STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solomons Nursing and Rehab Center	13325 Dowell Road Solomons, MD 20688

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49148 Based on observation, interview with staff, and record review it was determined that the facility failed to: 1) ensure a resident has a call bell within reach and is able to use it if desired and, 2) provide reasonable accommodations for a resident to assist with mobility. This was evident for 1 (Resident #44) observed during a tour of the facility and 1 (Resident #300) out of 2 residents reviewed for accommodations. The findings include: 1) On 8/8/2024 at 8:14 AM, the Surveyor observed Resident #44 laying in their bed and the call bell on the floor at the foot of the bed. The Surveyor expressed this concern with Licensed Practical Nurse (LPN) #16, who stated she would take care of it. On 8/9/2024 at 8:00 AM, the Surveyor observed Resident #44 laying in their bed. The Surveyor asked Resident #44 where his/her call bell was in case he/she needed to call for assistance. The resident stated he/she did not know. The Surveyor observed the call bell on the floor at the foot of the bed. On 8/9/2024 at 8:10 AM, the Surveyor informed LPN #16 of the second observation. The Surveyor observed LPN#16 clean the call bell and place the call bell on the bed next to the resident. LPN #16 confirmed that Resident #44 should have a call bell within reach. 44440 2) On 8/27/24 at 1 PM, the surveyor reviewed Resident #300's medical record. The review revealed that Resident #295 had a past medical history which included, but not limited to, surgical amputation, muscle weakness, unsteadiness on feet, and need for assistance with personal care. On further review a care plan was initiated for Resident #300 on 3/16/24 stating; Resident is a potential/actual rehabilitation candidate related to recent amputation. One of the interventions listed was to refer Resident to Physical Therapy (PT), Occupational Therapy (OT) and Speech to improve resident mobility, transfer, strengthening as recommended post evaluation. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor review of Occupational Therapy (OT) notes from a session dated 3/16/24 in which the OT documented, patient completed rolling to both sides with maximum assistance of 2, no bed rail available, requiring total dependence to maintain side lying to decrease caregiver burden during Activities of Daily Living (ADL)s. On a note written on 3/21/24 the OT wrote, the daughter voiced concerns that the patient does not have bedrails to assist during bed mobility, ADLs and pressure relief. The note further stated that the OT notified the team and daughters that an order for maintenance for bilateral bedrails had been placed on 3/16/24. The OT's follows by writing that the maintenance team stated they did not have bedrails available and had ordered them with a pending order. On 3/28/24 at 11:22 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the surveyor asked if a resident needed bedrails would they be available. The NHA stated the facility had recently ordered more. He recalled that all the rails were in use when Resident #300 needed them and that 10 more rails were ordered. He stated he would look for the invoice. Following the interview at 11:28 AM, the surveyor received an invoice for 10 bedrails dated 4/3/24. The surveyor voiced the concern to the NHA that the need for the bedrails was identified on 3/16/24 and the order was not placed until 4/3/24.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 42828 Based on observations and interviews it was determined that the facility failed to ensure information related to the Resident's [NAME] of Rights, including but not limited to the name and contact information of the Maryland's Long-Term Care Ombudsman program and a statement informing residents that they may file a complaint with Maryland's Survey Agency concerning any suspected violation of state or federal nursing facility regulation, was posted in easily viewed and accessible locations. This was found to be evident on all units/halls with resident care areas. The findings include: On 08/20/24 at 12:05 PM the surveyor toured all units with resident care areas in the facility. Observation of the Chesapeake, Patuxent, The Lodge, and Rehab area revealed that there were no signs posted showing the Residents [NAME] of Rights, information on how to contact and/or make a complaint to the state survey agency and the ombudsman office at the Department of Aging. During an interview with Staff #10 on 08/20/24 01:10 PM, the surveyor asked Staff #10 if there were any Resident Rights or information on filing a complaint with the State Survey Agency posted on the unit/halls. Staff #10 responded, We had them up at one point but must have been taken down when renovations began a year ago. On 08/20/24 at 01:21 PM the Nursing Home Administrator (NHA) provided the notice of Resident Rights poster to the survey team and said that he just located it and will post it in the hallway between the two units- opposite the main dining area. During an environmental tour of the facility on 8/21/24 9:45 AM the surveyor observed the required postings located on the wall between the two units- opposite the main dining area.