealed a Palliative Care note dated 1/05/24. The resident's care plan was reviewed but it did not contain a problem for palliative care. On 3/01/24 in an interview with the Resident #91's Unit Manager (LPN #12), she said that she was unaware that the resident was receiving palliative care services. During the interview LPN #12 read the consultation from Palliative Care and confirmed that the resident was in fact receiving palliative care services. She also reviewed the resident's care plan and confirmed that the resident's care plan was missing a problem for palliative care. 43096 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) On 2/21/24 at 9:30 AM, the surveyor observed that Resident #302's room had a contact precaution sign. A review of Resident #302's medical record on 2/28/24 at 9:24 AM revealed that the resident had a contact precaution order for C-diff from 2/17/24 to 2/26/24. Further review of Resident #302's discharge summary dated 2/16/24 from an acute care center prior to admission to this facility revealed that the resident had recurrent C-Diff. However, further review revealed that no care plan was initiated regarding C-diff (infectious disease). During an interview with the Director of Nursing (DON) on 2/28/24 at 2:10 PM, the DON stated that residents' care plan would be developed by nursing staff based on their condition. The DON confirmed that Resident #302 should have a care plan for the C-diff and validated the surveyor's concern. 8) On 2/21/24 at 9:57 AM, the surveyor observed that Resident #297 had a tube feeding material placed at his/her bedside. A review of Resident #297's medical record on 2/26/24 at 9:53 AM revealed that upon his/her admission, the resident had a G-tube (a tube inserted through the belly that brings nutrition directly to the stomach). During an interview with Licensed Practical Nurse (LPN #6) on 2/27/24 at 11:29 AM, LPN #6 said, Nurses documented tube feeding residents' conditions with dose, rates, and so on. Some details are indicated under the care plan. A review of care plan for Resident #297 on 2/27/24 at 1:20 PM revealed that the resident had care plan regarding nutrition. However, the care plan's approaches (implements) did not indicate details of tube feeding care. During an interview with the Director of Nursing (DON) on 2/27/24 at 2:11 PM, the DON stated that the care plan should indicate a caring G-tube by observing its function, residents' position, and complications. The DON validated the concerns. 47200 Based on medical record review and interview, it was determined that the facility staff failed to develop and initiate comprehensive person-centered care plans for residents residing in the facility. This was evident for 5 residents (Resident #47, #54, #57, #89, and #101) of 10 residents reviewed for pressure ulcers, 1 for complaint (MD00178503, Resident #91) of 16 complaints reviewed during the survey, 1 (Resident #302) of 1 resident reviewed for transmission based precaution, 1 (Resident #297) of 3 residents reviewed for tube feeding during the recertification/complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. A suprapubic catheter is a urinary drainage device surgically inserted through the abdomen into the bladder. C. diff (also known as Clostridioides difficile or C. difficile) is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon). C. difficile can also be transmitted from person to person by spores. [Center for Disease Control and Prevention] 1) On 2/23/24 at 10:14AM Resident #54 reported to the surveyor their history of falls and inquired to the surveyor as to why specific interventions were not put into place. At this time, the surveyor observed the room of Resident #54 and noted that there was no fall mat present. On 3/12/24 at 9:54AM the surveyor reviewed the medical record and observed a nursing note which included the following information regarding the resident dated 1/10/24 at 11:32PM: found on floor at bedside. On 3/12/24 at 9:58AM the surveyor reviewed the medical record which revealed a care plan was in place to address falls with the following intervention dated as created on the careplan beginning 1/11/24: Apply floor mat to right side of bed. On 3/12/24 at 10:06AM the surveyor conducted a review of the resident's medical orders which revealed no order was currently in place for a floor mat. On 3/12/24 at 10:27AM the surveyor conducted another observation of the resident, who was in their bed, with no fall mat present. On 3/12/24 at 10:30AM the surveyor conducted a dual observation with Staff #60, Geriatric Nursing Assistant, who confirmed with the surveyor that the resident did not have a fall mat in place. On 3/12/24 at 10:31AM the surveyor conducted a dual observation of Resident #54's room with Staff #12, Charge Nurse, Licensed Practical Nurse who confirmed there was no fall mat in place. At this time, the surveyor conducted an interview with Staff #12 who confirmed that the fall mat intervention listed on the careplan was to be in place after the resident's fall on 1/10/24. At this time, the surveyor shared their concern with Staff #12 who acknowledged and confirmed understanding of the concern. After the interview, the surveyor observed a fall mat sitting outside of the resident's room, in the hallway located next to the entrance to their room.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48168 Based on interview and record review it was determined that the facility failed to ensure that care plan meetings were conducted as required. This was evident for 4 (Resident #33, #82, #91 and #98) out of 67 residents reviewed for resident care, and one complaint (MD00178503) of 16 complaints reviewed during the recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The Minimum Data Set (MDS) is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 2/28/24 at 12:44 PM a record review of Resident #91's MDS assessment entries revealed that the resident had a quarterly MDS assessment completed for the assessment reference date 11/21/23. Further record review revealed that there was no documentation of any care plan meeting that corresponded with the MDS assessment of 11/21/23. On 3/01/24 in an interview with Resident #91's Unit Manager, Licensed Practical Nurse (LPN #12), the resident's care plan meeting dates were reviewed. LPN #12 could not find that the resident had a care plan meeting in November 2023. When asked who was responsible for ensuring that care plan meetings are held as required, LPN #12 