STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215265	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Nursing and Assisted Living Center	710 Obrecht Road Sykesville, MD 21784

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of the medical record and interview with facility staff, it was determined the facility failed to ensure: 1) a psychotropic medication prescribed as needed (PRN), had an end date that was limited to 14 days, and 2) residents were free from unnecessary medications. This was evident for 2 (Residents # 29, #22) out of 5 residents reviewed for unnecessary medications during the facility's recertification/complaint survey. The findings include: The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at §483.45(c)(3), as any drug that affects brain activities associated with mental processes and behavior (CMS, 2023). These drugs include, but are not limited to, drugs in the following categories: anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications. These medications can have serious potential risks, including side effects, drug interactions, and the possibility of neuroleptic malignant syndrome (a rare but potentially life-threatening condition) or tardive dyskinesia (a movement disorder that can develop if you take an antipsychotic medication) therefore requiring careful consideration and monitoring. The Minimum Data Set (MDS) is administered to all residents upon admission, quarterly, yearly, and whenever a significant change in an individual's condition occurs. It is a standardized assessment tool to comprehensively evaluate a resident's health status, functional abilities, and needs. It is the foundation for creating a personalized care plan that drives care rendered by the healthcare team within a nursing facility. 1) Lorazepam, also known by the brand name Ativan, is a prescription medication classified as a benzodiazepine. It is commonly used to treat anxiety disorders and insomnia resulting from anxiety or temporary situational stress. On 5/29/2025, at 8:18 AM, a review of Resident #29's medical record revealed that the resident was admitted to the facility in January 2025 with diagnoses of dementia, depressive disorder, and anxiety disorder. Also, a review of Resident #29's May 2025 Medication Administration Record (MAR) showed an order for Lorazepam 0.5mg, one tablet by mouth as needed every 8 hours for anxiety, which began on 5/23/2025. (continued on next page)

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

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #29's order history indicated that PRN Lorazepam orders were continuously active from 3/28/2025, through 6/06/2025, with specific order periods including: 3/28/25 - 3/29/25, 3/29/25 - 4/11/25, 4/11/25 - 4/25/25, 4/30/25 - 5/08/25, 5/08/25 - 5/22/25, and 5/23/25 - 6/06/25. The MAR also documented that Resident #29 received Lorazepam regularly: almost once a day, and sometimes twice a day (6 administrations in March 2025, 33 in April 2025, and 17 in May 2025). On 5/30/2025, at 11:57 AM, a review of Resident #29's Psychiatric evaluation notes revealed that on 4/11/2025, Psychiatric Nurse Practitioner (Staff #7) documented: the patient has been requiring Ativan, which has been helping to alleviate anxiety. Based on this positive response, we have decided to continue Ativan for another two weeks . However, no additional evaluation regarding Resident #29's Lorazepam use was documented in their medical records after this date. During an interview with Staff #7 on 5/30/2025, at 11:57 AM, she explained that due to Resident #29's worsening anxiety and depression, PRN Lorazepam was deemed necessary. The surveyor clarified with Staff #7 that the order had been continuously placed as needed since March 2025 and administered almost regularly. The surveyor expressed concern regarding the lack of rationale and/or ongoing evaluation for the medication's continued use. During an interview with the Director of Nursing (DON) on 5/30/2025, at 1:07 PM, the surveyor shared concerns about the issues described above. The DON validated these concerns. 2) On 5/29/25 at 9:01 AM review of Resident #22's medical record revealed the resident was ordered the following psychotropic medication: Rexulti oral tablet 2 mg (milligrams), give 1 tablet by mouth one time a day for dementia with behavior. The medication was ordered on 4/27/25 by Psychiatric Nurse Practitioner (PNP #7). On 5/29/25 at 11:09 AM review of Resident #22's 4/24/25 MDS revealed the following questions and responses in Section E0200: Behavioral Symptoms - Presence & Frequency: 1. Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)- Behavior not exhibited. 2. Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others)- Behavior not exhibited. 3. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)- Behavior not exhibited. 4. Did the resident reject evaluation or care? Behavior not exhibited. 5. Has the resident wandered? Behavior not exhibited. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, no hallucinations or delusions were documented in this MDS assessment for Resident #22. On 5/30/25 at 10:03 AM review of Resident #22's orders revealed the following order dated 10/25/24: Monitor resident behavior every shift for presence of: 1. agitation 2. anxiety 3. depressed 4. hallucinations 5. restlessness 6. refusal of care 7. other, indicate pt (patient) behavior in PN (progress note) Admin Notes: Enter a number for behavior that occurred during the shift. The treatment administration record (TAR), where the behaviors for the above order would be documented, were reviewed for the months of February, March, April, and May 2025. As the order stated, behaviors were to be documented each shift, for a total of 3 opportunities each day for facility staff to observe and document behaviors for Resident #22, however, there was not one shift in the past 4 months where a behavior was documented and/or one progress note written for a behavior not listed in the order. On 5/30/25 at 11:13 AM in an interview with Unit Manager (UM #1), when asked to clarify the above order, she stated if a resident exhibited any of the behaviors listed, the nurse would document the corresponding number. For example, if a resident was observed with agitation, the nurse would document a 1and if a behavior was observed that was not listed in the order, the nurse would document 7 and write a progress note about the behavior observed. During the interview, a dual observation was conducted of Resident #22's April 2025 TAR. During the dual observation, the surveyor stated there were not any numbers, just check marks and UM #1 stated that meant there were no behaviors observed for this resident on that shift. On 5/30/25 at 11:16 AM Registered Nurse (RN #12) was interviewed. When asked if she had observed Resident #22 exhibiting any behaviors such as agitation, anxiousness, refusal of care or any other behaviors, RN #12 stated she had seen him/her exhibit behaviors such as being aggressive, yelling out, and screaming. During the interview, when asked the last time she witnessed Resident #22 exhibit any behaviors, she stated she last saw him/her exhibit behaviors about 2 months ago. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/25 at 12:06 PM PNP #7 was interviewed. During the interview when asked about Resident #22, she stated s/he had a history of dementia, confusion, and depression. Additionally, s/he was currently taking Zoloft and Rexulti for behavior management. The surveyor shared concerns that there were no behaviors documented in Resident #22's February through May 2025 TAR's and no behaviors documented in his/her 4/24/25 MDS, however the resident was ordered a psychotropic medication, Rexulti, on 4/27/25. PNP #7 stated that in the note she wrote on 4/25/25, Resident #22 was observed with increased agitation and confusion. When asked who observed the increased agitation and confusion, PNP #7 stated she did. When asked if she had observed behaviors from Resident #22 on another occasion, PNP #7 stated, no, and that one observation was not an indication for a resident to be ordered a psychotropic medication. PNP #7 confirmed understanding of the concerns.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of the medical record and interview with facility staff, it was determined the facility failed to provide written notice of the bed hold policy to the resident/resident representative when the resident was transferred to the hospital. This was evident for 1 (Resident #6) out of 2 residents reviewed for hospitalization during the recertification/complaint survey. The findings include: On 6/2/25 at 2:55 PM a review of Resident #6's medical record was conducted and revealed that the resident was transferred from the facility to a hospital on 5/19/25. Further review of the medical record failed to produce evidence that the resident was given written notice of the bed hold policy. On 6/2/25 at 3:13 PM the surveyor requested evidence that Resident #6 was provided with written notice of the bed hold policy. On 6/3/25 at 8:33 AM the NHA provided documentation to the surveyor. Review of the documentation revealed a progress note dated 6/2/25 that noted late entry and stated the resident and family were notified by the nurse and UM that s/he would be sent to the ER (emergency room) for evaluation of chest pain, and the bed would be held according to their request. Further review revealed a blank Bed Hold Notice that was completely blank and had no information completed on the form. Finally, a letter was reviewed that had handwritten on it, mailed to daughter. No date was identified in the letter. On 6/3/25 at 9:03 AM in an interview with the NHA he stated, the resident and/or resident representative should be given the bed hold policy before they head out the door for transfer. During the interview he stated that the facility keeps a copy of that bed hold policy they give to residents or resident representatives. The surveyor noted that a bed hold notice was provided however it was blank. When asked if he had a copy of the bed hold policy that was provided to this resident, Resident #6 he stated, we do not and was unable to produce written evidence that the resident /resident representative was given written notice of the bed hold policy. The surveyor shared these concerns and the NHA verbalized and confirmed understanding of the concerns.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interview with facility staff, it was determined that the facility failed to ensure that residents were provided with summaries of their baseline care plans including a list of their medications. This was evident for 1 (Resident #6) out of 30 residents reviewed during the facility's recertification/complaint survey. The findings include: A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and medication list must be given to each resident and/or his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. On 5/29/25 at 12:01PM in an interview with the Director of Nursing (DON) when asked who initiates and completes the BLCP, she stated the supervisor or Unit Manager and the nurse initiate and complete the BLCP. When asked what the timeframe for completion was the DON stated the same day as admission, unless it is the weekend and the expectation would