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 42828 Based on observation and interview, it was determined that the facility staff failed to display the results of the annual recertification survey and plan of correction in a place readily accessible to residents, family members, and legal representatives. This was evident in 1 of 1 survey results book posted in the facility. The findings include: Surveyor observation of the lobby on 8/6/24 at 9 AM and 8/7/24 at 7:15 AM revealed no evidence of the survey inspection results in an open and readily accessible area for residents, staff, and visitors to review and a tour of the facility did not reveal any signs posted telling residents where the state survey results were located. On 8/7/24 at 7:30 AM an interview with the Director of Nursing (DON) revealed the Survey Results binder was located in the Nursing Home Administrator's (NHA) office. The DON confirmed the book would be provided to the survey team upon the NHA's arrival to the facility. On 8/7/24 at 8: 00 AM, the Nursing Home Administrator provided the survey team with the Survey Results binder. The NHA stated the book may have been removed from the reception area due to rennovations conducted at the facility. An interview with the DON on 8/7/24 9 AM revealed that staff failed to place the results of survey inspections in a place easily accessible to any persons to be reviewed. On 8/8/24 8 AM The surveyor observed the survey results in a binder on a table in the reception area with a sign that stated: Survey Results. Further inspection of the binder revealed the most recent survey results were the recertification survey on 9/13/2019.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review and interview with staff, it was determined that the facility failed to have a system in place to ensure that copies of the resident's Advanced Directives have been obtained and maintained in the resident's medical record. This was evident for 3 (Resident # 8, #70 and #291) out of 4 residents reviewed for Advanced Directives. The findings include: An Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. 1) On 8/8/2024 at 12:05 PM, a review of Resident #70's electronic and paper medical record, revealed no documents that indicated the resident's written Advanced Directive. On 8/13/2024 at 11:31 AM, the Surveyor conducted an interview with the Director of Social Services, Social Worker (SW) #17. SW #17 informed the Surveyor that she interviews the resident and/or resident representative and completes a Social Services Admission assessment within the electronic medical record. SW #17 continued, if the resident has an Advanced Directive on admission, she will get a copy from the resident or resident representative and review it. Subsequently, a copy of the Advance Directive will be imported into the electronic medical record as well as the paper chart under the Advance Directive tab. Durable Power of Attorney (DPOA) is a document that allows a person to choose someone to make health care decisions for them when they cannot make health care decisions for themselves. On 8/14/2024 at 9:18 AM, a review of Resident #70's Social Services Admission assessment filled out by SW #17, revealed that the resident had an Advance Directive and an appointed health care agent. During additional record review, the Surveyor identified a facility contract within the resident's electronic medical record which revealed that Resident #70 had a Durable Power of Attorney. On 8/15/2023 at 9:16 AM, during an interview with SW #17, the Surveyor was informed that she does not follow up with the resident or the resident representative when they do not provide the facility with a copy of the Advance Directive at admission or once an Advance Directive is executed. The Surveyor informed SW #17 that Resident #70 did not have a copy of his/her Advance Directive in his/her electronic or paper medical record even after the facility identified that the resident possessed one. On 8/15/2024 at 10:51 AM, the Director of Nursing (DON) confirmed that Resident #70 had a DPOA. The DON retrieved a copy from the resident representative, placed a copy in the resident's medical record, and provided the Surveyor with a copy. 50504 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #8 was admitted on [DATE] with diagnoses including Chronic Pain Syndrome, Altered Mental Status, Interstitial Pulmonary Disease and Atrial Fibrillation. Upon review of Resident #8's medical record on 08/12/24 at 09:47AM, the surveyor observed a copy of Resident #8's Maryland Medical Orders for Life-Sustaining Treatment (MOLST) dated 07/03/24. The surveyor did not observe a copy of the resident's Advance Directive in the medical record or documentation to show that an attempt was made to obtain the document. In an interview on 08/13/2024 at 11:31 AM to explain the facility's Advance Directive process, the Social Worker stated when a resident is admitted to the facility, during my initial assessment and the care plan meeting, I ask if they have an Advance Directive. If the resident has an Advance Directive, I get a copy and review it to make sure it matches the MOLST . If the resident has an Advance Directive, it will be found in the Electronic Health Record (EHR) and in the chart behind the Advance Directive tab. On 08/13/24 at 01:16 PM the surveyor reviewed Resident #8's Initial Admission Assessment completed by the Social Worker on 07/08/22. Under Section B Health Care Decision, it was documented that Resident #8 had an Advance Directive. The surveyor notified the DON on 08/14/24 at 1:09 PM that Resident #8's Advance Directive was not located in the medical record. The DON provided the surveyor with a copy of the MOLST dated 07/03/24. The DON did not provide the surveyor with a copy of Resident #8's Advance Directive. 