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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 15701 Based on review of administrative documents, and interviews of residents and staff it was determined that the facility failed to ensure that grievances and concerns from the resident (group) council were documented, reviewed, and responses provided to the group in writing. This was evident in a review of 9 of 9 resident council meeting minutes reviewed. The findings include: An introduction interview was held with the resident council president (Resident #78) on 2/27/24 at 12:00 PM. The resident council president revealed that he/she has lived at the facility for approximately 4.5 years. Upon request the resident council president provided permission for the survey team to review resident council minutes from the past 6-months. The resident council president revealed that the activity's staff assist in conducting the meetings and recording the minutes. Additionally, the resident council president revealed that he/she has not ever reviewed the bimonthly meeting minutes. Copies of the requested resident council minutes were received on 2/28/24. Review of the resident council meeting minutes did not reveal content as to what old business was reviewed. The concerns of the resident council were not documented in the meeting minutes. Review of the resident council meeting minutes from 2/21/24 simply documented Old Business: as reviewed. Under the Heading of GNA/Nursing was Concern Form Written, Under the heading Laundry was Concern Form Written, Under the heading Maintenance documented Concern Form Written, and under the heading Dietary documented Concern Form Written. Under the other department headings was documented no issues and under Activities it was documented that the residents want to continue with trips. Review of the 9 resident council meeting minutes provided to the survey team, revealed that they were all documented in the same style of not listing the actual concerns and not listing if the concerns of the previous meetings were reviewed. It was noted that each of the 9 resident council meeting minutes revealed, under Laundry a concern form was written at every meeting. An interview was conducted with the nursing home administrator on 3/4/24 at 9:56 AM. When asked, he indicated that the activities staff are to document concerns of the resident council on a concern form to be reviewed/addressed by the appropriate department with indication that the resident is usually informed within 72 hours of the initiation of the concern form. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was made on 3/4/24 for copies of all concern forms related to the resident council minutes that were provided to the survey team. At 11:06 AM on 3/5/24 the activity's director (staff #3) revealed she started at the facility in October 2023. She revealed that she had met with corporate staff but did not receive training related to conducting resident council meetings. Copies of the requested concern forms were provided by the activity's director (staff #3) on 3/5/24 at 12:07 PM. An interview was conducted with the resident council president on 3/5/24 at 12:30 PM to discuss the ongoing documented concern related to the laundry department. He/she indicated his/her own concerns with personal laundry not being returned timely and indicated that there are multiple residents that have of had missing clothing and personal property. The president was asked to assist in selecting resident council members for a group interview. On 3/7/24 at 1:30 PM a group interview was initiated with 7 residents who have attended resident council meetings. A consensus of the group indicated that the facility does not get back to the group with resolutions of the resident council concerns. The group shared ongoing concerns related to clothing not returned timely or not at all. The resident council concern of 2/15/24 related to residents' voiced concerns during council meeting of having holes in linen. The concern form revealed that a person was notified within 72 hours of registering the concern and that the person expressed satisfaction with the resolution. A majority of the group share dissatisfaction related to not having enough washcloths, towels, and bed linens. There were expressions of poor quality unsanitary washcloths and towels. One member indicated the staff get disrespectful to the residents if you ask for towels and wash cloths with other members acknowledging the same. The 2/25/24 concern with holes in the linen was signed by the Nursing home administrator on 2/19/23 and documented that it was filed in concern log 2/19/22. The residents were asked about two concern forms (dated 11/1/23 and 11/15/23) with the same concern of a resident having a loud tv at night. One of the two form indicated the person expressed satisfaction with the resolution and signed by the nursing home administrator on 11/16/23. Multiple residents stated the issue is ongoing. There was expressed concern related to the condition of shower rooms. The light in one of the shower stalls has been out for a long time and Water puddles and is left there for the next person. The puddled water in the shower stall is nasty. The council members indicated that the facility did not have an environmental services director and/or that they leave after a short stay. One of the members revealed that an environmental services director started at the facility on 3/4/24. After the meeting a concern form dated 11/1/23 detailed a concern as Shower rooms not clean. Equipment stored in shower rooms. Needs brighter light. The form was signed by the Nursing home administrator with indication of Based upon the investigation the concern was not confirmed. There was no documentation of a notification of a resolution and no indication of satisfaction with the resolution. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/8/24 at 9:29 AM the activity's assistant (staff#14) was asked to review a concern form dated 10/18/23. The details of the concern were written as GNA not answering light timely. The form documented Resident council as a resident's name. The form indicated that Unit managers/ DON (director of nursing) were spoken to regarding this concern. The form was blank in the section for facility staff use only. It did not list the staff person receiving the concern, or blanks were left for the following question, Was the person registering the concern form contacted within 48 hrs.? The section results of the investigation documented staff education and based on the investigation the concern was not confirmed. The resolve was documented as Activities spoke to unit manages and supervisor and stated they will educate staff. Per the form applicable sign-in sheets were not attached. There was not any indication that anybody was notified of the resolution within 72 hrs, and there was no indication that the resident council was satisfied with the resolution. There was no date or signature of the grievance official. Based upon her review she indicated that the concern as documented was incomplete. On 3/8/24 at 11:28 AM the resident council president was asked if the facility staff review the concerns identified at the previous meeting. He/she stated, there is not a real follow-up or review of the previous concerns. He/she further indicated that a resident brought up at several meetings that he/she needed a privacy curtain and it took the state to show up and he/she got a curtain. Review of the concern forms found one dated 12/22/23 indicating a resident was missing rings in the privacy curtain (no room # or name of resident). The concern form documented maintenance confirmed to activities issue is resolved. There was not any indication of the person expressing satisfaction and there was a date of completion by the grievance official. There was a second concern form dated 2/15/24 indicating resident needs his privacy curtain replaced. This was identified with a room number. This concern form revealed that the activities director confirmed that the resident received a privacy curtain and was signed by the nursing home administrator on 2/16/24. On 3/8/24 at 1:55 PM the activity director was asked how the resident councils' concerns from the previous meeting are reviewed with the residents and she stated that she asked the following: Did your concerns get addressed from the last meeting, does anybody have anything that still needs to be addressed. The surveyor indicated if this is the way that the previous concerns are reviewed then the resident would start the complaint process all over again. She acknowledged that it happens. She was asked to review the 10/19/23 concern form indicating the GNA not answering the light timely. She indicated that the documentation was incomplete and did not indicate a complete resolution. The concern form of 2/15/24 related to holes in the linen was provided for her review and she acknowledged that she has heard of concerns related to a lack of available linens (not enough). A follow-up interview was conducted with the nursing home administrator on 3/11/24 at 1:20 PM to review the survey concerns related to the concerns/complaints of the resident council not being properly reviewed with the council. He indicated that the appropriate department is to respond to the concern form and the concern form should be reviewed at the next meeting. He was shown a few of the concern forms that did not show complete documentation. The concern form dated 12/22/23 with a documented concern of Laundry not being picked up from rooms was not completed as he did not sign. The form indicated the person was notified in 72 hours. The form did not indicate when the resident council was notified and did the council express satisfaction. The 9/20/23 concern related to the resident council's concern of not getting condiments on food trays, was incomplete. The 11/1/23 concern related to dirty shower rooms, was reviewed with indication of the surveyors observation of lights not working and the puddling of water in one of the shower rooms.