be the next day. During the interview when asked why the BLCP was completed she stated it gives clear insight on how to proceed with patient care, make sure there is no gap between hospital care, and make sure we are not missing anything. On 6/2/25 at 9:11 AM, Resident #6's medical record was reviewed. The review revealed the resident was admitted to the facility on [DATE] but failed to reveal a BLCP or any evidence that Resident #6 had been provided with a summary of his/her BLCP along with a summary of his/her medications. On 6/2/25 at 9:31 AM the surveyor requested evidence Resident #6 received his/her BLCP including a list of medications within 48 hours of his/her admission date, 4/14/23. On 6/2/25 at 10:18 AM the DON provided the Peak-Peak Baseline Care Plans (V2) dated 4/14/23. The document had the date 4/14/23 circled however on page 8 of 8 in the Section, Signature of Resident or Representative it stated, I have received the above information and understand the content of this information. I understand any updated information will be communicated with me prior to, or at the care conference, after the comprehensive care plan is developed. and in the fields for resident signature and date and representative signature and date, both were blank. On 6/2/25 at 12:50 PM the surveyor requested any additional documentation that Resident #6 received his/her BLCP within 48 hours of his/her admission on [DATE]. On 6/2/25 at 1:55 PM during an interview with the Nursing Home Administrator (NHA), he stated there was no evidence that the resident received her BCLP within 48 hours of her admission date on 4/14/23.

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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. Based on a review of resident medical records and interviews with facility staff, it was determined that the facility failed to conduct care plan meetings of the interdisciplinary team for residents at the time of the quarterly revision of their care plan. This was evident for 4 (Resident #7, #12, #29, and #63) out of 6 residents reviewed for care plans during this recertification/complaint survey. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). 1) During a review of Resident #12's medical record on 5/29/25, at 9:49 AM, it was revealed that Resident #12's MDS assessments were completed on 7/14/24, 10/16/24, and 1/16/25, as quarterly assessments, and an annual assessment was completed on 4/16/25. The facility had a 'care plan conference sign-in sheet' which had undocumented dates, 11/12/24, and 2/13/25. Additionally, they had a care conference note documented on 11/12/24, in the progress note. However, the sign-in sheet did not match the MDS assessment timelines. 2) A review of Resident #29's medical record on 5/29/25, at 11:52 AM, revealed that the resident was admitted in January 2025, and an MDS assessment was completed on 3/04/25 (not due for quarterly assessment), with another quarterly assessment completed on 4/30/25. However, there was no documentation to support the facility held a care plan meeting with the resident and/or responsible party. 3) On 5/30/25, at 11:24 AM, the surveyor reviewed Resident #7's medical records. The review revealed that Resident #7 has resided at this facility for more than three years. The review of MDS assessments and care plan meetings from 2024 to current noted: MDS quarterly assessments were completed on 2/21/24, 5/21/24, 9/11/24, 12/12/24, 3/14/25, and 5/22/25. An annual review was completed on 6/18/24. However, there was only one note documented (dated 6/18/24) related to a care plan meeting with the resident's family member. 4) A review of Resident #63's medical record on 6/01/25, at 7:07 AM revealed that the resident was admitted in January 2025, and an MDS assessment was completed on 3/21/25. However, there was no documentation related to a care plan meeting. During an interview with the Director of Nursing (DON) on 6/02/25, at 8:43 AM, she explained that facility staff should conduct care plan meetings based on MDS assessments. She also stated that the MDS coordinator schedules these meetings, and the social worker should document them in the progress note. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 6/02/25, at 2:37 PM, the surveyor reviewed MDS assessments and care plan meeting records for Resident #7, #12, #29, and #63. The surveyor asked about the time windows for MDS assessment and care plan meetings. She said the MDS due date depends on the ARD date, which is 90-92 days. The surveyor asked if they needed to conduct a care plan review (including a care plan meeting) after the MDS assessment. The DON initially stated, MDS and care plan is two different thing not related. Then, she later said, I never said that it's not related. Another surveyor then asked how many days were allowed to follow up on a care plan review after an MDS assessment. She replied, I do not have the answers. I will ask the Social Worker who provided the documentation to you. In an interview with the MDS coordinator (Staff #30) on 6/04/25, at 2:43 PM, she explained that care plan meetings would be set up by social workers. These meetings would occur 72 hours upon admission, and every three months (quarterly, and/or for significant changes). She also explained that it is related to the MDS assessment, with care plan meetings expected to be held within 14 days after the MDS assessment. In an interview with the DON and Nursing Home Administrator (NHA) on 6/05/25, around 1 PM, the surveyor shared concerns regarding the facility's failure to conduct/document residents' care plan meetings in a timely manner. The DON validated the concerns.