44440 3) On 8/20/24 at 12:18 PM, the surveyor reviewed Resident #291's medical record. The review revealed that Resident #291 was admitted in late January 2023. Further review revealed that Resident #291 had a past medical history that included, but not limited to, dysphagia (difficulty swallowing), dysphonia (disorder of the voice), muscle weakness, unsteadiness of feet and need for assistance with personal cares. On further review a physician certification related to medical condition, substitute decision making and treatment limitation form was filled out for Resident #291. The attending physician checked the box stating, based on this examination, I hereby certify that this resident is; Capable of making an informed decision. This certification was dated 1/25/23. Next the surveyor reviewed the speech therapy notes. The review revealed that Resident #291 started working with speech on 1/25/23 and had a goal of resuming the least restrictive diet. In several of the early speech notes the therapist wrote that a family member continued to bring in thin liquid for Resident #291 even though Resident #291 was ordered to have a nectar thick liquid consistency and at one point an even thicker honey consistency. The note described that the Speech Therapist explained the risks and danger of consuming a consistency too thin when a Resident, with a compromised swallow, consumes thin liquids. The risks were noted as the resident could aspirate (when something enters the airway or lungs by accident) liquids potentially causing pneumonia. On further review a note written on 3/1/23 by the Speech Therapist stated, the patient reported I want you to [tell] them not to thicken my drinks anymore. Again in the note the Speech Therapist described explaining the risks to the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On review of Resident #291's medical record there was no discussion or meeting with the resident's primary care physician or interdisciplinary team to address Residents #291's desire to discontinue the thickened liquid treatment. On review of the grievance note written by Social Worker #17, Resident #291 stated he/she wanted to sign a waiver so that he/she could have thin liquids. On 8/21/24 at 10:18 AM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the NHA stated he was aware that Resident #291 did not want to continue the thickened liquid and that the family would bring him/her thin liquids in which he/she would drink with the family. The surveyor asked if a resident had the right to discontinue treatment he/she did not want. The NHA stated that a Resident has that right if they are deemed competent. He further stated he was unaware if this resident was competent however could recall that the Speech Therapist was very concerned about the resident aspirating and would not recommend thin liquids. He stated that Resident #291's desire to stop the thickened liquid was not discussed with Risk Management or the facility's Medical Director and no arrangement was made to address Resident #291's desire to discontinue thickened liquids.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42828 Based on resident and staff interviews, review of facility grievance logs, and resident medical records it was determined that the facility failed to protect residents from physical and verbal abuse. This finding was evident for 3 out of 9 residents (#58, #291, and # 18) reviewed for abuse. The Maryland Office of Health Care Quality (OHCQ) determined that this concern met the Federal definition of Immediate Jeopardy, and the facility was notified in writing of this determination at 6:00 PM on 8/23/24. The facility submitted an abatement plan to remove the immediacy while surveyors were on site. The abatement plan was accepted by the OHCQ at 11:30 PM on 8/23/24. The findings include: 1. On 8/19/24 at 11:00 AM, an interview with the Ombudsman revealed that Resident #58, reported that GNA/CMA #19 screams at him/her (Resident #58) a lot. The resident could not recall the correct pronunciation of GNA/CMA #19's name but he/she could identify her. The Ombudsman stated that they got permission from Resident #58 to speak to the surveyors. On 8/19/24 at 11:40 AM the surveyor observed Resident #58 sitting in a wheelchair, in the hallway near the nurse's station with a cup of coffee. The surveyor asked if they could have a moment to talk. Resident #58 agreed to speak with the surveyor and went to an empty open office near the nurses' station. Resident #58's coffee spilled and GNA/CMA #19 came into the office to help Resident #58 cleanup the spill on his/her clothes. After GNA/CMA #19 left the room, Resident # 58 said she (GNA/CMA #19 is the one I have a problem with. I am the only one she does not treat well. I have not noticed her treat anyone the way she treats me. The surveyor asked the resident to explain his/her statement. Resident #58 stated last week, (could not remember the day), my roommate was confused and wanted to go home. My roommate argues with me all the time. I pulled the curtain in my room to get my privacy, and my roommate pulled it back, so we got into it by exchanging words. [GNA/CMA #19] came into my room, put her face in my face and started hollering at me. I hollered right back at her. I feel disrespected and abused because she has no right to get in my face like that. On 8/19/2024 at 12:15PM the surveyor reported the incident to the Director of Nursing (DON) who stated that it was the first time she was hearing about it and would start an investigation. Review of Resident #58's medical record revealed a care plan created on 1/11/23 that stated Resident #58 has activities of daily living (ADL) limitations/deficits requiring staff assistance of 1 person for toilet use and transfers between surfaces. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/19/23 12: 45 PM Surveyors reviewed the grievance logs from 2023 through 2024. During review of the 2023 grievance binder, a grievance dated 5/18/2023 written by the Director of Social Work, (SW) #17, stated: on 5/18/23 around noon, I was walking past the Patuxent nurse's station when I heard loud yelling. I looked over and saw [GNA/CMA #19] beside the med cart and [Resident #58] sitting in his/her wheelchair. [GNA/CMA #19] was yelling at [Resident #58] about something. I can't recall what she was saying because I was so shocked to hear her yelling so loud. Further review of the grievances revealed another grievance dated 4/27/23, involving Resident #58. The person voicing the concern was Resident #58 who stated they felt that staff were always rushing when providing care for him/her. The resident said that when staff wake them up in the morning, they do it by hollering at them. Surveyors held an interview with SW #17 on 8/22/24 at 11:15 AM. Surveyors reviewed the grievances dated 5/18/23 and 4/27/23 with SW #17. SW #17 confirmed that she witnessed and documented the incident of verbal abuse when GNA/CMA #19 yelled at Resident #58 on 5/18/23 and she documented Resident #58's concerns on 4/27/23 about staff hollering at him/her. When surveyors asked SW #17 to describe the facility's grievance filing process, she stated that she is the grievance officer and the process is to type the concerns, log them, and then send the grievance document to the DON and the Nursing Home Administrator (NHA). Then she assigns the grievance to the appropriate department supervisor for review and action. When surveyors asked SW #17 what happened after the grievances had been assigned, she stated that she was not given any results or resolutions nor was she responsible for following up with the grievances. SW #17 went on to say that the grievances dated 5/18/23 and 4/27/23, were given to the Unit Manager at the time, Assistant Director of Nursing (ADON), Staff #3, with a copy to the prior DON, Staff #34, and the NHA. Review of the grievances dated 5/18/23 and 4/2723 showed that the DON/UM was denoted as the assigned department supervisors to address the grievance. Later during the interview, SW #17 confirmed that the witnessed verbal abuse (Resident #58) on 5/18/23, the grievance on 4/27/23 from Resident #58 about staff hollering at him/her, and the grievance where Resident #18 reported rough treatment and embarrassment, were reportable incidents but could not recall if the incidents were reported to the state. 2. Review of the grievance binder labeled 2024 revealed a grievance dated 4/10/24 and the person voicing the concern was Resident #18. The grievance stated: that during a care plan meeting on 4/9/24, Resident #18 wanted to move to a different unit to get away from GNA/CMA #19 because GNA/CMA #19 was being rough with him/her, telling him/her what to do, like a child. The grievance also noted that there was an incident where GNA/CMA yelled down the hall to Resident #18 you're not going to eat that candy before mealtime there were other people around and Resident #18 felt embarrassed. Resident #18's care plan showed that due to past cerebrovascular accidents, the resident had an ADL self-care deficit with right side weakness. The resident required one staff assistance to turn and reposition in bed and with toilet use. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was held on 8/23/2024 at 9:20 AM with the NHA. The surveyors and the NHA reviewed the two grievances related to Resident #58 and the grievance from Resident #18. The surveyor asked the NHA what the process was for any grievance filed at the facility and he replied: SW #17 was the designated grievance officer, and she documented the grievances, determined which department should address them, and forwards a copy of the grievance to myself, the DON and the appropriate department supervisor/head of which the concern/grievance addressed. The NHA went on to say that the assigned department supervisor was to follow up with the resident/complainant in concern to resolve the grievance. 