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 44441 Based on medical record review and staff interviews, it was determined that the facility failed to notify the resident/resident's representative in writing of the bed-hold policy upon transfer of a resident to an acute care facility. This was evident for 2 (R#118, R#12) of 5 residents reviewed for hospitalization during the recertification/complaint survey. The findings include: The bed-hold policy describes the facility's policy of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . 1) On 2/21/24 at 12:56 PM during the initial rounds on the unit, Resident #118 revealed that s/he was sent out to the hospital late last year for a medical condition. Resident was asked if s/he was provided a notification for a bed hold prior to hospitalization and s/he stated they were unsure. A review of Resident #118's medical records on 3/5/24 at 2:11 PM revealed a nurse progress noted dated 11/24/23 which documented that resident was sent out to the hospital on November 2023 for a medical condition. On 3/6/24 at 10:10 AM a review of the facilities transfer form and progress notes did not reveal that the resident was given a bed hold notification. The Director of Nursing (DON) was asked to provide documentation. She provided the Hospital transfer form with the bed hold notification. Review of these documents on 3/6/24 at 10:17 AM showed that the bed hold notification form was not signed by the resident or staff to indicate that it was reviewed with the resident and a copy provided. The DON was asked to look through the forms provided and verify. She confirmed that the bed hold notification form was not signed by either the resident or the nurse initiating the transfer and that there was no indication that the resident received a copy. 2) On 2/22/24 at 10:24 AM in an interview, Resident #12 revealed that s/he was hospitalized on two occasions and that one was for a fall with injury. A review of the Resident #12's medical records on 2/26/24 at 10:18 AM revealed that Resident #12 was sent out to the hospital on December 2022 and on February 2022. The eINTERACT SBAR summary for providers documented in detail on both dates about the reason for the hospitalization and the incident that led up to it. On 2/27/24 at 1:11 PM the surveyor conducted an interview with staff #15 a Licensed Practical Nurse (LPN). Staff #15 was asked if residents were given any kind of notification prior to sending them out. She stated that residents are given a bed hold policy and notice of transfer prior to transfer and that signed copies are placed on their physical charts. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/24 at 1:22 PM the surveyor looked in the resident's physical chart but was unable to find the bed hold policy. Staff #15 indicated that Resident #12's chart was thinned but was unsure if the documents were scanned into the electronic medical records or kept by medical records in a binder. She offered to check with medical records and get back to the surveyor. On 2/27/24 at 1:34 AM, the Director of Nursing (DON) was asked to provide the bed hold policy documents given to Resident #12 on transfer out to hospital. She brought an emergency room Checklist" form. Review of the form showed that copy of the bed hold agreement was not checked off as given on both transfers dates. The DON stated that the facility sends residents out with the bed hold notification letters but do not retain a copy. She was asked how the facility can prove that a copy was provided to the resident. She was unable to provide a response. She was made aware that this was a concern. The DON said the bed hold notification was being revamped and they will be sending it out by certified mail from here on.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44441 Based on medical record review and interview, it was determined that the facility failed to meet professional standards of practice as evidenced by 1) failing to ensure nursing staff documenting opioid use on the Medication Administration Record (MAR) and Controlled Drug Administration Record (also known as control sheet). This was evident for 2 (Resident #88 and #124) out of 3 residents reviewed for administration of narcotic medication, and 2) failing to ensure that a licensed nurse had specific competencies and skill sets necessary to care for a dialysis resident. This was evident during a review of a complaint incident during an annual survey. The findings include: 1) On 02/22/24 at 9:10 AM review of a complaint intake MD00200471 had that an arterial needle and clamp was left in Resident #82's dialysis access point prior to discharging resident from the dialysis session on 11/30/23. Further this was not discovered by the nurse until more than 2 hours later when the resident was found bleeding from the access site with the needle and clamp pulled out. Review of the nurses note dated 11/29/23 on 3/4/24 at 11:55AM documented that the nurse found Resident #82's Arteriovenous Fistula (AVF) a connection between an artery and vein for dialysis access bleeding out at 2:30 PM while doing rounds. A needle and a white clamp were found on the resident's lap in bed. The bleeding was controlled, the physician was notified and follow up interventions implemented. Further review of the nurses note documented on 11/29/23 had that resident returned back to unit from dialysis at 12pm. Nurse obtained blood pressure at 12:48pm on pt right arm and administered medication at 12:49. GNA took resident to room to assist resident back in bed to be changed and setup for lunch at 12:51pm On 3/4/24 at 12:16 PM review of the dialysis communication form dated 11/29/23 asked on the Post Dialysis Assessment section is dressing clean dry and intact. The response was, No - clamp, needle attached to patient. Staff #20 a Registered Nurse (RN) was asked in an interview on 3/7/24 at 8:12 AM their expectation for when a dialysis resident returns from dialysis. She stated that the nurse was expected to assess the residents' vital signs (V/S), the AV fistula site and dressing for bleeding and monitor the resident. She explained that residents are checked as soon as they return from dialysis and before they are transported back to their rooms or to bed or chair. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/7/24 at 1:43 PM Staff #32 an Agency Licensed Practical Nurse (LPN) who took care of Resident #82 at the time of the incident was asked to recall the incident. She stated that the resident came back to the unit and was taken to their room and assessed 15-20 minutes later. She looked at the fistula site, saw the needle and clamp but did not think there was anything wrong with it being left there. She did not notify anyone, neither did she call the dialysis unit for clarification on what to do with the needle and clamp. She stated that she was doing her 2pm rounds when she noticed that Resident #82's arm was in a pool of blood, the needle and clamp has been pulled out by the resident. She called for emergency help. Staff #32 was asked if she got any training in caring for dialysis patient prior to hire, she said she did not and was not a trained dialysis nurse. The Director of Nursing (DON) was sitting in on the interview and was asked how she ensures that agency staff are competent to take care of dialysis patients. The DON responded that such incident has never happen before and she had assumed that the Agency nurses were competent to take care of dialysis residents. She was made aware that this was a concern. Cross reference F726 43096 2) Oxycodone hydrochloride is part of a group of drugs known as opioids. Opioids include any drug that acts on opioid receptors in the brain and any natural or synthetic drugs that are derived from or related to the opium poppy. Tramadol is a strong pain medication used to treat moderate to severe pain that is not being relieved by other types of pain medicine. It is a synthetic opioid that acts in the brain and spine (central nervous system) to reduce the amount of pain. Opioid (also known as narcotics) pain medications are potent and effective at managing moderate to severe pain but have significant side effects and the potential for abuse. As a result, facilities are required to track the medication carefully and be able to reconcile administered doses of opioids with evidence of that medication's dispensation. A controlled medication utilization record (known as a count sheet) is a form to record controlled medication dispense. It documents the details for each use of any controlled substance amount removed from its original containers, including date, time, the dose given, the signature of the nurse administering medication, the amount remaining, wasted, and the signature of who checked. On 2/23/24 at 9:35 AM, the surveyor reviewed the facility's narcotic books and residents' narcotic count sheets on Unit 2 B and Unit 3 A. The surveyor randomly selected three residents' records and compared them with their Medication Administration Records (MAR). 2a.) The review revealed that Resident #124 had been prescribed Oxycodone 5mg, one tablet every 6 hours as needed for pain. On 2/23/24 at 9:38 AM, the review of Resident #124's Oxycodone count sheet revealed that the medication was pulled 28 times from 2/01/24 to 2/20/24. However, 9 of them were not documented in the resident's MAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2b.) On 2/23/24 at 9:40 AM, the review of Resident #88's medical records revealed that the resident had ordered one tablet of Tramadol 50mg one tablet every 6 hours as needed for pain. The Tramadol count sheet documented that Resident #88's Tramadol was pulled from the medication cart 30 times from 2/01/24 to 2/21/24. However, 9 of them were not reported in the resident's MAR. During an interview with Licensed Practical Nurse (LPN #42) on 2/23/24 at 9:45 AM, LPN #42 confirmed that nurses should record residents' narcotic medications use in the count sheet and their Medication Administration Record (MAR). On 2/23/24 at 12:07 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the facility nurses are supposed to document all narcotic administrations in the residents' count sheets and medication administration records. The surveyor shared concerns about Resident #88 and #124's records for narcotic use. The DON validated the concerns. Cross reference F 755