stated it was the social worker's responsibility. When asked if LPN #12 knew of any reason the resident's care plan meeting was missed, she replied No. On 3/14/24 at 8:36 AM in an interview with the Director of Nursing (DON) regarding social worker responsibility at the facility, the DON explained that the facility did not have a social worker on staff from January 2023 through October 2023, but had intermittent social work services provided by corporate social workers. The current social worker was hired in November 2023. The DON also said that she was not surprised that Resident #91's care plan meeting was missed due to the inconsistent social work services over the past year. 43096 2) A review of Resident #98's medical record on 2/28/24 at 12:49 PM revealed that the resident's MDS assessment were completed annually and quarterly (annual assessment on 8/04/23, and quarterly assessment completed on 11/29/22, 2/27/23, 5/25/23, 11/04/23, and 2/04/24). However, Resident #98's care plan meeting was not documented after the MDS assessment in November 2022, February 2023, and August 2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 3/05/24 at 10:37 AM, the surveyor reviewed Resident #98's care plan meeting documentation with the DON. The DON stated that care plan meetings should be updated quarterly when MDS is assessed. She confirmed that there were missed care plan meeting records. Also, the DON said, Since March 2023, there has been a vacant social worker. We hired someone to train them and left several times. So, we didn't have social worker from 2022 to October 2023. The interim social worker who worked at the other building covered this building slightly but was not actively working. The DON validated the above findings about the absence of documentation for Resident #98's care plan meeting. 44441 3) On 3/04/24 at 11:02 AM review of Resident #33's medical records revealed that resident had care plan meetings on 8/31/23. The prior meeting was held on 10/13/22. Further review of the medical record did not show any documentation of a care plan meeting held between 10/14/22 to 8/30/23, which was a gap of 10 months. 4) On 3/4/24 at 11:23 AM review of the Resident #82's medical records and the social worker's progress notes revealed that a care plan meeting was held on 8/24/23. Prior to that, the last care plan meeting was held on 9/22/22, a gap of 11 months, Further review did not produce any more documentation pertaining to a care plan meeting held from 9/21/22 to 8/23/23. The Director of Nursing (DON) was asked to provide the missing documentation. The documentation provided by the DON did not have care plan meetings documented for the requested missing period. In an interview on 3/04/24 at 11:33 PM staff #2 a Social Worker (SW) was asked how often care plan meetings were held for residents. She stated that it was quarterly and when there was a significant change such as an admission to hospice or change in their level of care or for new admissions. She was asked where the documentation can be found, and she said in the resident medical records. She was made aware that the documentation for care plan meetings could not be found for Resident #33 and #82 for a period of 10-11 months. She stated that it meant that the care plan meetings were not held. On 3/05/24 at 1:59 AM The Director of Nursing (DON) was asked about the expectation for holding care plan meetings. She said that meetings are held quarterly. She was made aware of the concern. She explained that the facility did not have a social worker during that period.

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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. 44441 Based on observation, record reviews and staff interviews, it was determined that the facility failed to: 1) to maintain safety by allowing the bed of a resident at risk for fall to be in the up position when care was not being provided thereby placing resident at high risk for injury. This was evident for 1 (#51) of 6 residents reviewed for accidents; 2) to assess residents' fall risk after the fall incident occurred. This was evident of 1 (Resident #98) out of 6 residents reviewed for falls; 3) ensure resident's outside consult appointment had follow-up. This was evident for 1 (Resident #292) out of 67 residents reviewed for following appointments during this recertification/complaint survey. The findings include: 1) On 3/5/24 at 8:52 AM the surveyor observed Resident #51 in bed, fast asleep. The resident's bed was elevated up to about 3 feet high, there was no one in the room and no sign that care was being rendered at the time. Review of the resident's care plan with a completion date of 1/22/24 on 3/5/24 at 9:00 AM revealed that resident had a care plan for fall related to (r/t) immobility. Resident #51 was also documented as having self-care deficit requiring transfer with Hoyer lift with 2 persons assist under the care plan interventions. Further interventions were to keep bed in the low position except when rendering care. On 3/5/24 at 9:16 AM Staff #16-an agency Geriatric Nursing Assistant (GNA) came to the resident's room, she was asked if it was safe for the bed be left at that height. She proceeded to lower the bed stating, that's how I found it; I don't know if that's how it's supposed to be". On 3/5/24 at 9:25 AM Staff #17 a Registered Nurse (RN) was asked if the resident's bed should be left in the up position when care was not being rendered. She stated that resident's bed can be up for bed changes and resident care but should be put down afterward to prevent potential injury from fall. Staff #12 a unit manager was asked on 3/5/24 at 9:30 AM the expectation for the height of resident's bed. She stated that the bed should be at the lowest position to maintain safety and prevent falls especially for residents at risk. She was made aware of the concern. 43096 2) A review of Resident #98's medical records on 3/05/24 at 9:06 AM revealed that the resident had a fall without witness on 1/07/24, which resulted in a large hematoma and laceration to the face. Resident #98 was transferred to the hospital for further evaluation and readmitted to this facility on 1/25/24. Further review of Resident #98's medical records revealed that the facility staff had assessed the resident's fall risk upon admission and quarterly. The most current fall assessment was on 10/11/23. However, there was no fall assessment after the fall incident in January 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 3/05/24 at 10:43 AM, the DON confirmed that the facility staff assessed residents' fall risk upon admission, every three months, and after an actual fall occurred. The surveyor reviewed Resident #98's fall assessment documentation with the DON. The DON verified that Resident #98's fall assessment was not done after the fall occurred in January 2024. 