3. On 8/21/24 at 10:18 AM, the surveyor interviewed the Nursing Home Administrator (NHA) and asked if he was aware of any allegations that Resident #291 made in regards to abuse. The NHA stated he could not recall any allegations. On 8/22/24 at 9 AM, the surveyor reviewed the grievance log from 2023. A typed note dated 4/12/23 at 11 AM stated that this social worker spoke with Resident #291 regarding allegations that he/she was abused and neglected by staff. The statement described that a Geriatric Nursing Assistant (GNA) roughly grabbed Resident 291 by the arms and yanked him/her up in the wheelchair causing him/her to hit his/her elbow against the wheelchair. In the statement Resident #291 gave a description of the GNA and stated the GNA was very rough and rude while providing care. Resident #291 also stated he/she does not want this GNA to take care of him/her anymore. On 8/22/24 at 11:44 AM, the surveyor interviewed Social Worker #17. During the interview SW #17 stated that she recalled taking the statement from Resident #291 and was told by the nurse that prior to the interview Resident #291 wanted to speak with her. After speaking with Resident #291 the GNA was identified as GNA #11. SW #17 further stated the GNA #11 no longer is employed at the facility related to another incident. The surveyor asked SW#17 if other interviews were conducted or if the allegation was reported to the NHA. SW #17 stated any time a grievance or allegation was obtained a copy of the statements was sent to the Director of Nursing (DON), Unit Manager, department head related to grievance, and the NHA. She further stated she could not recall that she was asked to follow up on this allegation. On 8/23/24 at 9:46 AM, the surveyor interviewed the NHA. During the interview the NHA confirmed Resident #291's abuse allegation was never reported to the police or the Office of Health Care Quality (OHCQ) or that an investigation was conducted to follow up on the allegation. On 8/23/24 at 4:15 PM the surveyors held an interview with the NHA and the DON. The surveyors discussed concern that there was a grievance showing witnessed staff to resident abuse on 5/18/23, additional grievances filed by residents on 4/27/23 and 4/10/24 alleging abuse, all of which confirmed the facility failed to ensure residents were free from abuse and prevent further abuse from occurring. The surveyor asked the NHA whether the written statement by SW #17 on 5/18/23 meets the definition of abuse, and he replied yes. The surveyor asked the NHA about the grievance filed by Resident #58 on 4/27/23 and whether the details would be considered an allegation of abuse to which he replied: yes, it is. In addition, the surveyor asked the NHA whether the grievance filed by Resident #18 on 4/10/24 would be considered an allegation of abuse, to which he answered, I can see how it can be interpreted as abuse. The NHA went on to say that he could see there was a pattern showing that GNA/CMA #19 was mentioned in these grievances. The surveyor requested documentation to show the grievances were addressed. The NHA confirmed that there was no documentation of resolution or follow-up for the reviewed grievances. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Office of Health Care Quality determined that the concern met the Federal definition of Immediate Jeopardy, and the facility was notified in writing of this determination at 6:00 PM on 8/23/24. On 8/23/24 at 9:15 PM, the facility submitted an abatement plan. The abatement plan was accepted by the OHCQ on 8/23/24 at 11:30 PM. The plan included: termination of GNA/CMA #19's employment; reports made to the OHCQ, Ombudsman and police department regarding- Resident #58's allegations of abuse for dates 5/18/23 and 8/19/24; Resident #18 allegations of abuse for date 4/10/24. The plan also included interviews of current residents to evaluate if there were any other reportable incidents; In-services conducted on the grievance process and identifying abuse; Daily audits of the grievances and residents by the NHA to identify abuse. The date of compliance for all actions was 8/28/24. On 8/23/24 11:30 PM the facility submitted an acceptable abatement plan. On 8/26/24 at 1130 AM, the DON confirmed that GNA/CMA #19 was terminated on 8/23/24 at about 3:30PM. The DON also confirmed that allegations of abuse for Residents #58, #18, and #291 were reported to OHCQ, the police, and Ombudsman on 8/23/24. On 8/29/2024 at 11 AM, the survey team confirmed the facility followed their abatement plan and the Immediate Jeopardy was abated on August 28, 2024.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on medical record review and interview it was determined that the facility failed to provide written transfer notice to the resident and/or the responsible representative. This was found to be evident for 2 (Resident #8 and #20) of 2 residents reviewed for hospitalization s. The findings include: 1) On 08/15/24 at 10:00 AM a review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. On 01/06/24, Resident #8 was transferred to the hospital and returned 1/10/24, then transferred again to the hospital on 06/24/24 and returned on 06/28/24. On both occasions, there was no documentation and/or evidence in the medical record to indicate that the facility staff notified Resident#8 /Resident #8's representative (RP) in writing of the reason for the transfers to the hosptal. 08/16/24 at 11:25 AM the Administrator gave surveyor documents which revealed that the Ombudsman was notified of Resident #8's transfers to the hospital. No document was given to verify that the resident and/or the RP was notified in writing of the transfers. In an interview with the Director of Nursing (DON) on 8/16/24 at 11:52AM, the DON was informed of the surveyor's findings and asked about the written documentation for transfers /discharges. The DON responded. I do not know if it was being done. 49148 2) On 8/21/2024 at 9:10 AM, a review of Resident #20's electronic medical record revealed that the resident was transferred to the hospital on 6/1/2024 at 8:38 AM after he/she became unresponsive while eating breakfast. Resident # 20 was admitted to the hospital due to low blood pressure and altered mental status and returned to the facility on [DATE]. Additional review of the electronic medical record and the physical chart revealed that there was no documentation to indicate that the resident nor his/her representative was notified in writing of the hospital transfer on 6/1/2024. The facility was unable to provide documentation that a written notice was given to Resident #20 and/or the residents representative for the hospitalization on [DATE].