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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 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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 43096 Based on medical record review, staff interview, and observation, it was determined that the facility failed to provide appropriate treatment and services for the care of a resident with a urostomy upon admission. This was evident for 1 (Resident #88) of 1 resident reviewed for urostomy care during the survey. The findings include: Urostomy is a result of a surgery that creates a way for urine to leave your body in cases where your bladder is damaged or removed. During an interview with Resident #88 on 2/21/24 at 10:52 AM, the resident said, I was diagnosed with bladder cancer in 2022. Since then, I had a bag for urine. Also, the resident stated that the facility nurses did not empty, monitor, and assess his/her urostomy. A review of Resident #88's medical record on 2/27/24 at 8:20 AM revealed that the resident had an order to change urostomy per physician order within 24 hours as needed and change catheter tubing and bag for malfunction, contamination, odor or sedimentation as needed. However, there was no order and documentation for urostomy care, including monitoring and assessment. Also, further review of Resident #88's care plan revealed that it did not indicate resident-centered and measurable interventions for urostomy care. In an interview with Licensed Practical Nurse (LPN # 6) on 2/27/24 at 11:29 AM, LPN #6 stated that usually nurse aides empty the urostomy bags, and nurses measure the amount, check security, and assess the site. LPN #6 said the urostomy care orders should be placed under the physician's order. On 2/28/24 at 11:48 AM, the Director of Nursing (DON) was interviewed. She confirmed that Resident #88 should have an order for urostomy care, and the care plan should indicate its details. The DON validated the surveyor's concern.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43096 Based on observation, medical record review, and interview, it was determined that the facility failed to place a physician's order for the indication of Oxygen administration and develop and implement a person-centered comprehensive care plan with resident-centered goals for respiratory care to include oxygen therapy. This was evident for 1 (Resident #302) of 1 resident reviewed for respiratory care during the survey. The findings include: On 2/22/24 at 9:17 AM, the surveyor observed that Resident #302 had a settled Oxygen nasal cannula 4L (liter) prepped at the bedside. However, Resident #302 did not apply Oxygen. Further observation Resident #302 on 2/28/24 at 10:03 AM, the resident had 2 L of Oxygen via nasal cannula. A record review of Resident #302's medical record on 2/28/24 at 10:20 AM revealed that the resident had an order of Oxygen via Nasal Cannula at 2 Liter started on 2/27/24. However, the order did not indicate why the resident needed Oxygen therapy. Also, no care plan was developed for Resident #302 ' s Oxygen therapy. On 2/28/24 at 11:48 AM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed that an Oxygen order needed to be placed with the indication, and a care plan must be developed. The DON validated the surveyor's concern about Resident #302's Oxygen use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 44441 Based on record review and staff interview, it was determined that the nurse failed to do a timely assessment on a resident post dialysis, this was evident during a review of a complaint MD00200471 during the survey. The findings include: On 02/22/24 at 9:10 AM review of a complaint MD00200471 alleged that Resident #82 was not assessed immediately upon return to the unit from dialysis and that it took an hour before an assessment was completed. Review of the nurse note documented on 11/29/23 that resident returned back to unit from dialysis at 12pm. Nurse obtained blood pressure at 12:48pm on pt. (patient) right arm and administered pt. medication at 12:49. GNA took pt to room to assist pt back in bed to be changed and setup for lunch at 12:51pm Review on 3/4/24 at 11:55AM of the nurses note dated 11/29/23 documented that the nurse found Resident #82's Arteriovenous Fistula (AVF) a connection between an artery and vein for dialysis access bleeding out at 2:30 PM while doing rounds. A needle and a white clamp were found on the resident's lap in bed. The bleeding was controlled, the physician was notified and follow up interventions implemented. On 3/5/24 at 3:03 PM Staff #18 a License Practical Nurse (LPN) was asked about post dialysis process and she stated that staff are required to do vital signs and check the resident's dialysis port immediately they return from dialysis. The unit manager Staff #12 was asked on 3/5/24 at 9:30 AM when post dialysis assessments were required to be completed. Staff #12 responded it should be done immediately the resident came back to the unit; post dialysis assessments should be done immediately. The Director of Nursing (DON) was asked on 3/5/24 at 10:33 AM the expectation for when a resident returns from dialysis. She stated that once a resident was done with dialysis and brought back to the unit, the expectation was that the resident should be assessed within 10-15 minutes of return if there was nothing going on emergently. She was made aware of the concern for Resident #82.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44441 Based on record reviews and staff interviews, it was determined that the facility failed to ensure that a licensed nurse was competent to care for a dialysis resident. This was evident during a review of a complaint incident MD00200471 during an the survey. The findings include: On 02/22/24 at 9:10 AM review of a complaint intake MD00200471, alleged that an arterial needle and clamp was left in Resident #82's dialysis access point prior to discharging resident from the dialysis session on 11/30/23. Further this was not discovered until more than 2 hours later when the resident was found bleeding from the access site with the needle and clamp pulled out. Review on 3/4/24 at 11:55AM of the nurses note dated 11/29/23 documented that the nurse found Resident #82's Arteriovenous Fistula (AVF) a connection between an artery and vein for dialysis access bleeding out at 2:30 PM while doing rounds. A needle and a white clamp were found on the resident's lap at the bedside. The bleeding was controlled, the physician was notified and follow up interventions implemented. Further review of the nurse note documented on 11/29/23 had that resident returned back to unit from dialysis at 12pm. Nurse obtained blood pressure at 12:48pm from the right arm and administered medication at 12:49. The Geriatric Nursing Assistant (GNA) took resident back to room to be changed and setup for lunch at 12:51pm On 3/4/24 at 12:16 PM review of the dialysis communication form dated 11/29/23 had on the Post Dialysis Assessment section is dressing clean dry and intact. The response was, No- clamp, needle attached to patient. Staff #20 a Registered Nurse (RN) was asked in an interview on 3/7/24 at 8:12 AM their expectation for when a dialysis resident returns from dialysis. She stated that the nurse was expected to assess the residents' vital signs (V/S), the AV fistula site, dressings for bleeding and monitor the resident. She explained that residents are checked as soon as they return from dialysis and before they are transported back to their rooms or to bed or chair. On 3/7/24 at 1:43 PM Staff #32 an Agency Licensed Practical Nurse (LPN) who was caring for Resident #82 at the time of the incident was asked to recall what happened. She stated that the resident came back to the unit and was taken to their room and assessed 15-20 minutes later. She looked at the fistula site, saw the needle and clamp but did not think there was anything wrong with it being left there. She did not notify anyone or call the dialysis unit to come remove it. She was doing her 2pm rounds when she noticed that Resident #82's arm was in a pool of blood, the needle and clamp has been pulled out by the resident, she called for emergency help. Staff #32 was asked if she got any training in caring for dialysis patient prior to hire, she said she did not and was not a trained dialysis nurse. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was sitting in on the interview and was asked how she ensures that agency staff are competent to take care of dialysis patients. The DON responded that such incident has never happen before and she had assumed that the Agency nurses were competent to take care of dialysis residents. She was made aware that this was a concern. Cross reference F658