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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. Based on review of medical records and interviews with facility staff, it was determined that the facility failed to follow physician orders for a resident. This was evident for 2 (Residents #6 and #22) out of 30 residents reviewed during the facility's recertification/complaint survey. The findings include: 1) The surveyor reviewed Resident #6's medical record on 5/28/25 at 1:20 PM. The review revealed the resident had weight loss from 11/1/24 - 12/6/24. Further review of the medical record revealed Resident #6 was ordered weekly weights one time a day every Sunday for 4 weeks on 12/6/24. Per the order, the first weight should have been obtained on 12/8/24; however, there was no weight observed in the medical record for this date. Furthermore, there was no weight obtained on 12/22/24. Only half, 2 out of 4 weights were obtained for this order. The other 2 weights from the order were obtained but were not obtained on Sunday as ordered. Additionally, Resident #6 was ordered weekly weights one time a day every Sunday for 4 weeks on 2/4/25. The 4th weight from that order should have been obtained on 3/2/25; however, there was no weight observed in the medical record for this date. There were weights from the remaining 3 Sundays; however, the weights were not obtained on Sunday as ordered. On 6/2/25 at 1:55 PM during an interview with the Nursing Home Administrator (NHA), a dual observation was conducted of the 12/6/24 weekly weights order and the corresponding weights from the order. The NHA verified and confirmed that the weights were not obtained timely and that there were weights not obtained as ordered (12/8 and 12/22). Additionally, a dual observation of the 2/4/25 weekly weights order and corresponding weights was conducted. The NHA verified and confirmed that the weights were not obtained timely and that there were weights not obtained as ordered (3/2/25). The surveyor shared concerns that there were missing weights and weights not obtained as ordered for a resident that had already been identified with weight loss. The NHA acknowledged understanding of the concerns. 2) The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. On 5/29/25 at 1:37 PM review of Resident #22's medical record revealed a medication regimen review was completed on 12/11/24 with irregularities noted. On 5/29/25 at 2:30 PM, the surveyor requested the pharmacist's recommendation from 12/11/24. On 5/30/25 at 11:56 AM review of the pharmacist's recommendation from 12/11/24 revealed the pharmacist recommendation was to consider ordering a serum magnesium level for Resident #22. Further review of the pharmacist's recommendation revealed the provider agreed with the recommendation as evidenced by their checking the agree box, signing, and dating the document on 12/13/24. On 5/30/25 at 11:56 AM review of Resident #22's medical record revealed an order dated 1/2/25 for a magnesium level. Further review of the medical record failed to reveal any magnesium lab results for this order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/25 at 1:00 PM the surveyor requested the magnesium lab results from the 1/2/25 order. On 6/2/25 at 10:14 AM in an interview with the Director of Nursing (DON), she stated there were no lab results (for the magnesium level) from the 1/2/25 order. The surveyor shared concerns that the order was not followed. The DON verbalized and confirmed understanding of the 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. Based on a review of resident medical records and interviews with facility staff, it was determined that the facility failed to ensure drug records were maintained in a manner that allowed for reconciliation of dispensed and administered medication. This was evident for 2 (Resident #29 and #165) out of 3 residents reviewed for administration of controlled medication during this recertification/complaint survey. The findings include: A controlled substance is a drug or chemical regulated by a government due to its potential for abuse, harm, or psychoactive effects. These substances are often classified into different schedules (or categories) based on their potential for abuse and accepted medical uses, including both illicitly used drugs and prescription medications designated by law. 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. Oxycodone is a narcotic medication, which is a controlled substance, used to treat moderate to severe pain. Lorazepam, also known by the brand name Ativan, is classified as a Schedule IV controlled substance. It is a prescription medication classified as a benzodiazepine. It is commonly used to treat anxiety disorders and insomnia resulting from anxiety or temporary situational stress. On 5/30/25 at 10:57 AM, the surveyor reviewed the medical records of two randomly selected residents (Resident #29 and #165), comparing their Medication Administration Records (MAR) with their count sheets. 