3) A part of the complaint review on 3/12/24 at 10:48 AM revealed that Resident #292 was admitted to this facility in September 2023 for amputation rehabilitation. Further review of the discharge summary from an acute care facility dated 9/06/23 revealed that Resident #292 needed to follow-up with the Vascular Surgery Center on 9/11/23 and the Wound Healing Center on 9/12/23. However, there was no documentation regarding Resident #292's appointments for 9/11/23 and 9/12/23 in his/her medical records, including electronic and hard copy records. During an interview with Registered Nurse (RN # 20) on 3/12/24 at 10:54 AM, RN #20 explained that residents' outside consultation visits would be documented under the progress notes, along with the results, any changes, and subsequent appointments. On 3/12/24 at 1:50 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that Resident #292's family members were usually involved in his/her appointment. Also, she said, The family members canceled the appointment without notifying us several times. The surveyor requested that documentation be submitted to support how the facility manages Resident #292's appointments. At 2:36 PM on 3/12/24, the DON confirmed that Resident #292's appointments on 9/11/23 and 9/12/23 were missed. The DON validated the concerns about failing to follow the resident's appointment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on medical record review and interview of facility staff it was determined the facility failed to: 1) ensure physician ordered wound treatments are performed and receive timely wound consultation and 2) provide accurate ongoing assessment of skin and wounds and receive timely wound consultation. This was evident for 2 (#295, #293) out of 10 residents reviewed for wounds during the facility's recertification survey. The findings include: 1) Resident #295's closed medical record was reviewed on 2/27/24, in relation to MD00192462, MD00192745, and MD00193830. Resident #295 was admitted to the facility on [DATE]. Review of a Skin and wound record dated 4/7/23 revealed that the facility staff identified a pressure injury on the resident buttock. Documentation revealed that the resident's attending physician was notified and indicated treatment to clean left buttocks wound with wound cleanser, dry apply bacitracin daily till healed. Review of the April 2023 treatment administration record did not show that the order was transcribed to record, therefore there was no documentation that the treatment was performed. An initial wound evaluation by the consultant wound care physicians was conducted 17 days after the identification of the wound. Per the wound physician's documentation, the wound had deteriorated. On 2/28/24 at 11:34 AM an interview with medical record review was conducted with the director of nursing. She read the nurse's Skin and wound record dated 4/7/23 and was informed that the treatment order was not found on the treatment administration record(TAR). She was asked to provide a copy of the treatment record for April of 2023. At 2:19 PM on 2/28/24 she acknowledged that the treatment was not transcribed too the TAR with no indication of the resident receiving treatment. 2) Resident #293's closed medical record was initially reviewed on 2/28/24 in relation to intake MD00175027. Resident #293 was admitted to the facility on [DATE]. Review of the 2/16/22 skin and wound records revealed that the resident was evaluated to have a new in house acquired wound that was Moisture Associated Skin Damage (MASD) with measurements of 12 cm by 9 cm. The wound was assessed to have a light amount of thin red drainage. Further description of the wound was documented as Large space macerations from buttocks (a condition that occurs when a wound experiences excessive moisture), skin fold of thigh and rectal areas. Open blister areas. The treatment was documented as Cleansing and moisture barrier applications with each incontinent episode. Review of the wound evaluation dated 2/21/22 was shown to be incomplete without any measurements of the wound. The skin condition of the wound remained as moisture associated skin damage. There was no documentation of a treatment change. The wound evaluation of 3/8/22 was 20 days after the wound was identified on 2/16/22. The wound had deteriorated to two wounds, one on the buttock and one on the sacrum. The measurement of the buttock wound was documented as 14 cm to 10 cm. The sacrum wound was listed as a newly in house acquired wound, described as red and macerated, darker at center, macerations around with measurements of 9 cm x 10 cm x depth of .05 cm. New wound treatments were prescribed and initiated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 3/15/22 wound evaluations revealed that both wounds continued to deteriorate/declining. The measurements of the buttock wound were documented as 14 cm x 12 cm x depth of 1 cm with indication of slough and necrotic tissue with thin, watery, pale red to pink moderate amount of drainage. There was a musty odor and reddened surrounding thigh and back. The sacrum wound measurements were 12 cm x 5 cm x 0.5 cm with the same descriptions as the buttock wound with additional information as Wound is between skin folds. Other opened areas around and under the thigh. Need to control the moisture from urine, and a further indication to try an air mattress. Both wounds were not staged and without indication of pressure wounds. Review of the attending physician notes revealed no documentation of a wound in his 2/21/22 note. A nurse practitioner's (staff #40) note of 3/8/22 failed to document any assessment of the wounds. The resident's attending doctor's note of 3/14/22 documented on the resident's pressure injury of skin sacral region as The patients sacral decubitus ulceration is monitored , currently on Medihoney, with indication that the patient's protein intake was augmented with ProSource 30 mg bid. The attending's physician's note documented Wound surgery will continue to follow. The consultant wound physicians' initial wound evaluation was dated 7 days after the attending physicians note on 3/21/22. The wound consultants documented that the resident had a stage 4 sacrum pressure wound full thickness. Measurements of the sacrum wound were 10 cm x 13 cm x 2.4 cm. On 3/12/24 at 8:35 AM an interview/discussion was held the cooperate nurse (staff#11). Discussion related to the lack of weekly wound assessment based on review of the Skin and Wound Records. She confirmed that she had reviewed the incomplete documentation on the 2/21/22 skin and wound record and 20 days between the 2/16/22 assessment and the 3/8/22 assessments and noted the potential inaccurate assessments related to MASD and not pressure related. It was previously noted that resident #293's attending physician no longer worked at the facility. The notation the doctor made related to Wound surgery will continue to follow when in fact the consultants had seen the resident a week later.