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 42507 Based on observations, review of daily staffing records, and staff interview it was determined that the facility failed to consistently post the nurse staffing data at the beginning of each shift, the ratio of licensed and unlicensed staff to residents, and failed to retain the posted daily nurse staffing data for a minimum of 18 months. This was evident on 4 of 4 nursing units and in the facility lobby during the recertification/complaint survey. The findings include. 1. On 3/8/2024 at 9:00 AM, Surveyor requested from the Director of Nursing (DON) copies of the daily assignment sheets for the past three (3) months (December 2023 through February 2024). On 3/8/2024 at 1:02 PM, review of the Daily Assignment sheets for 3B Unit was completed for the month of December 2023. Random review of the daily assignment sheets to exemplify the missing data follows: On 12/1/2023 on Unit 3B (census 38): for 3-11 P (evening shift) 3 nurses (no title) and 1 supervisor (no title). For 11- 7 (night shift) 2 nurses (no title). On 12/2/2023 on Unit 3B (census 39): for 3-11 (evening) and 11-7 (night) shifts, 2 nurses (no title). On 12/4/2023 on 3B unit, no staffing sheet for 11-7 (night) shift. On 12/5/2023 on 3B unit, no staffing sheet for 11-7 shift. DON and NHA (Nursing Home Administrator) made aware that the staffing sheets provided did not indicate the titles of the nurses (RN and/or LPN). DON took the sheets to revise and indicate the titles of the nurses. 2. On 3/11/2024 at 9:42 AM, a review of Unit 3A's staffing sheets from December 2023 through March 7, 2024 revealed the following missing data: No staffing sheets for the following dates: 2/13/2024, 2/14/2024, 2/15/2024, 2/16/2024, 2/17/2024, 2/18/2024, 2/19/2024, and 2/20/2024. 4 staffing sheets for 3-11P shift without dates: Dates written in pencil on top of sheets with question mark (12/2/23? 12/10/23? 12/7/23? 12/15/23? 2/25/24?); and 2 sheets for 11P-7A without dates (12/1/23? 12/3/23? and 12/23/23? all written in pencil). 3. On 3/11/2024 at 10:51 AM, a review of Unit 3B's staffing sheets from December 2023 through March 7, 2024, revealed no staffing sheets for 2/15/2024, 2/16/2024, 2/18/2024, and 2/19/2024. 4. On 3/11/2024 at 11:54 AM, a review of Unit 2A's staffing sheets from December 2023 through March 7, 2024, revealed - on 1/14/2024, No nursing staff listed for 11P-7A (night) shift. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	6 staffing sheets for 7-3 P (day) shift, 4 staffing sheets for 3-11p (evening) shift, and 1 for 11AM-7A (night) shift had no dates on them. 5. On 3/11/2024 at 2:11 PM, a review of Unit 2B's staffing sheets from December 2023 through March 7, 2024, revealed No staffing/assignment sheets for 12/5/2023, 12/6/2023, 12/7/2023, 12/8/2023, and 2/10/2024. On 3/12/2024 at 8:30 AM, surveyor requested from the DON, copies of the posted daily nurse staffing data for December 2023 and January 2024. DON stated she was going to get them. On 3/12/2024 at 8:58 AM, DON returned with a copy of nurse staffing data for 11-7 shift dated 3/11/2024. She stated that the scheduler did not have any more copies of the posted daily nurse staffing data available. They were not keeping them, she stated. She further stated that the night shift supervisor oversaw changing the forms and replacing them with the current one, but she (DON) was not aware that the scheduler was not keeping copies of the staffing data. DON stated that she knew they were supposed to keep the posted daily nurse staffing data for at least 18 months following federal regulations and apologized for not having them. However, she stated that she was going to find out if the scheduler had at least a week's record of the postings. On 3/12/2024 at 9:05 AM, DON gave the surveyor 2 more copies of daily nurse staffing data for 7-3 shift and 3-11P shift dated 12/2/2023. She stated that was all they could find. On 3/12/2024 at 9:10 AM, a review of the 3 copies of posted daily staffing data provided to the surveyor was completed: Under Nursing Hours, the number of RNs, LPNs, and GNAs was not indicated. On 12/2/2023 on All Units (census 125) for 7-3 (day shift) = No ratios for licensed and unlicensed staff to residents for 7-3 (day) shift. on All Units (census 126) for 3-11 (evening shift) = No ratios for licensed and unlicensed staff to residents for 3-11 (evening) shift. On 3/11/2024 on All units (census 128) for 11-7 (night) shift = No room assignments for licensed staff (nurses). On 3/13/2024 at 9:04 AM, the Director of Nursing (DON) was notified of surveyor's concerns regarding posted nurse staffing information that was provided. The surveyor reviewed the lack of daily shift posting of all the requirements for posting of staffing with the DON who confirmed the above surveyor findings.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 43096 Based on a review of the medical record and interview with staff, it was determined the facility staff failed to monitor and/or document the resident's inappropriate behavior related to mental health. This was evident for 1 (Resident #24) of 5 residents who were reviewed for behavioral-emotional issues during the survey. The findings include: A review of the facility's self-report regarding Resident #24 on 3/06/24 at 9:26 AM revealed that the resident had inappropriate behavior, such as entering other resident's rooms, taking their food, and hitting them in June 2023. Further record review for Resident #24 revealed that the Psychologist had followed the resident regularly and as needed after the incident. The Psychologist ordered that Resident #24 be monitored for mood/sleep/appetite/behavior and documented. A review of Resident #24's medical records on 3/06/24 at 10:00 AM revealed that the resident had orders of monitoring inappropriate behaviors but not limited to wandering, disturbed mood, smearing feces on items throughout their room, getting in other residents' beds, eating other residents' food, going in other residents' rooms, taking food from others' trays, and anxiousness. During an interview with Licensed Practical Nurse (LPN #30) on 3/07/24 at 8:09 AM, LPN #30 stated that residents' behavior needed to be documented in the electronic medical record system. LPN #30 said, We do the check list in the electronic medical record every shift, and details will be written in the progress note. However, a review of Resident #24's medical record on 3/07/24 at 10:00 AM revealed that there was no checklist for the resident's behavior and no documentation in the progress note about the behavior monitoring. The Director of Nursing (DON) was interviewed on 3/07/24 at 1:52 PM. The DON stated that residents' behavior issues would be documented only if the incident was identified. The surveyor asked her if there was any documentation about behavior monitoring and how we could validate residents who had behavior issues monitored and identified. The DON said, I understand your concerns.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on a review of the medical record and interview with staff, it was determined that the facility staff 1) failed to ensure narcotics removed from the resident's supply were administered to the resident, as evidenced by staff documenting the removal of narcotics without documentation of the need for the narcotic or documentation that the narcotic was administered to the resident. This was evident for 3 (#88 and #124) of 3 residents reviewed for Controlled drug administration and medication administration records reviewed during the survey, and 2) failed to timely provide medication to meet the needs of the residents. This was evident for 1 (#116) of 5 residents reviewed for medications during the recertification/complaint survey. The findings include: Oxycodone hydrochloride is part of a group of drugs known as opioids. Opioids include any drug that acts on opioid receptors in the brain and any natural or synthetic drugs that are derived from or related to the opium poppy. Tramadol is a strong pain medication used to treat moderate to severe pain that is not being relieved by other types of pain medicine. It is a synthetic opioid that acts in the brain and spine (central nervous system) to reduce the amount of pain. Opioid (also known as narcotics) pain medications are potent and effective at managing moderate to severe pain but have significant side effects and the potential for abuse. As a result, facilities are required to track the medication carefully and be able to reconcile administered doses of opioids with evidence of that medication's dispensation. A controlled medication utilization record (known as a count sheet) is a form to record controlled medication dispense. It documents the details for each use of any controlled substance amount removed from its original containers, including date, time, the dose given, the signature of the nurse administering medication, the amount remaining, wasted, and the signature of who checked. 1a) On 2/23/24 at 9:35 AM, the surveyor reviewed narcotic books on Unit 2 B and 3 A. The review of the count sheet in the narcotic book revealed that Resident #124 had been prescribed Oxycodone 5mg, one tablet by mouth every 6 hours as needed for moderate to severe pain. The sheet contained Resident #124's Oxycodone 5mg removed date, time, quantity used, route, quantity remaining, and nurse's sign including below days: 2/01/24 at 5:34 AM 2/01/24 at 6:25 (no AM/PM documented) 2/04/24 at 9:30 AM 2/04/24 at 9 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/08/24 at 9 PM 2/13/24 at 6:00 (no AM/PM documented) 2/16/24 at 12:00 PM 2/16/24 at 6 PM 2/17/24 at 5:30 PM However, a review of Resident #124's Medication Administration Record (MAR) on 2/23/24 at 9:40 AM revealed the above dates were not documented for the resident's Oxycodone 5mg administration. During an interview with Licensed Practical Nurse (LPN #42) on 2/23/24 at 9:45 AM, LPN #42 stated that nurses should record residents' narcotic medications use in the count sheet and their Medication Administration Record (MAR). 1b) The review of Resident #88's count sheet revealed that the resident had an order of Tramadol HCL oral tablets 50mg, given one tablet by mouth every 6 hours as needed for pain. The sheet documented that Resident #88 received Tramadol 50mg, including below dates: 2/02/24 at 12 PM 2/03/24 at 11 AM 2/08/24 at 9 PM 2/13/24 at 9:37 AM 2/16/24 at 2 AM 2/17/24 at 11:30 AM 2/18/24 at 10:30 (no AM/PM documented) 2/18/24 at 4:30 (no AM/PM documented) 2/19/24 at 10 (no AM/PM documented) However, a review of Resident #88's MAR on 2/23/24 at 10:10 AM revealed that the above dates were not documented for the resident's Tramadol administration. On 2/23/24 at 12:07 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the facility nurses were supposed to document all narcotic administrations in the residents' count sheet and medication administration records and validated surveyor concerns. 