1) Resident #29 had order of prescribed medication Lorazepam 0.5mg oral as needed for anxiety. Review of Resident #29's MAR for May 2025 and his/her Lorazepam count sheet noted discrepancies. - The count sheet recorded Lorazepam 0.5 mg as administered on 5/24/2525, at 7 PM; however, no corresponding documentation was found in the MAR. - The count sheet documented Lorazepam 0.5 mg as administered on 5/30/25, at 1 AM; however, no record was found in the MAR. 2) Resident #165 was admitted to this facility in May 2025 for recovery from a right acetabulum (a concave surface of the pelvis) fracture. The resident had two separate orders for pain management: Oxycodone 5 mg, one tablet by mouth every 4 hours as needed for moderate pain; and Oxycodone 5 mg, two tablets (total dose 10 mg) by mouth every 4 hours as needed for severe pain. A review of Resident #165's MAR and Oxycodone count sheet revealed discrepancies: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The count sheet documented Oxycodone 10 mg administered on 5/23/25, at 9:30 AM; however, no records were found in the MAR. - The count sheet documented Oxycodone 5 mg administered on 5/23/25, at 1:25 PM; however, no documentation was found in the MAR. - The count sheet recorded Oxycodone 10 mg given on 5/27/25, at 4 AM; however, no documentation was found in the MAR. - The count sheet recorded Oxycodone 5 mg as given on 5/27/25, or 5/28/25, at 2 AM. The handwritten number for the date looked like a 27 or 28, with the top part of the second digit clearly resembling a 7, but its bottom curve extended into a closed loop, giving it the appearance of an 8. However, there was no record for Oxycodone 5 mg administered on either 5/27/25, or 5/28/25, at 2 AM in the MAR. - The count sheet showed that one tablet of Oxycodone 5 mg was given on 5/30/25, at 4 AM; however, the MAR only showed 10 mg of Oxycodone administered on 5/30/25, at 10:48 AM. This did not allow for reconciliation of the time and dose. During an interview with Licensed Practical Nurse (LPN #29) on 5/30/25, at 8:35 AM, the nurse stated that controlled medication administrations require documentation on both the count sheet and the MAR with accurate date and time. During an interview with the Director of Nursing (DON) on 5/30/25, at 12:46 PM, she confirmed that controlled medication administrations by facility nurses must reconcile with both the count sheet and the MAR. The surveyor reviewed Resident #29's and #165's medical records (MAR) and shared concerns regarding the discrepancies in these two sets of documentation. The DON validated these concerns.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on medical record review and interviews with facility staff, it was determined that the facility failed to document/respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 1 (Resident #1) out of 5 residents reviewed for unnecessary medication use during this recertification/complaint survey. The findings include: During an interview with the Director of Nursing (DON) on 5/29/2025, at 9:16 AM, she explained the procedures for obtaining medication orders for residents. She stated, When we get a new admission, the admitting nurse enters the medications. Supervisors review the medications, and the pharmacist reviews them within 2-4 hours. A report is then sent through their website. If drug interactions are noted, they are sent via email to the provider and DON. Then, I print and give them to the provider for review and sign-off. I hand it to the provider, and the provider reviews it. They agree, disagree, or note 'other,' then sign/date and provide a rationale for disagreement. The surveyor asked how the facility staff documented these recommendations. The DON stated she placed them in the pharmacy recommendation binder in her office, not in the resident's paper chart or in [name of electronic medical record cloud]. The surveyor also inquired about the timeline for the provider addressing the pharmacy recommendations. The DON confirmed that they were expected to be completed within 72 hours. On 5/29/2025, at 9:29 AM, the surveyor reviewed Resident #1's medical record. The review revealed that the Monthly Medication Review (MRR) dated 4/07/2025, was documented as 'yes' for the question, A medication regimen review was completed; any irregularities noted during review? However, there was no documentation to support the pharmacy's recommendation or the action taken by the facility staff. On 5/29/2025, at 9:52 AM, the DON presented the Pharmacy recommendation binder. The binder contained several communication forms between the pharmacy and the facility. The DON stated she printed out all emails from the pharmacy, including residents' MRRs. The surveyor asked the DON to find Resident #1's MRR for April 2025. She searched through the binder twice but found no documentation. At 10:01 AM, the DON said, I can't find it. I will contact [name of facility attending doctor] to find it. In a subsequent interview with the DON on 5/30/2025, at 2:40 PM, she confirmed that Staff #7 (Psych Nurse Practitioner) held Resident #1's MRR for April 2025 until the previous day (5/29/2025). She then produced a copy of Resident #1's MRR, signed by Staff #7 on 4/11/2025, which concerned eligibility for GDR (Gradual Dose Reduction). The surveyor expressed concern that prior to the surveyor's intervention, there was no documentation to support that an MRR had been reviewed and/or that the facility had responded to it. The DON validated this concern.