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interview it was determined that the facility failed to: 1) conduct care plan meetings after each Resident Assessment, 2) hold quarterly care plan meetings for residents, and 3) failed to include interventions for a resident's activity care plan. This was found evident in 3 (Resident #290, #8, and #72) out of 4 residents reviewed for care planning. 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) On 8/14/24 at 9:52 AM, the surveyor reviewed Resident #290's medical record. The review revealed that Resident #290 was admitted to the facility in mid 2013. Next the surveyor reviewed the MDS assessment for Resident #290 along with the care plan meeting notes and sign in sheets. Resident #290 had a quarterly MDS assessment on 8/16/20 and 11/16/20 however no care plan meeting notes were noted for these assessment dates. On 8/16/24 at 7:39 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated she was not the DON at the time of these assessments and could not find any additional documentation that the care plan meetings were done following the 8/16/20 MDS assessment and 11/16/20 assessment. On 8/16/24 at 9:08 AM, the surveyor interviewed the Social Worker #17. During the interview the SW#17 stated she started working at the facility in 2021 and when she started the process for scheduling care plan meetings was for the facility to mail a letter to the Responsible Party (RP) and have the RP call and make the care plan meeting. She followed by stating that meetings were not being done. She further stated that currently the MDS coordinator gives the list of Residents who had their MDS assessment to the front desk and they call to make the care plan meeting with the RP. 50504 2) The surveyor reviewed Resident # 8's medical record on 08/14/24 at10:38 AM. The review revealed that Resident #8 had a quarterly MDS assessment completed on 08/02/24 and an annual assessment completed 05/11/24. There was no evidence in the medical record that a care plan meeting was held with Resident# 8 or Resident#8's representative and the interdisciplinary team around the time of either the quarterly or the annual MDS assessments. A further review on 08/14/24 at 10:45 AM revealed the last careplan meeting was held on 12/5/23 at 11:30 AM and the resident's spouse and son attended. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor interviewed the Director of Social Work, SW #17, on 08/15/24 at 9:15AM. During the interview, SW #17, stated I do not have a record to show that a careplan meeting was held for Resident #8 after 12/5/23. We keep a log of residents' care plan meetings. The surveyor asked the SW #17 for a copy of the log. The log was reviewed for the period January 2024 to July 2024. Resident #8's name or his/her RP did not appear on the log. 3) A review of Resident #72's medical record on 08/19/24 at 8:10AM revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Major Depressive Disorder. A careplan was developed on 8/12/24 for therapeutic activities. The goal stated The resident will express satisfaction with type of activities and level of activity involvement when asked through the review date. Date Initiated: 08/12/2024 Target Date: 08/20/2024. There were no interventions indicated on the care plan to achieve the goal. 08/19/24 at 08:32 AM the surveyor notified the DON of the findings and inquired as to the reason there were no interventions for therapeutic activities on Resident #72's careplan. The DON stated she did not know but would ask the Activities Director. Later on 08/19/24 at 4:30 PM, the surveyor observed that Resident #72's Careplan was updated with interventions for therapeutic activities.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44440 Based on record review, interview, and observation it was determined that the facility failed to provide necessary services to maintain good personal hygiene for dependent Residents. This was found evident in 2 (#291 & #45) out of 8 Residents reviewed for Activity of Daily Living (ADL) cares. The findings include: 1a) On 8/20/24 at 12:18 PM, the surveyor reviewed Resident # 291's medical record. The review revealed that Resident #291 was admitted in late January 2023. Further review revealed that Resident #291 had a past medical history that included, but not limited to, dysphagia (difficulty swallowing), dysphonia (disorder of the voice), muscle weakness, unsteadiness of feet and need for assistance with personal cares. On further review a progress note written by Licensed Practical Nurse (LPN) #13 stated Resident #291 requires extensive assistance with ADLs and uses a wheelchair and walker while in the facility. On 8/21/24 at 12:20 the surveyor requested shower records for Resident #291 from the Director of Nursing (DON). On 8/22/24 