42507 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) A review of complaint MD00203449 on 3/13/2024 revealed an allegation that Resident #116 was not receiving his/her medications on time as prescribed. During an interview with Resident #116 on 3/13/2024 at 9:50 AM, Resident #116 stated that s/he had spinal surgery and while in the hospital and was supposed to be taking both IV (intravenous) and oral antibiotics. The resident stated that s/he was supposed to be getting three (3) different antibiotics, but the staff were not giving them to him/her. On 3/13/2024 at 1:35 PM a review of nurses' progress notes revealed Resident #116 was transferred to the hospital on 2/27/2024 and returned/readmitted to the facility on [DATE] with diagnoses that included but not limited to Plantar ulcer and osteomyelitis s/p multiple toe amputations, and cervical osteomyelitis (bone infection). On 3/13/2024 at 2:10 PM, a review of Resident #116's physician orders revealed the following active orders: a. on 3/13/24 Cefepime HCl Solution 2 GM/100ML Use 2 gram intravenously every 8 hours for infection until 04/18/2024 23:59 Pharmacy b. on 3/12/24metronidazole Oral Tablet 500 MG (Metronidazole) Give 500 mg by mouth three times a day for ANTI-BIOTIC until 04/19/2024 Further review of the orders report revealed two (2) discontinued orders for Metronidazole 500 MG tablet to start on 3/12/2024 at 0800 (8:00 AM) and 0900 (9:00 AM) respectively. On 3/14/2024 at 8:35 AM, reviewed Resident #116's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2024: IV antibiotic, Cefepime HCL, ordered to be given every 8 hours (3 times a day) and to start on 3/13/2024 was not given at all on 3/13/2024. Resident #116 was given the first dose on 3/14/2024 at 0600 (6:00 AM), two days after re-admission on 3/11/2024 to the facility The first dose of oral Metronidazole ordered to be given three times a day was administered on 3/12/2024 at 1700 (5:00 PM). On 3/14/2024 at 8:55 AM, review of progress notes revealed the following documentation by nursing: 3/12/2024 22:59 Orders - Administration Note Text: waiting pharmacy delivery and 3/12/2024 15:00 Orders - Administration Note Text: metronidazole Oral Tablet 500 MG. Give 500 mg by mouth three times a day for ANTI-BIOTIC until 04/18/2024 23:59 Unavailable, MD aware, patient aware, stop date adjusted to 3/19/24 On 3/14/2024 at 9:20 AM, surveyor reviewed hospital discharge summary dated 3/11/2027 at 5:37 PM: date of admission: 2/27/2024 at 10:27 AM. Active Problems: Chest pain, unspecified type, Acute hematogenous osteomyelitis of other site, Osteomyelitis of vertebra. Further review of the discharge summary revealed that the resident was to start taking the following medications upon discharge: Cefepime (Maxipime) infusion 2 g every 8 hours (last time given 5 PM on 3/11/2024) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metronidazole (Flagyl) 500 mg tablet, 1 tablet by mouth every 12 hours (last time given was on 3/11/2024 at 2:15 AM). Vancomycin infusion (Vancocin) 1.75 g daily (last given at 2 AM). On 3/14/2024 at 11:25 AM, an interview was completed with the Director of Nursing (DON) regarding Resident #116 not getting some of his/her antibiotics (Metronidazole 500mg tablet and Cefepime 2 g infusion) started on time. DON confirmed that Resident #116 did not get his/her antibiotics on time and stated that she was made aware of the medications not being given by the resident. DON stated that the 3-11 (evening shift) supervisor failed to put in the orders for the antibiotics when Resident #116 returned from the hospital. DON also stated that the 2A unit manager failed to do a complete chart check the next day after re-admission and Resident #116's orders for the antibiotics were missed. DON further stated that she reviewed the orders, and the resident was currently getting all their medications. DON added that they have already addressed the issue with the 2 A unit manager and the 3-11 supervisor would be written up.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48168 2) On 2/28/24 at 10:00 AM a review of Resident #44's medical record revealed documentation that pharmacy recommendations were made on 11/06/23 and 12/08/23 but gave no details. Further review revealed documentation from the pharmacist, one dated 11/06/23 with recommendations for nursing and the physician, and one dated 12/08/23 which indicated no irregularities. On 3/05/24 at 11:08 AM in an interview with the Director of Nursing (DON), the DON was asked to provide the physician documentation of response to the pharmacy recommendations for 11/06/23 and 12/08/23. On 3/05/24 at 11:43 AM the DON informed the surveyor that there was no physician response documentation for either 11/06/23 or 12/08/23. She further explained that the facility recently conducted a mock survey several weeks prior to the recertification survey and they discovered a problem with physician response to pharmacy recommendations and that they were working to improve compliance with this requirement. 43096 3) A review of Resident #98's monthly Medication Regimen Review (MMR) on 2/28/24 at 12:49 PM revealed that the pharmacist recommendations were made on 7/14/23, 8/15/23, 9/07/23, 10/05/23, 11/08/23, 12/08/23, 1/05/24, and 2/09/24 with details: On 7/14/23, the pharmacist recommended changing the hydrocortisone (for anti-itching) cream to PRN (as needed) or discontinuing it. On 8/15/23, the pharmacist commented that to clarify directions as either one tablet or two tablets for resident has a new order for Oxycodone 5mg give two tabs every 6 hours PRN for give one tab every 6 hours PRN for pain 7-10. On 9/07/23, the pharmacist recommended clarifying the same order as last month (8/15/23). On 10/05/23, the resident ordered Bio-freeze gel twice a day for the back and Menthyl 5% patch for the lower back twice a day. The pharmacist recommended clarifying which medication the resident should be receiving for the lower back. On 11/08/23, the pharmacist commented to change menthol patch and Lidoderm path order one of these to apply one at 9 AM and remove at 9 PM and other patch to be applied at 9 PM and removed at 9 AM. On 12/06/23, the pharmacist recommended that please document blood pressure with each dose of Midodrine (hypotension medication) due to ordered parameters. On 1/05/24, the pharmacist left a recommendation the same as on 11/08/23. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/09/24, the pharmacist asked to clarify hydralazine (for hypertension), senna (stool softening), and Renvela (for control phosphorus) dose and frequency upon Resident #98's readmission. However, a further review of Resident #98's medical record revealed that no physician's response (like agree, disagree, and other) was documented about the pharmacist's recommendations. During an interview with the Director of Nursing (DON) on 3/05/24 at 12:24 PM, the DON insisted that the Medical Regimen Review (MRR) should be reviewed by the physician with the response and required to record the date and sign. The DON said it should be scanned and uploaded to residents' medical records. The surveyor shared concerns about the absence of Resident #98's MRR response. DON stated that the facility was aware of the issue and was working on it. 47200 Based on record review and interview it was determined the facility failed to act upon a medication regimen review pharmacy recommendation. This was evident for 3 of 6 residents (Resident #37, #44, #98) reviewed for psychiatric medications during the facility's recertification survey. The findings include: 1) On 2/28/24 at 11:33AM the surveyor requested documentation from the Director of Nursing (DON) for the pharmacy recommendation that was made on 2/9/24 for Resident #37 as part of their monthly medication regimen review. On 2/28/24 at 12:39PM the surveyor reviewed the 2/9/24 pharmacy recommendation documentation which revealed the following recommendation had been made by Staff #62, Consultant Pharmacist: Resident has been on Seroquel 25mg twice a day since February 2023. Please consider a gradual dose reduction (GDR) or please document specifically if a GDR is clinically contraindicated at this time. Per psych notes, a GDR may be considered. The surveyor further observed that there was no physician/prescriber response documented on the form where a section was provided for the selection of whether they agree, disagree, or have other response, and includes a line for their signature and date signed. Upon further review of the physician notes and medical orders, no information could be found indicating that the pharmacy recommendation was acted upon. On 2/28/24 at 1:07PM the surveyor conducted an interview with the DON who stated the following information regarding the pharmacy recommendation for Resident #37: No, the GDR was not done. Cross reference to F758.

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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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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47200 Based on record review and interview it was determined the facility failed to implement a gradual dose reduction (GDR) for a resident receiving a psychotropic medication. This was evident for 1 of 1 resident reviewed for psychiatric medications during the facility's recertification survey. The findings include: On 2/28/24 at 10:45AM the surveyor reviewed the medical record of Resident #37 which revealed the following information in their active medical order: Seroquel oral tablet 25mg, Give one tablet by mouth two times a day. On 2/28/24 at 11:04AM the surveyor reviewed the psychiatry note dated 2/21/24 for Resident #37 which revealed the following information: Current Psychiatric Medications: Quetiapine 25 mg po (by mouth) bid (twice per day.) Decreased from 37.5mg bid to 25mg bid on 2/25/23. GDR Seroquel 25mg po qd (every day) 2/21/24. Upon further review of the note dated 2/21/24 the following recommendation had been made by Staff #61, Certified Registered Nurse Practitioner (CRNP-PMH): GDR of Seroquel is clinically indicated at this time due to improvement in mood and behaviors. Will begin slow GDR of Seroquel. Patient has been without any psychotic symptoms or agitation for some time. S/he will benefit from GDR of Seroquel at this time since mood has been stable. no behavioral issues noted. Mood, sleep, appetite, and behavior are all stable and consistent with baseline. At this time, the surveyor noted the resident's active medication order failed to reflect the dosage decrease recommendation made by Staff #61 on 2/21/24. On 2/28/24 at 11:25AM the surveyor conducted an interview and inquired to the Director of Nursing (DON) as to what the length of response time was after a psychiatric provider makes a recommendation for a GDR, to which they responded: Within one day's time, at max. The DON further reported they would need to get back to the surveyor on why the GDR had not yet began for Resident #37. On 2/28/24 at 11:33AM the surveyor requested documentation from the DON of the pharmacy recommendation that was made on 2/9/24. On 2/28/24 at 12:39PM the surveyor reviewed the 2/9/24 pharmacy recommendation documentation which revealed the following recommendation had been made by Staff #62, Consultant Pharmacist: Resident has been on Seroquel 25mg twice a day since February 2023. Please consider a gradual dose reduction or please document specifically if a GDR is clinically contraindicated at this time. Per psych notes, a GDR may be considered. The surveyor futher observed that there was no physician/prescriber response documented on the form where a section was provided for the selection of whether they agree, disagree, or have other response, and includes a line for their signature and date signed. On 2/28/24 at 1:07PM the surveyor conducted an interview with the DON who stated the following information regarding the pharmacy recommendation for Resident #37: No, the GDR was not done.