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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. Based on clinical record review and staff interview, it was determined that the facility nursing staff failed to ensure medications were administered or withheld according to physician's orders. This was evident for 2 (Resident #3 and #28) out of 30 residents in the survey sample. The findings include: 1) A review of Resident #3's clinical record on 6/4/25 revealed the resident's primary physician ordered Metoprolol (cardiac medication) 50 mg (milligrams) to be administered twice a day and to hold for a systolic blood pressure (top number) of less than 110 or a heart rate less than 60. A review of the resident's medication administration record (MAR) on 5/14/25 revealed the nursing staff took the resident's blood pressure, and it was 109/76 which meant the medication was to be held but the nurse administered the medication. On 5/24/25, the nursing staff did not take the resident's blood pressure in the morning but still administered the medication despite the physician having ordered parameters that instructed the nurse whether to hold the medication. Further review of the clinical record revealed there were no progress notes explaining why the nurse administered the medication on 5/14/25 and 5/24/25. The Director of Nursing was interviewed on 06/05/25 at 10:39 AM. She was shown the MAR and the errors. She acknowledged the finding, and she said she thinks she educated staff already for this issue but was not sure which month she had reviewed with them. 2) A review of Resident #28's clinical record on 6/4/25 at 11:14 AM revealed the resident's primary physician ordered Oxycodone (pain medication) 5 mg to be administered every 6 hours as needed for pain if the resident rates pain level as being between 5 and 10 on a 0 to 10 scale and to hold for sedation, decreased respirations, or altered mental status. A review of the resident's Medication Administration Record (MAR) revealed the resident rated their pain level as a 4 on 5/21, 5/25, and 5/28 but received the medication anyway. The Director of Nursing was interviewed on 06/05/25 at 10:39 AM. She was shown the MAR and the days the resident was administered the medication even while outside of the ordered parameters. She acknowledged the finding, and she said she thinks she educated staff already for this issue but was not sure which month she had reviewed with them.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, and staff interview, it was determined that the facility staff failed to ensure a resident received routine dental services. This was evident for 1 (Resident #3) out of 30 residents in the survey sample. The findings include: Resident #3 was interviewed on 5/28/25 at 9:11 AM. The resident was asked if they have been seen by a dentist since admission and if they are having any dental issues such as a suspected cavity, tooth pain, or a cracked tooth. The resident said they have never been to a dentist, and they have issues with their teeth and would like someone to take care of it. A review of Resident #3's clinical revealed that the resident was admitted on [DATE] and has never been seen by a dentist. The Director of Nursing was interviewed on 06/04/25 at 08:45 AM. This surveyor had requested all dental consults since Admission. She informed the surveyor that there were no dental consults in the clinical records because the resident did not have any problems. This surveyor told her that the resident said they had issues with their teeth and wanted them taken care of. She replied that she was unaware that the resident wanted to see a dentist. The surveyor stated that the resident should have had routine dental visits not just when there was an issue.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined that the facility staff failed to discard protein drinks past their use by date. This was evident for 2 out of 3 unit-based kitchens observed during the recertification/complaint survey. The findings include: During the tour of the kitchen on the Eastern Shore nursing unit on 6/4/25 at 10:08 AM two 4-ounce cartons of vanilla reduced sugar Mighty Shake (a fortified nutritional shake) were observed in the refrigerator. The cartons had a use by date of 5/30/25. Staff #21 was shown the shakes, and she said, I'll take care of it. She then appeared to put them back in the refrigerator. During the tour of the kitchen on the Baltimore nursing unit that served the lower numbered rooms on 6/4/25 at 10:14 AM one 4-ounce carton of vanilla reduced sugar Mighty Shake (a fortified nutritional shake) was observed in the refrigerator. The carton had a use by date of 5/30/25. Staff #22 was shown the shake, and he immediately threw it out. The Dietary Manager (Staff #20) was interviewed on 6/4/25 at 2:07 PM. This surveyor informed her that the containers of Mighty Shake were past the use by date. She asked, what they did with the containers. This surveyor said the staff in the Baltimore nursing unit (lower numbers side) immediately threw it out. The staff in Eastern Shore said, I'll take care of it and appeared to put them back in the refrigerator. Staff #20 said, I'll check to see if they were thrown out. The Dietary Manager came to the conference room on 6/4/22 at 2:22 PM and informed the survey team that the Mighty Shakes had been discarded by the staff person.