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on observation, record review, and interview it was determined that the facility failed to ensure resident #92 received adequate supervision and failed to prevent elopement. This was evident for 1 of 2 residents reviewed for accidents during the facility's recertification survey. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy. After the incident, the facility developed, initiated, and completed a plan of correction to prevent further elopement of residents. Therefore, this deficiency will be cited as past non-compliance. The date of correction was 1/28/2022. The findings include: On 3/4/24 at 12:46 PM the surveyor reviewed the facility's self-report form sent to the Office of Health Care Quality for an incident that occurred on 1/26/22 regarding Resident #92. The self-report form indicated the facility's Administrator (during that time) received a call from the hospital regarding the resident having been found by EMS walking in the facility neighborhood and was brought to the emergency room . At this time, the surveyor began a review of the facility's complete investigation file for the 1/26/22 incident. On 3/4/24 at 12:46 PM the surveyor reviewed the facility's follow up self-report form dated 2/2/22 which noted the date/time of the incident occurrence was 1/26/22 at 2:18PM. The form additionally reported: After video surveillance and maintenance check of wander guard system; it was determined that Resident #92 had a functional wander guard in place (was checked prior to and after the incident and found to be functional.) There was a noted equipment malfunction of the system at the main entrance which resulted in no alarm sounding as Resident #92 exited the facility. Surveyor review of the medical record revealed the resident's care plan upon their admission in 2021 which included they were at risk for elopement, diagnosis of dementia, and exhibited wandering behavior. Further review of the medical record revealed a plan of care note dated 1/26/22 at 6:00 PM for Resident #92 which included the following information: Patient left the building with functioning wander guard in place on [his/her] left ankle. Further review of the medical record revealed a nurse note dated 1/26/22 at 10:09 PM which included the following information: Resident was able to elope from facility earlier today, approximately at 1400 hours. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon surveyor's review of the Medication Administration Audit Report for 1/26/22 the following information was revealed: 1.) behavior monitoring by the nurse for wandering every shift which was scheduled to occur at 3:00PM on 1/26/22 had no documentation or staff sign off present, 2.) the following nursing care for the resident scheduled to occur on 1/26/22 at 3:00PM was documented by Staff #63, Licensed Practical Nurse (LPN,) on 1/27/22 at approximately 11:04PM, approximately 32 hours after their 3-11 shift on 1/26/22 began: vital signs task, turn and reposition every 2 hours, pain level, barrier cream application, pressure reducing wheel chair cushion while out of bed, wander guard to right ankle, check for placement, and wander guard for elopement risk every shift, 3.) medications and nursing care scheduled to be given on the 3-11 shift on 1/26/22 at 4:30PM, 5:00PM, 5:30PM, 8:00PM, 9:00PM, and 10:00PM, were documented as administered by Staff #63, LPN, on 1/27/22 at approximately 1:13AM. On 3/8/24 at 10:40 AM the surveyor shared their concerns as to the dates/times on the Medication Administration Audit Report to the Director of Nursing, Administrator, Staff #54, Corporate Director of Operations, and Staff #11, Regional Corporate Nurse. No further clarification of the dates/times of care/medication sign-off was provided at that time. On 3/8/24 at 11:38 AM the Director of Nursing informed surveyors that there was no documentation during the 3-11 pm shift on 1/26/22. They further reported that later, on 1/27/22 staff input documentation for 1/26/22. They further stated: When they realized [Resident #92] was gone, they should have begun documenting from that point on and I talked to IT and they should have backdated the documentation to 1/26/22 when they input it on 1/27/22. They didn't backdate it. The surveyor further inquired to the DON if they would expect staff to backdate documentation if it had not been performed, to which they replied: No, but from the time they realized they should have begun documenting. Upon surveyor review of the facility's investigation interview form for Staff #57, Licensed Practical Nurse, it was documented that they reported they had worked on 1/26/22 on the 3-11 pm shift, did not see Resident #92 on that date, and: I cannot remember seeing [him/her] The documentation further revealed Staff #57 did not notice Resident #92 was missing, and was assigned to Resident #92 on 1/26/22. Upon surveyor review of the food cart delivery schedule, the unit the resident resided on was scheduled to receive dinner at 5:15 PM. Review of the facility's documented interview with Staff #56, Geriatric Nursing Assistant, (GNA) on 1/26/22 revealed they reported no when asked if they took Resident #92's dinner tray into the resident's room, and reported they had not seen the resident on 1/26/22, although they confirmed working the 3-11pm shift on 1/26/24 and were the GNA assigned to Resident #92 for that shift. On 3/4/24 at 1:26PM the surveyor was provided with January and February 2022 documentation logs of wander guard checks having been performed after the incident on 1/26/22, however, the surveyor noted that there were 29 days of checks signed off as occurring in the month of February 2022, which should have only had 28 days of checks within that month. January and February check logs were reviewed and found to be consistently completed at the current time, for 2024. On 3/4/24 at 1:32 PM, the surveyor concluded rounding with Staff #10, Director of Maintenance, which included observations and testing of the facility's exit doors, coded keypads, and testing for the function of two wander guard system units, one which was located near the front lobby elevator and one which was located at the interior set of front doors to the facility in the lobby. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/4/24 at 2:16 PM the surveyor conducted an interview with the facility Administrator, who reported that to their knowledge, there had been no other elopements since 1/26/22. When the surveyor requested documentation of wander guard system checks performed leading up to 1/26/22 they indicated the documentation may be located in storage. On 3/4/24 at 2:39 PM, the facility Administrator brought Staff #55, Maintenance Assistant to the surveyor, unsolicited by the surveyor. At this time, the surveyor conducted an interview with Staff #55 who reported information that conflicted in nature with the self-report made by the facility to the Office of Health Care Quality regarding the incident on 1/26/22. Staff #55 reported they had been asked to review the security footage of the incident and their understanding of the event was that Resident #92 followed someone out the door immediately behind them. Staff #55 further reported that the security footage they found, they showed to the previous facility Administrator. Staff #55 additionally reported that they believed the documentation of their maintenance checks of the wander guard system prior to 1/26/22 was located within the building in the file cabinet. The Administrator stated: We are still seeing if we can locate that documentation. Staff #55 stated regarding locating the documentation: I am not aware my director has yet, I believe s/he has. Staff #55 was not aware at the time of the interview of an equipment malfunction having occurred. Staff #55 reported the upgrades,which were made after the elopement, to the surveyor. On 3/4/24 the surveyor noted there was no evidence included in the facility's complete investigation file as to any repairs having been made on 1/26/22 in response to the mechanical failure having occurred. On 3/4/24 the surveyor reviewed the facility's incident investigation form. Documentation on the form under section 8c revealed a place to document if a protective device was ordered, which was checked no, and a place to document if the protective device was in place at the time of the incident, which was checked as n/a. Further review of the form revealed the following: Resident left unattended on 1/26/22 at approximately 2:15 PM. Despite the fact that resident's wander guard was intact and functional, entrance door to facility did not alarm. On 3/6/24 at approximately 12:09 PM the surveyor received and reviewed the hospital discharge summary for Resident #92 which documented the following: Encounter for medical screening examination; Abrasion of knee; At risk for elopement from healthcare setting. Further review of the documentation revealed the resident arrived at the Hospital Emergency Department on 1/26/22 at 5:45 PM however, no details could be found to provide clarification of events leading up to the resident's arrival. The surveyor requested for the facility to provide further documentation. On 3/7/24 at 1:23 PM, the surveyor received the Hospital Emergency Department Clinical Summary dated 1/26/22 which detailed the following information regarding Resident #92: Patient stated complaint: Encounter for medical screening; Accidental fall, Wondering Person/[NAME]. On 3/7/24 at 1:23 PM, the surveyor additionally received Resident #92's Hospital Emergency Department Clinician Note which included the following information: found wandering in the street after eloping from NH (nursing home). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/4/24 at 8:04 AM the surveyor observed Resident #92 near the facility's front desk engaged in exit-seeking behavior, carrying a bag packed with personal items, with various staff present attempting to re-direct the resident. At this time, the surveyor confirmed the Resident's name with the Unit Manager 3rd Floor, Licensed Practical Nurse Staff #12 On 3/4/24 at 8:04 AM the surveyor observed the front desk was staffed with security personnel, who when asked by the surveyor, were able to immediately refer the surveyor to a log kept at the front desk for documentation of checks being performed for the current functioning of the wander guard system. On 3/4/24 at 8:04 AM the surveyor observed a posting behind the front desk which included photos of facility residents considered at risk for elopement. On 3/4/24 at approximately 8:04 AM the surveyor was able to hear an audible noise present indicating the resident was within proximity of the wander guard device located near the front desk. On 3/4/24 at approximately 8:04 AM the surveyor conducted an interview with Staff #51, Human Resources, who confirmed with the surveyor that the audible noise heard was the wander guard system alarm. On 3/7/24 at 9:10 AM the surveyor conducted an observation of the facility's front door systems with Staff #55, Maintenance Assistant. The front door wander guard systems were audible and the mag-lock system was found to be engaged appropriately during testing. On 3/7/24 at 11:05 AM the surveyor communicated the concern of Immediate Jeopardy and concerns to the following facility staff: Administrator, Director of Nursing, Staff #54; Corporate Director of Operations, and Staff #11, Regional Corporate Nurse. At this time, the surveyor requested all documentation of measures/actions the facility took and/or put into place to prevent further incidents. Staff #54, Corporate Director of Operations, reported to surveyors that the facility did not have any camera footage of the incident, and there was no audio capability. On 3/7/24 at 1:23 PM, the surveyor was provided with copies of emails from Staff #57, Corporate Director of Facility Maintenance and Safety Operations, who reported that on 1/26/22 they received a call notifying them around 6 pm and they reported to the facility to check the wander guard system. The surveyor noted that in an email dated 1/27/22, Staff #57 communicated the following information: Wander guard system still seems to be working OK. On 3/14/24 the surveyor reviewed and verified the completion of the facility's plan of action which was formulated in response to the 1/26/22 incident which included the following interventions completed by1/28/2022. 