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on observations and interviews it was determined that the facility failed to remove expired medications and properly store medications. This was evident found on 1 of 2 medication storage rooms, and 1 of 3 medication cart, and 1 medication cart left unattended by nursing staff. The findings include: The surveyor observed a refrigerator in the medication storage room at unit 3 B on 2/26/24 at 10:18 AM with attending Licensed Practical Nurse (LPN #4). The surveyor found 2 bags of 100ml (milli-litter) Intravenous Ertapenem (antibiotic medication) in the refrigerator. The bags had labeled with used by 2/15/24. The LPN #4 verified that the medications were expired. On 2/26/24 at 10:24 AM, the surveyor observed 3A unit medication cart with LPN #5. The surveyor noticed that unlabeled med cup with 11 unidentifiable pills located in the 1st drawer of 3A unit med cart. LPN #5 said, these are for Resident #40. She/he just reported having upset stomach, I wanted to hold them at this point. LPN #5 was asked was there any label written for that medication. LPN #5 confirmed that nothing was marked or written for it. During an interview with the Director of Nursing (DON) on 2/26/24 at 12:55 PM, the surveyor shared concerns about unlabeled medication. The DON validated it. On 3/05/24 at 9:43 AM, the surveyor observed a medication cart parked in front of Resident room [ROOM NUMBER] without nursing staff attending. The surveyor found a bubble pack of Diltixem ER (a hypertension medication) 180 mg on the medication cart. At 9:45 AM on 3/05/24, the surveyor asked a charge nurse (LPN #12) about the bubble pack. LPN #12 said, I will put it back. It should not be placed here. During an interview with the DON on 3/05/24 at 10:23 AM, the surveyor shared concerns regarding medication storage. She validated the concerns.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 48168 Based on observation, interview, and record review it was determined that the facility failed to ensure residents received needed dental services. This was evident for 1 resident (Resident #101) of 2 residents reviewed for dental services during the recertification survey. The findings include: On 2/21/24 at 10:42 AM in an observation and interview with Resident #101, the surveyor observed that the resident did not have any teeth. During the interview the resident explained that follow-up with a dentist regarding dentures was supposed to have happened in September 2023 but had not happened yet. On 3/05/24 at 9:58 AM a review of Resident #101's medical records revealed documentation dated 7/26/23 that the resident had a dental visit with impressions made for dentures, and that a follow up was to be done on 8/15/23. No documentation of any follow-up was found in the record. On 3/05/24 at 10:15 am in an interview with the Unit Manager (Staff #12), she said that there has been a problem with the company that provided dental services, and that the resident was scheduled to have an appointment next week for follow up regarding dentures. On 3/05/24 at 10:25 am in an interview with the Director of Nursing (DON) regarding Resident #101's lack of dentures, the DON said that she was aware that dental services for this resident had not been provided as needed.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47200 Based on observations of the facility's kitchen, review of kitchen records and interviews of dietary staff, it was determined that the facility: 1.) failed to ensure sanitary practices were followed in accordance with professional standards for food service safety; 2.) failed to store food in accordance with professional standards for food service safety, 3.) failed to store, label, and monitor expiration, of food in accordance with professional standards for food service safety, and 4.) failed to ensure monitoring and oversight of kitchen equipment and environment. These deficient practices have the potential to affect all residents. The findings include: 1.) On 2/21/24 at 7:58AM, the surveyor conducted observations of the facility's kitchen at which time the surveyor observed Staff #46, Dietary Aide, without a hair restraint, and Staff #45, Dietary Cook, standing over the steam table stirring hot cereal with no hair restraint covering their beard. On 2/21/24 at 8:02AM the surveyor observed Staff #46 obtain and put on a hair restraint. On 2/21/24 at 8:02AM the surveyor conducted an interview with Staff #45, Dietary Cook, who confirmed with the surveyor that the facility requires kitchen staff to wear hair restraints. On 2/21/24 at 8:21AM the surveyor observed a disposable container of food sitting on top of the kitchen's microwave. Upon opening of the container, the surveyor observed a dinner meal which had a crusty brown layer covering the food. At this time the surveyor conducted an interview with Staff #47, Dietary Cook, who reported the following regarding the container of food: That must have come from last night. On 2/21/24 at 8:25AM the surveyor observed food debris splattered across the dish sink area. On 2/21/24 at 8:25AM the surveyor observed a metal shelf located in the dishwashing area which had a layer of debris and food crumbs present, a dirty brown tinged dried rag, and disposable gloves. On 2/21/24 at 8:25AM the surveyor observed a cart in the dishwashing area which held four disposable containers of old food and dirty dinner trays with tickets dated 2/20/24. On 2/21/24 at 8:35AM the surveyor observed two movable dish racks in the dishwashing area holding clean plate covers, some of which were located on the bottom row of the dish racks sitting directly on a layer of food debris and small pieces of trash. On 2/21/24 at 08:45AM the surveyor observed the plastic sugar bin sitting on the floor with the container's lid hanging open, situated in a sink area. On 2/21/24 at 8:46AM the surveyor shared concerns and rounded the kitchen with Staff #48, Dietary Aide, who acknowledged the surveyor's concerns. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/27/24 at 12:12PM the soap dispenser at the staff handwashing sink located in the kitchen was observed by the surveyor to be broken. Upon further observation, the soap dispenser was unable to dispense an appropriate amount of soap. The surveyor conducted an observation of the dispenser with Staff #48, Dietary Aide, who acknowledged the surveyor's concern and confirmed the amount of soap being dispensed was inadequate. Staff #48 reported to the surveyor that they were not previously aware of the concern. On 3/11/24 at 2:18PM the surveyor observed two stacks of wet resident food trays standing upright together, with no separation in between, on the dishwashing sink area. On 3/11/24 at 2:18PM the surveyor conducted an interview with Staff #46, Dietary Aide, who reported to the surveyor that the trays are stored like this (pointing to the two stacks of trays) and then the trays are taken and stacked onto a cart located next to the serving line. On 3/11/24 at 2:36PM the surveyor shared kitchen concerns with Staff #49, Certified Dietary Manager, who acknowledged the concerns and reported they were in the process of having equipment ordered to better support the drying process. On 3/12/24 at 2:31PM the surveyor observed a white, cloudy appearing film coating on the rim of the the ice dispenser and the tray for the ice/water machine located in the 3A nutrition room. On 3/12/24 at 2:31PM the surveyor observed approximately a one inch layer of ice build up and a pool of dried beige colored liquid in the small refrigerator located in the 3A nutrition room. On 3/12/24 at 2:35PM surveyors observed white, cloudy appearing film coating on the rim of the ice dispenser located in the 3B nutrition room. On 3/14/24 during the exit conference it was communicated that there were concerns present regarding the kitchen. 2.) On 2/21/24 at 8:04 AM upon surveyor's initial tour of the kitchen, the walk-in refrigerator/freezer door was observed propped open. Written temperature logs were observed posted on the outside of the walk-in refrigerator/freezer which revealed a morning and afternoon temperature was recorded for both the walk-in refrigerator and the walk-in freezer for 2/21/24.The surveyor noted the time was 8:04AM, and a temperature was recorded for the refrigerator and freezer for 6:00AM and 1:00PM, with the initials of Staff #45, Dietary Cook. On 2/21/24 at 8:10AM the surveyor conducted an interview with Staff #45 who confirmed they had recorded the 2/21/24, 6:00AM and 1:00PM temperatures for the walk-in refrigerator and freezer. Staff #45 stated the following to the surveyor: I fill it out ahead of time because I leave in the afternoon. At this time, the surveyor shared the concern with Staff #45, who acknowledged the concern. Staff #45 further informed the surveyor: I typically know what the temps are around that time. At this time, the surveyor requested copies of the kitchen temperature logs. On 2/21/24 at 8:22AM the surveyor observed the temperature gauge on the outside of the walk-in refrigerator which was taped over and labeled do not use. At this time, the surveyor entered the walk-in refrigerator and observed the thermometer which read 60 degrees. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/21/24 at 8:28AM the surveyor observed an ice cream freezer box with a container of ice cream inside. The surveyor further observed an incomplete temperature log labeled February 2024 posted on the ice cream freezer box. At this time, kitchen staff confirmed with the surveyor that the ice cream freezer box was actively used for the storage of ice cream. The facility failed to record morning and afternoon temperatures for the ice cream box, and failed to record the time the evening temperature was taken for the following dates: 2/1/24 2/2/24 2/3/24 2/4/24 2/5/24 2/6/24 2/7/24 2/8/24 2/9/24 The facility failed to record the evening temperature of the ice cream box on the following dates: 2/10/24 2/11/24 On 2/12/24 the facility failed to record the time the afternoon and evening temperatures were taken for the ice cream box. The facility failed to record any temperatures and the log was left blank for the ice cream box for the following dates: 2/13/24 2/14/24 2/15/24 2/16/24 2/17/24 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2/18/24 2/19/24 On 2/20/24 the facility failed to record the evening temperature for the ice cream box. On 2/21/24 the facility failed to record the morning temperature for the ice cream box. On 2/21/24 at 8:31AM the surveyor observed a large refrigerator box which contained milk cartons stacked up to the refrigerator's lid/door. The surveyor observed a one inch opening present between a damaged rubber-type liner and the door to the box. Upon further observation, the front of the refrigerator box was unlatched. On 2/21/24 at 8:33AM the temperature gauge for the milk refrigerator box was observed located on the side of the refrigerator which did not have the opening present. At this time the surveyor reviewed the temperature log labeled February 2024, which was posted on the outside of the milk refrigerator box. On 2/6/24 and 2/7/24 the facility failed to record legible morning milk refrigerator box temperatures. On 2/20/24 the facility failed to record the afternoon and evening milk refrigerator box temperatures. On 2/21/24 the facility failed to record the morning milk refrigerator box temperature. On 2/21/24 at 8:33AM the surveyor noted the last temperature recorded on the February 2024 temperature log for the milk refrigerator box was on 2/20/24 at 5:30AM. On 2/21/24 at 8:36AM the surveyor observed the temperature log posted on the reach-in snack/nourishment refrigerator which revealed the morning temperature and afternoon temperature for 2/21/24 was crossed out. On 2/21/24 at 8:46AM the surveyor shared concerns and rounded the kitchen with Staff #48, Dietary Aide, who acknowledged the surveyor's concerns. On 2/26/24 at 11:43AM the surveyor shared general kitchen concerns with the Director of Nursing and Staff #11, Corporate Regional Nurse and notified them that detailed kitchen concerns were relayed to Staff #48, Dietary Aide. On 2/27/24 at 12:05PM an additional ice cream freezer box with a temperature log posted on it was observed by the surveyor. On 2/21/24 the facility failed to record the evening temperature for the additional ice cream box On 2/22/24 the facility failed to record the time the afternoon temperature was taken, and the evening temperature for the additional ice cream box. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/23/24 the facility failed to record any temperatures for the additional ice cream box. On 2/24/24 the facility failed to record the evening temperature for the additional ice cream box. On 2/26/24 the facility failed to record the afternoon and evening temperatures for the additional ice cream box. On 2/27/24 at 12:05PM the surveyor shared the concern with Staff #48, Dietary Aide, and requested a copy of the additional ice cream box temperature log. On 2/27/24 at 11:46AM the surveyor reviewed the food temperature log which revealed documentation of both puree and mechanical soft food temperatures, however, it could not be distinguished from the log as to what foods these were. The surveyor observed the following information documented on the temperature log dated 2/27/24: mech 11:46; 189, puree 11:46; 185, puree 11:47; 189, puree 11:47; 185. At this time, the concern was shared with Staff #48, Dietary Aide, who acknowledged understanding of the concern. On 2/27/24 at 11:57AM the surveyor observed and noted that white out paint had been added to several February 2024 temperature logs posted throughout the kitchen. On 3/11/24 at 2:36PM the surveyor shared concerns with Staff #49, Certified Dietary Manager, who acknowledged the concerns and observed the milk refrigerator box with the surveyor and confirmed the issue with the damaged seal was still present. Upon opening of the milk refrigerator box, after surveyor intervention on 2/21/24, it was observed that milk cartons were no longer present. Staff #49 reported to the surveyor that the milk cartons were moved to the walk-in refrigerator. 3.) On 2/21/24 at 8:12AM the surveyor observed a metal pan containing what appeared to be chicken salad in the walk in refrigerator with only a date present which read: 2/19/24. On 2/21/24 at 8:13AM the surveyor observed an unlabeled metal pan of what appeared to be shaved meat. On 2/21/24 at 8:13AM the surveyor observed an unlabeled metal pan of what appeared to be a tomato based soup with vegetables. On 2/21/24 at 8:14AM the surveyor conducted an interview with Staff #44, Dietary Aide, who reported the following to the surveyor: Usually we throw the food away the day after the date on the pan.When the surveyor inquired as to how staff know when the pan of unlabeled meat expires, Staff #44 responded: I'm not sure, I don't know what that is. On 2/21/24 at 8:24AM the surveyor observed the walk in refrigerator with Staff #47, Dietary Cook, who reported the pan of unlabeled meat was gyro meat which should be labeled, as well as the soup. Staff #47 further reported that dietary cooks and aides are responsible for the monitoring of expiration of foods, and that staff are expected to use the labels to indicate when the food is to be thrown away. When the surveyor inquired as to how staff know when the unlabeled items are to be disposed of, Staff #47 replied: You wouldn't know. At this time, the surveyor and Staff #47 exited the walk-in refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/21/24 at 8:36AM the surveyor observed two unlabeled square plastic containers, one which contained a red colored liquid, and one which contained a purple colored liquid. On 2/21/24 at 8:46AM the surveyor shared concerns with Staff #48, Dietary Aide, who acknowledged understanding of the concerns and reported to the surveyor that their expectation of kitchen staff is for food labels to filled out to include the expiration date of the foods. Staff #48 further relayed there was a paper guide for the kitchen staff to follow regarding guidance for determining expiration dates of foods. On 2/27/24 at 12:09PM, after surveyor intervention, the surveyor observed a paper posting on the door to the walk-in refrigerator/freezer which stated the following: All items put into the walk in must be wrapped, labeled, dated, thank you. 4.) On 2/21/24 at 8:17AM the surveyor observed a broken square plastic container with a sharp edge stored on a metal rack in the sink area. On 2/21/24 at 8:46AM the surveyor observed a vertical rectangular metal push plate with approximately a two inch sharp edge exposed on the kitchen's exit door. At this time, the surveyor shared the concern with Staff #48, Dietary Aide, who confirmed the observation and acknowledged the surveyor's concern. On 2/21/24 at 8:48AM the surveyor observed two cook pans which appeared to have a black coating present which was scraped away throughout the cooking surfaces of the pans. On 2/27/24 at 12:08PM, after surveyor intervention, the surveyor observed the push plate to the kitchen exit door was replaced. On 3/11/24 at 12:24PM the surveyor observed two cook pans which appeared to have a black coating present which was scraped away throughout the cooking surfaces of the pans. 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 2:36PM the surveyor shared the concerns with Staff #49, Certified Dietary Manager, who acknowledged the surveyor's concerns, and removed the cook pans from use.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47200 Based on observation, record review, and interview it was determined the facility failed to: 1.) ensure certification for medical ineffectiveness of treatment documentation was complete (Resident #102), and 2.) ensure the accuracy of a medical order (Resident #39). This was evident for one out of one certification of medical ineffectiveness of treatment form reviewed by the surveyor, and one out of one medical order for insulin reviewed by the surveyor. The findings include: 1.) On 2/21/24 at 2:17PM the surveyor observed a form located in the paper chart for Resident #102 which provided certification from two providers regarding the medical ineffectiveness of treatment for the resident. Upon review of this form, it was found that the first certification documented by Staff #43, Physician, failed to identify what treatment(s) were being certified to be medically ineffective. On 2/26/24 at 11:20AM the surveyor conducted an interview with the Director of Nursing who reported Staff #43 was an attending physician for the facility until July 2023, and provided their contact information. On 2/26/24 at 11:35AM the surveyor conducted an interview with Staff #43, Physician, who reported the form is used to designate the medically ineffective procedure(s.) At this time, the surveyor shared their concern with Staff #43, who acknowledged the concern and inquired as to whether they had performed the first or second certification for the resident. On 2/27/24 at 1:12PM the surveyor shared their concern with Staff #41, M.D, Medical Director, who acknowledged the surveyor's concern and reported that Staff #43 was no longer with the facility. 