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and staff interviews, the facility failed to adequately monitor and track residents receiving antibiotics. This deficiency was evident for 2 (Resident #22 and #166) out of 4 residents reviewed for antibiotic use and the facility's antibiotic stewardship program during the recertification/complaint survey. The findings include: Background on Antibiotic Stewardship: Effective antibiotic stewardship requires a facility to develop and implement robust policies, procedures, or protocols to ensure residents needing antibiotics are treated appropriately. This is crucial for minimizing the risk of adverse drug reactions, preventing unnecessary antibiotic administration, and mitigating the development of antibiotic-resistant organisms. A facility-wide process for monitoring antibiotic use is essential, with results and feedback consistently reported to nursing staff and prescribing clinicians. On 6/02/2025, at 12:04 PM, during an interview with the Director of Nursing (DON), who also serves as the Infection Control Preventionist, she stated that the facility had an antibiotic stewardship program. The DON indicated that residents' antibiotic use was discussed in daily clinical meetings, weekly risk meetings, and monthly Quality Assurance and Performance Improvement (QAPI) meetings. On 6/03/2025, at 8:11 AM, the surveyor reviewed the facility's antibiotic stewardship binder. This binder contained policies, analytical data, and several printed antibiotic stewardship records with varying formats: a) Nursing home antimicrobial stewardship guide - Monitor & sustain stewardship: This document included fields for resident name, room number, admission date, admission source, onset date, type of infection, signs and symptoms, diagnostic tools used (and criteria met), HAI/CA/NHA/other nosocomial designation, X-ray or lab results, prescribing clinician, prescription date and duration, antibiotic name, and Rx number. However, this documentation frequently had blank sections from admit date to x-ray or lab result. b) Weekly antibiotic starts: This record listed the month, week ending date, number of new antibiotic starts, total number of residents on antibiotics, and the number of residents admitted with an antibiotic prescription. c) Weekly antibiotic starts, weekly starts details: This document included patient name, date written, drug label name, directions, and prescribers. Notably, it lacked critical additional information such as start and end dates, lab results, and signs and symptoms. During an interview with the DON on 6/03/2025, at 9:28 AM, the surveyor questioned the lack of detailed information for residents on antibiotics within the facility's stewardship binder. The DON responded, the binder was from the pharmacist, not what I used for review. I reviewed them in our meetings (clinical, risk, and QAPI). The surveyor then requested the data discussed in these meetings. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:29 AM on 6/03/2025, the DON provided the Copper Ridge nursing weekly risk meeting minutes binder. A review of this binder revealed weekly risk meeting notes with an antibiotics section that included residents' names and diagnoses. However, crucial details such as lab results, the specific name of the antibiotic, signs and symptoms, duration of use (start and end dates), and documented side effects were absent. At 11:20 AM the same day, the DON stated that the facility's medical director utilized the [Name of Electronic Medical Records System] dashboard to review each resident's antibiotics during their meetings. She further commented, we reviewed through electronic record, I don't get why it needed to be documented our meeting minutes again. On 6/03/2025, at 11:49 AM, a review of antibiotic documentation for four residents was revealed that: - Resident #22 was prescribed Cephalexin 500mg once a day for a Urinary Tract Infection, effective 5/15/2025. This antibiotic use was not listed in the facility's risk meeting minutes. - Resident #166 had an order for Levofloxacin 750 mg once a day for a Urinary Tract Infection, effective 5/03/2025. This antibiotic use was also not listed in the facility's risk meeting records. During an interview with the DON on 6/03/2025, at 2:31 PM, the surveyor expressed concern regarding the inadequate monitoring of residents' antibiotic use. The DON validated these concerns.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on medical record review and staff interviews, the facility failed to adequately screen residents for eligibility and document their pneumococcal and influenza (Flu) vaccination status. This deficiency was evident for 2 (Resident #29 and #54) out of 5 residents whose immunization records were reviewed during this recertification/complaint survey. The findings include: Pneumococcal Vaccine: The pneumococcal vaccine helps prevent pneumococcal disease, an illness caused by Streptococcus pneumonia bacteria. The Centers for Disease Control and Prevention (CDC) recommends this vaccine for individuals aged 65 years or older, and for adults aged 19 through 64 with certain medical conditions or risk factors. Influenza (Flu) Vaccine: Flu is a contagious respiratory disease that spreads annually, typically between October and May. While anyone can contract the flu, it poses a greater risk to certain populations, including infants and young children, individuals 65 years and older, pregnant individuals, and those with specific health conditions or weakened immune systems. Influenza vaccines are effective in preventing influenza. 