at 7:16 AM, the surveyor reviewed the shower and skin sheets provided by the DON. The first date on the shower sheet was dated 2/21/23 and Resident #291 had no documentation that a shower was completed on that day. On 2/24/23, 3/3/24, 3/7/23, 3/10/23, and 3/14/23 Resident #291 had a shower documented as completed. No documentation for a shower on 3/17/23 and on 3/21/23 a bed bath was documented as given due to a refusal, Again no documentation of a shower was given on 3/24/23 or 4/7/23. The surveyor interviewed the DON after review of the records. The DON stated she was unable to find the shower sheets for the earlier part Resident #291's stay. She further stated that without documentation she would not be able to confirm that showers were done. The surveyor reviewed the facility's policy and procedure for shower and tub baths. In the policy it states, at a minimum, the resident will be offered at least 2 full baths or showers per week. The policy further states that the date and time of the shower or tub bath was performed should be documented as well as if the Resident refused with the intervention taken. 1b) On 8/27/24 at 6:13 AM, the surveyor observed from the hallway that Resident #45's call light was on and noted a staff member walk into the room. Shortly after the light was turned off and that same staff member left the room to attend to an alarm from the room next door. On 8/27/24 at 6:14 AM, the surveyor knocked and entered into Resident #45's room and observed that Resident #45 was the only resident in the room, The surveyor interviewed Resident #45 and asked if he/she had just put on the call light. Resident #45 responded yes and that he/she told the Geriatric Nursing Assistant (GNA) that he/she needed to go to the bathroom. He/she further stated because of the limitations he/she had he/she would probably have to use a bedpan and was waiting for physical therapy to get up. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the interview the surveyor observed, from the hallway, the GNA who answered the light return into Resident #45's room, retrieve a paper and a phone, and walk out of the room and down the hallway. On 8/27/24 at 6:39 AM, the surveyor asked staff at the nurses station for the staffing assignments and was informed that GNA #21 was assigned to Resident #45. On 8/27/24 at 6:54 AM, the surveyor interviewed GNA # 21. During the interview the surveyor asks if the night shift GNA had given report and if she was aware that Resident #45 had requested to use the restroom. Staff #21 stated she was not aware and at this time looked up and stated that Resident #45's call light just went on and that she would go talk to Resident #45. The surveyor followed GNA #21 to Resident #45's room and heard Resident #21 report he/she needed to use the bathroom. On 8/27/24 at 6:56 AM, the surveyor interviewed the Registered Nurse (RN) Staff #27 the nurse assigned to Resident #45 on the night shift. She stated it was never reported to her that Resident #45 had to use the bathroom this morning. The surveyor reviewed Resident #45's care plans. A care plan was initiated stating, Resident #45 has Activities of Daily Living (ADL) limitations requiring staff assistance for bed mobility, locomotion, walking, bathing, hygiene/dressing, oral care, toileting, transferring related to activity intolerance. Additionally, Resident #45 had a care plan stating he/she was at risk for bladder/bowel incontinence related to impaired mobility. On 8/27/24 at 7:16 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor described the observation that Resident #45's request to use the bathroom was first addressed 52 minutes after the first request and only after putting on the call light again. The DON agreed that the resident's needs should have been addressed timely and after the first request.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record facility policy review, and interviews, it was determined that the facility failed to: 1) adequately document responses to treatment of skin conditions and 2) provide 2-person assistance to ensure resident safety during transfers. This was found evident for 2 (Resident #291 an #29) of 4 residents reviewed for wounds and resident- assisted transfers. The findings include: 1) On 8/20/24 at 12:18 PM, the surveyor reviewed Resident # 291's medical record. The review revealed that Resident #291 was admitted in late January 2023. Further review revealed that Resident #291 had a past medical history that included, but not limited to, dysphagia, dysphonia, muscle weakness, unsteadiness of feet and need for assistance with personal cares. The surveyor reviewed the progress notes for Resident #291 and discovered on 2/20/23 that Licensed Practical Nurse (LPN) #16 documented that Resident #291 had an open area to the coccyx and that the area was cleaned, a foam dressing was applied and the doctor and Responsible Party (RP) was made aware. On that same day Registered Nurse RN #3 documented on assessment there was no open area noted and that the sacrum had blanchable redness. The note further stated treatment was ordered, barrier cream applied and foam dressing placed. On 2/28/23 Staff #3 wrote a note again stating that Resident #291 has blanchable redness to the sacrum and that barrier cream and a foam dressing were applied. The note further stated Resident #291 had an order for daily dressing changes. On further review of the