1. Assessment of the resident for injury on return and document any skin breakdown on skin sheets. 2. Notify guardian. 3. Update wandering assessment and elopement careplan for incident upon resident's return. 4. Complete incident report. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Interview staff on duty 7-3 and 3-11 shift 1/26/22 6. Check wanderguard system to ensure door alarms when wanderguard present. 7. Audit current residents identified at risk for elopement to ensure that device is in place, within expiration date, has MD orders, is being signed off qshift as in use and qd as functioning, is care planned, on GNA kardex, and picture at front desk 8. Ensure that adequate supply of wanderguards are in house and staff know where they are located. 9. Re-assess current residents' wandering assessments to ensure any elopement risk is clearly identified. 10. Initiate a careplan for at risk for elopement if any new at risk residents identified. 11. Re-educate staff on the policy for missing resident and nursing staff on making rounds at the start of every shift. 12. Educate receptionists/security guards on the contents of the wanderguard book and importance of notifying staff if a resident is attempting to leave the facility unattended. 13. Educate receptionists on the use of equipment to check the function of the front door wanderguard system qshift. 14. Review residents with wanderguards daily x2 weeks, then weekly x 2weeks, then monthly for 3 months to ensure MD orders are written, function is checked qd and documented on TAR, placement is checked q shift and documented on TAR, assessments and care plans are up to date and wander guard is functional and within expiration date. 15. Report results of the wander guard audits monthly x 4 months to the QAPI committee which will determine whether any need for further audits and/or action plans. 16. Documentation of staff education 17. Evidence of work performed to upgrade the front door locking system on 1/28/22. 18. Documentation of initial assessment confirming all residents were accounted for. 19. Documentation of ongoing performance improvement audits. 20. Documentation of 2024 weekly maintenance inspections of fire/exit doors and wander guard system.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45733 Based on observation, medical record review, and interview, it was determined that the facility staff failed to provide required care to the residents' percutaneous endoscopic gastrostomy (PEG) sites. This was evident for 1 (Resident #290) out of 2 residents reviewed for PEG site management during the survey. The findings include: A PEG is a tube that is inserted through the abdominal wall into the stomach. It is used to provide nutrition and medication to a resident. The routine care of a PEG tube site must include the regular monitoring and cleaning of the insertion site to prevent skin break down, leakage, and infections. Review on 3/11/24 at 3:23 PM of Resident #290's closed record found that he/she was admitted in March 2022 with the diagnoses of cerebral infarction, dysphagia with PEG tube placement, and dementia. However, on 3/11/24 at 3:53 PM, review of the Treatment Administration Record (TAR) from 3/24/22 through 10/22/23, revealed that the PEG site care was not included in the TAR form and subsequently there was no evidence that the PEG site care had been completed for the resident for the entire time. A TAR is a record that contains the prescribed care that must be provided and the documentation of the completed care. During interview on 3/12/24 10:20 AM, the Director of Nursing (DoN) stated that the TAR should include PEG site care to ensure that the nurse staff would monitor and clean the PEG site every shift consistently. The DoN was made aware that it was a concern that there was no evidence of the nursing staff ever providing required PEG site care.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48168 Based on record review and interviews it was determined that the facility failed to ensure resident's care was directed by a physician. This was evident for 1 facility reported incident (MD00203534) of 27 facility reported incidents reviewed during the recertification survey. The findings include: On 3/13/24 at 9:15 am a review of the facility reported incident MD00203534 revealed that Resident #71 went on a leave of absence (LOA) on 3/02/24 and returned later that same day. A review of the resident's medical record revealed documentation that confirmed the resident left the faciity on [DATE] and returned to the facility later the same day. Further review of the resident record revealed that there was no order for the resident's leave of absence on 3/02/24. On 3/14/24 at 10:55 am an interview with the Director of Nursing (DON) was conducted. When asked if she could locate the physician's order for the LOA on 3/02/24 she explained that the resident had an order to go on a LOA on 3/01/24 but the resident did not go that day. The DON explained that there was a physician's order for the 3/01/24 LOA, and that a new order should have been obtained for the LOA on 3/02/24 but that was not done, there was no order for the resident's LOA on 3/02/24. She acknowledged that the lack of order was a deficiency.