2.) On 2/29/24 at 8:55AM the surveyor observed the following active medical order in the medical record of Resident #39 for sliding scale insulin administration: Admelog SoloStar 100units/ml (Insulin Lispro) Inject as per sliding scale: if 0-200= 0 unit; 201-250= 2 units; 251-300= 4 units; 301-350= 6 units; 351-400= 8 units; 401+ = 0 units. Notify MD if less than 60 or greater than 400, subcutaneously before meals and at bedtime every Mon, Wed, Fri for diabetes. Upon further record review on 2/29/24 at 8:55AM the surveyor noted the resident's prior sliding scale insulin order directed that 10 units be given for a blood glucose of 400+, and 10 units was observed on the medication administration record for the month of January 2024 as having been administered to Resident #39 for a blood glucose of 400+, on 9 occasions. On 2/29/24 at 8:55AM the surveyor conducted an interview with the Director of Nursing (DON) who confirmed with the surveyor that the medical order for Admelog sliding scale insulin had a transcription error. Regarding the order directing zero units of Admeolg insulin to be given for a blood glucose of above 400, the DON reported to the surveyor: yes, this is incorrect. At this time, the surveyor shared the concern. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/24 at 9:04AM the surveyor again shared the concern with the DON, who acknowledged understanding of the concern.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 48168 Based on record review and interview it was determined that the facility failed to obtain the proper information for residents who received hospice services. This was evident for 1 (Resident #47) of 1 residents reviewed for hospice services during the recertification survey. The findings include: On 3/05/24 at 2:10 PM a review of Resident #47's electronic medical record revealed an order to admit the resident to hospice services on 5/18/23. No hospice documentation was found in the electronic medical record. On 3/06/24 at 11:29 AM a review of Resident #47's paper chart revealed that there was no Hospice Certification or Recertification forms, no hospice election form, and no hospice plan of care in the resident's record. On 3/06/24 at 12:01 PM in an interview with the Director of Nursing (DON), she was asked where the hospice certification, election form, and hospice plan of care could be found. The DON said that the hospice documentation should be in the resident's paper chart, and that she would look for these documents.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 15701 Based on observation and staff interview it was determined the facility failed: 1) to maintain 2 bathtubs in operating condition. This was evident during environmental rounds of the facility for 2 of 2 bathtubs found out of 4 observed bathing areas of the facility; 2) ensure lift equipment utilized for resident care was maintained in a safe condition for use. This was evident for 2 out of 2 lift devices observed during the survey. The findings include. 1. Environmental observations conducted on 3/5/24 at 2:26 PM in the 3A central bathing room found The Bather 2001 electronic jet tub with trash and a broom in the dirty tub. The tub was not in working condition. Observation of the 2A central bathing room found The bather 2001 in non-working order. On 3/8/24 at 10:39 AM the maintenance director (staff #10) confirmed the dirty non-operational electronic jet tub in the 3A central bathing room and per discussion he indicated that both electronic jet tubs did not work. On 3/12/24 at 3:45 PM, a concern related to the in operational tubs in the 3A and 2A central bathing rooms was shared with the nursing home administrator. 47200 2. On 2/23/24 at approximately 9:15AM the surveyor observed a hoyer lift (ultralift 3500x) located in the Unit 3, 3rd floor resident hallway with a cracked grey plastic covering over the base of the lift which had an approximately four inch long broken area with a sharp edge exposed and several additional jagged plastic edges. On 2/23/24 at approximately 9:15AM the surveyor conducted an interview with Staff #38, Unit Manager, Registered Nurse. The surveyor observed the hoyer lift condition with Staff #38, and further observed the controller for the lift (identified as 2B controller #10,) which had part of a medical glove box taped to it as a covering over a broken area. The surveyor directly shared their concerns with Staff #38 at this time who acknowledged that very much so, the lift was in an unsafe condition for use. The surveyor observed Staff #38 take a photograph of the broken hoyer base covering with a phone, and then physically remove the lift from the hallway, enter the elevator with it, and take it to the maintenance area on the first floor. Staff #38 reported the lift was removed from use. On 2/26/24 at 11:43AM the surveyor shared the concern with the Director of Nursing (DON) and Staff #11, Regional Corporate Nurse, at which time the DON communicated the following: The hoyer lift was taken down to maintenance and was taken out of commission. At this time, the DON and Staff #11 acknowledged understanding of the surveyor's concern and confirmed awareness of the sharp edges present on the lift. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 9:44AM the surveyor observed a different patient lift (labeled steady aid lift) located in the maintenance hallway on the first floor which had approximately a two inch broken area on the plastic base cover of the lift with an exposed sharp edge sticking upward. On 3/14/24 at 9:44AM the surveyor conducted an interview with Staff #10, Director of Maintenance. At this time, the surveyor shared the concern and inquired as to if they were aware of the sharp broken edge on the (steady aid lift) base cover, to which they replied they were not aware. Staff #10 further explained this lift was located there for a mechanical issue. When the surveyor inquired as to documentation that is kept of repairs made to equipment by the facility maintenance staff, they reported to the surveyor that records are not maintained of the repairs that the facility maintenance staff perform. When the surveyor inquired as to the status of the (ultralift 3500x) hoyer lift, Staff #10 reported it was taken off the nursing floor completely, and the equipment is kind of old and hard to acquire the parts for.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 43096 Based on documentation review and interview, it was determined that the facility failed to maintain an effective training program for new and existing staff. This was evident for Geriatric Nursing Assistant (GNA #50) and Registered Nurse (RN #53) of 8 employees' training records reviewed during this recertification survey. The findings include: 1) The surveyor review of staff training records on 3/13/24 at 11:05 AM revealed that GNA #50 was hired on 12/20/23, and the GNA facility orientation form (a checklist for care areas like resident care, mobility, devices, vital signs, infection control, others, and documentation with the completed date and observed person's signature) filled out on 1/08/24. However, the review revealed that some skilled areas did not have the completed date and signatures of the observed person. The blank session included, but was not limited to, nail care, suprapubic care, ostomy care, wheelchair seatbelt, lap buddy, side rails, temperature, feeding, meal set up, encouraging fluid intakes, thick liquids, intake/output, care of enteral residents, and documentation. During an interview with the Director of Nursing (DON) on 3/13/24 at 1:32 PM, the DON insisted that all new GNAs needed to complete a GNA facility orientation sheet to prove they were qualified to care for residents. The surveyor shared GNA #50's records with the DON. She said, GNA #50 can't work without completing this form. I will figure it out. The DON validated the surveyor's above concern. 2) A review of RN #53's employee file on 3/13/24 at 11:40 AM revealed that he/she was hired in June 2016. The file also contained RN #53's training records from the time of hiring. However, there were no additional records to support that he/she received training. During an interview with the Director of Nursing (DON) on 3/13/24 at 1:32 PM, the DON stated that all nurses are required to receive abuse, neglect, and exploitation training annually. The DON said, Maybe the HR (Human Resources) had RN #53's training records. I will double-check it. At 2:01 PM on 3/13/24, the DON and Staff #51 (HR) confirmed that RN #53 had not had any documentation for training since 2020. Staff #51 said, We had a new training program from 2020. I can review the data from 2020. I can't find any records for RN #53. Also, Staff #51 explained that the company's corporate education center assigns [computer-based training program] routinely, and HR pulled the entire staff's education record and reported them to each department supervisor. Staff #51 said, I just figured out RN #53 did not complete the required training. This is the first case of those who didn't receive timely training. I will follow up with the Nursing Home Administrator. On 3/13/24 at 2:30 PM, the DON validated the surveyor's concerns regarding RN #53's training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 43096 Based on a review of employee file documentation and interviews, it was determined that the facility failed to have a process to ensure all Geriatric Nursing Assistants (GNAs) have no less than 12 hours of education per year, and the education included annual dementia management training and resident abuse prevention training. This is evident for 1 (GNA #52) of 5 GNA employment files reviewed during this recertificate survey. The findings include: The surveyor reviewed randomly selected 5 GNAs employee files on 3/13/24 at 11:05 AM. The review revealed that GNA #52 was hired in October 2021. The file contained the staff who received training upon hire in 2023. However, there were no annual training records, including dementia management and resident abuse prevention, in 2022. During an interview with the Director of Nursing (DON) on 3/13/24 at 1:32 PM, the DON stated that the corporate office would assign employees' annual training through a computer-based training program and in-person training provided as needed. The surveyor shared GNA #52' s training records with the DON. The DON validated that GNA#52 did not have a required annual training in 2022.