1) On 6/02/2025, at 10:00 AM, a review of five randomly selected resident immunization records revealed that Resident #29, admitted in January 2025, had no documented record for either the Flu or Pneumococcal vaccine. During an interview with the Director of Nursing (DON) on 6/03/2025, at 9:18 AM, she confirmed that if a resident was admitted in January, facility staff should have offered the Flu vaccine. The DON also explained that if a resident is a candidate for the Pneumonia vaccine, staff should obtain their vaccination status upon admission. The surveyor then reviewed Resident #29's vaccination records with the DON, who confirmed the lack of data for both Flu and Pneumococcal vaccines for this resident. 2) On 6/02/2025, at 10:20 AM, a review of Resident #54's vaccination record indicated that the resident was admitted in May 2025. However, there was no documentation of their pneumococcal vaccine status. In an interview with the Director of Nursing (DON) on 6/03/ 2025, at 9:22 AM, the surveyor inquired about Resident #54's pneumococcal vaccine status. The DON stated, I will look more. However, no additional documentation was subsequently provided to the surveyor.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on medical record review, staff employee file review, and staff interview, it was determined the facility failed to maintain document related to residents' and staff' COVID-19 vaccination status. This was evident for 2 (Resident #3 and #54) out of 5 residents, and 1 (Staff #16) out of 5 staff reviewed for COVID vaccination records during this recertification/complaint survey. The findings include: 1a) On 6/2/2025 at 10:00 AM, a review of 5 randomly selected resident immunization records revealed that Resident #54, admitted in May 2025, did not have his/her COVID-19 vaccination status in their medical chart. During an interview with the Director of Nursing (DON) on 6/2/2025 at 1:19 PM, the DON stated that the facility monitored resident immunization status through ImmuNet (Maryland's immunization information system), hospital records, and direct communication with residents or their family members. When questioned about Resident #54's COVID-19 vaccination status, the DON responded, I will look more. Subsequent review of Resident #54's medical record progress note on 6/5/2025 at 10:39 AM, indicated that facility staff contacted the resident's Responsible Party regarding their COVID-19 vaccine on 6/2/2025 at 3:37 PM. This action occurred after the surveyor's intervention. Additionally, the immunization tab within the electronic medical record was updated on 6/2/2025. 1b) On 6/2/2025 at 10:30 AM, a review of resident immunization records showed that Resident #3, admitted in August 2023, had refused the COVID-19 Pfizer Booster on 3/21/25. However, documentation for primary COVID-19 vaccination status was absent from their electronic medical records. During an interview with the DON on 6/2/2025 at 3:03 PM, the surveyor discussed Resident #3's COVID-19 vaccination status. Given that the refusal form was signed on 3/21/2025: 25 months after the resident's admission date, the surveyor requested supporting documentation to explain the delay in follow-up. The DON stated she would investigate further, but no additional documentation was provided to the surveyor. 2) On 6/2/2025 at 2:00 PM, a review of 5 randomly selected employee health files revealed that Staff #16, hired in December 2024 for direct resident care, lacked documentation supporting their COVID-19 vaccination status. On 6/2/2025 at 2:30 PM, the DON provided a vaccination declination form for Staff #16, signed on 6/2/2025. The surveyor informed the DON that this did not demonstrate the facility's awareness of Staff #16's COVID-19 vaccination status at the time of hire. On 6/3/2025 at 9:28 AM, the DON validated these concerns when reviewed by the surveyor.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interviews, it was determined that the facility failed to ensure that all residents were adequately equipped with the ability to call for assistance, if needed, through a communication system. This was evident for 1 (Resident #58) out of 4 resident rooms assessed for call light accessibility during the recertification/complaint survey. The findings include: On 5/28/25 at 8:47 AM, during the initial screening phase of the survey process, it was observed that Resident #58's call bell was on the floor in the resident's room and unreachable for the resident when laying in bed. On 6/3/25 at 10:26 AM, an observation of Resident #58's room revealed that the resident's call bell remained out of reach. The call bell was wedged under the resident's wardrobe. In an interview with Certified Medication Aide (CMA #25), she was made aware of Resident #58's call bell location. CMA #25 attempted to remove the call bell from the floor; however, she stated that she was unable to remove the wedged call bell, but would notify maintenance to address the concern. On 6/5/25 at 10:30 AM, in an interview with the Nursing Home Administrator (NHA), he was notified that Resident #58's call bell was out of the resident's reach since the start of the survey process on 5/28/25.