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 42507 Based on medical record review and interview, it was determined the facility staff failed to follow physician orders by administering as needed (PRN) pain medication outside the prescribed parameters. By failing to follow the prescribed parameters for the medication administration, the resident was given an unnecessary medication. This was identified for 2 (#116, #57) of 67 residents reviewed for medications during a recertification/complaint survey. The findings include: 1) On 12/26/2024 at 8:08 AM, review of Resident #116's medical record revealed the resident was admitted to the facility in March 2023 with medical diagnosis that include but not limited to: Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle, pain in right hand, Type 2 Diabetes Mellitus with diabetic neuropathy and Atrial Fibrillation. On 2/26/2024 at 8:20 AM, review of physician orders revealed an active order with a start date of 11/15/2023, for Oxycodone tablet 15 mg, give 1 tablet by mouth every 4 hours as needed for pain 5-10. Further review of the orders revealed a discontinued order for Oxycodone 20 mg tablet, give 1 tablet by mouth every 4 hours as needed for pain 7-10, start date 4/5/2023 and discontinued on 11/9/2023. On 2/26/2024 at 8:46 AM, review of the Medication Administration Record (MAR) for February 2024 was completed. PRN Oxycodone 15 mg was given outside ordered parameters of 5-10 pain level for med administration on the following dates: On 2/1/2024 - for pain score 4, On 2/7/2024 - pain score 0, On 2/17/2024- pain score 0, On 2/18/2024- pain score 4, and On 2/24/2024- pain score 4. A review of MAR for September 2023 revealed staff documentation that Resident #116 was given PRN Oxycodone 20 mg on the following dates for pain of less than 7/10 contrary to physician orders: On 9/2/2023 - Pain score 5, On 9/8/2023 - Pain score 5, On 9/9/2023 - pain score 5 & 5, On 9/10/2023 - pain score 6 & 5, (continued on next page)

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Future Care Cold Spring	4700 Harford Road Baltimore, MD 21214

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/15/2023 - pain score 5 & 6, On 9/18/2023- pain score 5, On 9/19/2023- pain score 5, On 9/21/2023 - pain score 6 &5, On 9/23/2023 - pain score 5, On 9/24/2023- pain score 6 & 5, On 9/25/2023 - pain score 5, On 9/27/2023 - pain score 6 & 5 & 5, On 9/28/2023- pain score 6, and On 9/30/2023- pain score 5. On 2/28/2024 at 11:11 AM, Surveyor reviewed Resident #116's February MAR with Licensed Practical Nurse (LPN #8) and the 2A Unit Manager (UM #7). They both confirmed that Oxycodone was given inappropriately on the day/time when the resident's pain score was below 5. UM#7 stated that the nurses who administered the Oxycodone should have offered something else like Tylenol based on the pain score. If there was no order for Tylenol, the doctor should have been contacted for an order for a breakthrough pain medication. UM #7 added that she was going to educate the staff on pain management and PRN pain medication administration. On 2/28/2024 at 11:34 AM, an interview was completed with the Director of Nursing (DON): She stated that prior to administration of pain medications (routine and PRN), pain assessment must be done, and a pain score documented. She stated that staff were supposed to look at the orders and follow the parameters prior to any med administration. DON reviewed and confirmed that the Oxycodone was given out of parameters on the days that the resident's pain score was below 7 for September 2023 and below 5 for February 2024. DON stated that the expectation was that the nurse should have given a pain med that matched the pain score and/or contact the physician if no other pain medications were ordered/ available, and/or get something for breakthrough pain. DON validated that staff did not follow physician orders and Resident #116 was given an unnecessary drug. She indicated she would follow up with staff. 2) During a review of Resident #57's medical record conducted on 2/29/2024 at 8:45 AM, surveyor noted active physician orders dated 11/15/2023 for Oxycodone tablet 5 mg, give 0.5 mg by mouth every 8 hours as needed (PRN) for pain 7-10. On 2/29/2024 at 9:14 AM, a review of the Medication Administration Record (MAR) for February 2024 was completed. PRN Oxycodone 0.5 mg was given outside ordered parameters of 7-10 pain level for med administration on the following dates and times: On 2/8/2024 at 20:10 (8:10 PM): pain score 5, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/2024 at 16:44 (4:44 PM): pain score 5, On 2/22/2024 at 10:11 AM: pain score 5, On 2/22/2024 at 19:59 (7:59 PM): pain score 6, and On 2/28/2024 at 18:08 (6:02 PM): pain score 0. For January 2024, Oxycodone was given on the following dates and times for pain score below 7/10: On 1/8/24 at 0603 (6:03 AM), 1/9/2024 at 0538 (5:38 AM), on 1/10/2024 at 2200 (10:00 PM), on 1/11/2024 at 1510 (3:10 PM), on 1/12/2024 at 0249 (2:49 AM), 1/25/24 at 0915 (9:15 AM), and 1/28/2024 at 1715 (5:15 PM), the resident was given Oxycodone for pain score of 6. On 1/22/2024 at 0212 (2:12 AM), pain score was 2, at 1127 (11:27 PM) and 2216 (10:16 PM) pain score was 5. On 1/24/2024 at 2207 (10:07 PM), pain score was 0, and on 1/27/2024 at 1540 (3:40 PM), pain score was 0. On 2/29/2024 at 9:41 AM, the Director of Nursing (DON) was made aware of the above findings. DON stated that she has contacted the facility Staff Educator to educate staff on following the pain scale when administering narcotics.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47200 Based on observation and interview of facility residents and staff it was determined the facility failed to ensure food was palatable and served at a safe and appetizing temperature. These deficient practices have the potential to affect all residents. The findings include: On 2/23/24 at 9:02AM the surveyor conducted an interview with Resident #22 who reported the following concern: The person in charge of the kitchen is no longer here, we were getting really good food, but now, we get food like chicken a'la king with no taste to it, I couldn't eat it. By the time food gets to us, it is cold, our cart is the third cart. On 2/22/24 at 10:50AM the surveyor conducted an interview with Resident #116 who described the facility's food as terrible and reported that most of the time, they did not eat it. On 2/23/24 at 8:50AM the surveyor conducted an interview with Resident # 57 who reported they did not like the food, and it is always cold, never get a warm meal. On 3/11/24 at 12:24PM the surveyor observed the serving line and steam table as lunch was being served and noted that steam was present on the right and center wells, but less steam was present on the left well. Upon closer observation, the indicator light below the left well which was holding turkey burgers on the steam table was broken. At this time, Staff #49, Certified Dietary Manager observed and acknowledged the surveyor's concern and reported the following: I can get maintenance to fix it. On 3/11/24 at 12:42PM the surveyor observed the plate warmer system with plates stacked above the warmer well and noted the indicator light on one of the wells was missing. On 3/11/24 at 12:42PM Staff #49, Certified Dietary Manager, confirmed with the surveyor that the facility was not yet finished serving the residents, and at this time, a test tray was immediately made on the tray line, and immediately handed to the surveyor and Staff #49, and temperature testing was performed at this time, revealing a temperature of 106.7 Farenheit for the turkey burger patty which had just been removed from the steam table. The surveyor noted the waffle fries were cool to the touch. Staff #49 confirmed that residents who attend dialysis receive their food after their session, and the food is re-heated at that time. The test tray food was covered and taken to the facility's conference room for immediate testing of palatability. The bottom half of the turkey burger bun was found to be soggy, and not palatable, with no garnish or toppings. The waffle fries were chewy, dry, difficult to eat, and hard crunching was audible upon tasting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 44441 Based on observation, staff interviews and record reviews, it was determined that the facility 1.) failed to utilize appropriate infection control process with the hanging of a urinary bag (Resident #51) 2.) failed to ensure that the Infection Prevention Control program (IPCP) policy was reviewed and updated annually and 3.) failed to assure that staff were educated to handle and process dirty laundry in a manner to prevent the spread of infection. This was evident during the annual recertification survey. The findings include: 1. Upon surveyor's initial tour on 2/21/23 at 9:39AM an observation was made of Resident #51 lying in bed, Further observation revealed that he had a Urinary catheter a device that drains urine from the bladder. The urinary bag was hanging on a Velcro attached to the bed frame, half of the bag was in contact with the bare floor. On 2/21/24 at 9: 22 AM Staff #15 came into the room while the surveyor was still there, she was shown the urinary catheter touching the floor, she readjusted the bag, so it did not touch the floor and stated that she was just starting to make her rounds. Resident #51's urinary catheter was again observed touching the bare floor on 3/5/24 at 9:25 AM. Staff #17 a Registered Nurse (RN) was made aware of this concern. She stated that the urinary catheter should be hung in such a way as to prevent it from being in contact with the floor to prevent infection. She readjusted the bed height, so the bag was no longer in contact with the bare floor. On 3/5/24 at 9:30 AM staff #2 a unit manager was asked the expectation for hanging a urinary bag. She stated that it should hang below the bladder level and off the floor. She was made aware of the concern. 2. On 2/23/24 at 12:04 PM, the surveyor finished reviewing the facilities policy and procedure manual on infection control. The manual was dated 2021. The Director of Nursing (DON) was asked to provide an updated version. The DON came back on 2/23/24 at 12:30 to report that she could not find an updated version. She stated that it has not been updated since 2021. She explained that the 2021 copies are the most current. On 2/29/24 at 10:11 AM, Staff #1, the Assistant Director of Nursing (ADON) and the Infection Preventionist (IP) was asked how often their IP policy and procedure manuals were supposed to be updated. She stated that it was done annually and revised by their corporate office. She was made aware that the IP policy provided was dated 2021 and asked to provide an updated version. She was unable to provide one. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On 3/4/24 at 10:15 AM the surveyor went to the laundry room and observed the laundry aid Staff #26 in the dirty utility room sorting dirty laundry and putting them in the washing machine. She was wearing a pair of clear plastic gloves, she was not wearing a mask, or gown. The surveyor observed a box of regular gloves on a shelf in the dirty laundry room, no other Personal Protective Equipment's (PPE) was seen. Staff #1 the IP person was asked on 3/12/24 at 2:54 AM about training for laundry staff in relation to PPE utilization for sorting dirty laundry. She stated that she was not the one who does the training for the laundry staff but will check their training records to see if they were trained. Another Laundry aid Staff #28 was observed on 3/13/24 at 8:43 AM in the dirty laundry room sorting dirty laundry, she was wearing a regular mask and a clear plastic glove, she was not wearing a gown. She was asked what sort of training was provided to her during orientation. Staff #28 explained that the prior laundry aids trained her before they left and that she was told to just use mask and gloves when sorting dirty linens. On 3/13/24 at 09:39 AM Staff #26 a laundry aid was asked in an interview what sort of training she got in relations to wearing PPE while sorting dirty linen. Staff #26 stated that she was not trained to use PPE to sort dirty linens. She stated that she was not even aware that they were required to wear PPE while sorting dirty linens. 03/13/24 09:45 AM the Director of Nursing (DON) provided copies of a skill validation checklist related to donning and doffing but not specific to sorting of dirty laundry, there was no other document provided to show that the laundry staff were trained in infection control related to sorting of dirty laundry with PPE. She was made aware that this was a concern.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 15701 Based on observation, resident interview, and staff interview it was determined that the facility staff failed to ensure a cord used to turn on/off a call light was attached to the call system. This was evident for 3 of 5 call lights in the 3A central bathing room. The findings include: On 3/5/24 at 2:26 PM observations of the 3A central bathing room revealed that 2 of 3 shower stalls did not have a cord attached to the call switch wall panel. The call switch wall panel for the toilet did not have an attached cord. The call system should be accessible to a resident lying on the floor and without a cord that reaches the floor a resident would not be able to access the call system. On 03/08/24 at 10:39 AM, the maintenance director (staff #10) confirmed the findings with the surveyor of call cords not attached to the 3 of the 5 call switch wall panels in the 3A central bathing room. On 03/11/24 at 1:30 PM the nursing home administrator was informed of the observations made with the maintenance director of the call system that lack cords to the shower room floor in the 3A central shower room.