progress notes dated 3/1/23, 3/13/23, 3/15/23, 3/18/23 and on 3/19/23 treatment to the sacral area is documented as done, however no description of the skin integrity was documented. Licensed Practical Nurse (LPN) #24 documented the area as a sacral wound. On 8/28/24 at 1:27 PM, the surveyor interviews RN #3. During the interview RN #3 stated that she remembered that Resident #291 did not have an open wound and she recalls re-assessing Resident #291 after a nurse had written it was open. The surveyor asked RN #3 where the characteristics of the wound were documented. She stated that in her notes and it was documented as blanchable redness not open. The surveyor reviewed the Treatment Administration Records (TAR) for Resident #291 for March and April of 2023. On review an order was entered on 2/20/23 and stated to cleanse open area to sacrum with normal saline, dry, apply zinc and optifoam dressing daily and as needed for wound care. Review of the March TAR showed on 3/21/23, 3/23/23 and 3/29/21 no dressing change was documented as done. On review of the April 2023 TAR on 4/7/23 and 4/11/23 no dressing change was documented as done. On 4/24/23 a new order was written that stated, Apply barrier cream to Moister Associated Damage (MAD) to sacrum every shift and as needed for wound care. These orders were checked and completed for April 2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the facility's policy and procedure titled, Non-Pressure Ulcers/Injury Wound Management. The policy lists arterial ulcers, diabetic ulcers, Moisture-Associated Skin Damage (MASD), surgical wounds, venous or stasis ulcers as examples and gives the definitions. In the general guidelines it states, staff will be encouraged to promptly report any observations of change in the resident ' s skin integrity. It further states evaluation/assessment of non-pressure injury wounds will be completed weekly and with significant changes in condition of the ulcer/injury by the licensed nurse and/or practitioner. The documentation of the evaluations /assessment of the wound will be maintained in the resident's medical record and interventions to promote healing of the wound and to minimize recurrence of development will be incorporated in to the resident's care plan. Resident centered interventions and treatments will be prescribed by the physician/practitioner and administration of the treatments will be documented in the resident ' s medical record. Documentation may include; Location of wound, date the wound was acquired, Description of the wound to include measurements (length, width, depth), presence/absence of any tunneling or undermining, type of tissue (epithelial, granulation, sloth necrosis, ect), presence/absence and type of drainage, surrounding tissue description, and presence/absence of pain with the wound. On 8/29/24 at 7:40 AM, the surveyor conducted an interview with the Director of Nursing (DON). In the interview the surveyor asked where the weekly assessments of the skin condition were located. The DON stated weekly skin assessments are completed and checked on the TAR and the shower sheets. The surveyor asked about documentation of identified skin conditions or wounds and documentation of characteristics or measurements. The surveyor relayed the concern that if the skin condition/wound is not documented with characteristics or measurements weekly, then how can the facility measure or know if the treatment is working or appropriate. The surveyor also showed the DON the missing date of wound care documentation for Resident #291 for both March and April of 2023. 50504 2) Review of the Facility Reported Investigation (FRI) for MD00206729 revealed that Resident #29 was admitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infraction affecting Right Dominant Side, Acquired Absence of Right Leg Above the Knee, Conductive hearing Loss and Chronic pain. On 08/22/24 at 12:15 PM an interview with Resident #29 revealed that he/she experienced pain in the left shoulder while being transferred by an aide. The resident could not remember the date of the incident. On 08/22/24 at 12:35PM a review of Resident's #29 medical record revealed the resident reported to Staff #24 that on that on 6/15/2024 at approximately 2030 the assigned GNA, transferred him/her in a rough manner from wheelchair to bed. The transfer caused the resident to injure the left shoulder causing him/her to yell out in pain. Resident #29 also reported the incident to Staff# 26 on 6/15/24 at 9:30 PM. On 06/17/24 an X-ray of Resident #29's left shoulder was done and the result was, There is no fracture or periosteal reaction Resident #29 Physician's Order stated, the resident requires 2-person assist for transfers. Start Date10/11/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #29's Care Plan stated the resident has limited physical mobility relating to disease process arthritis and right AKA (Above the Knee Amputee). Intervention: I need the assistance of 2 caregivers for boosting up in bed. Date initiated: 02/07/24. On 08/27/24 at 07:21AM the surveyor informed the Director of Nursing of the findings and of the potential for injury related to Resident # 29's one-person transfer instead of a two person transfer. The DON responded I understand what happened.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on surveyor observation, review of medical records and interview of facility staff, it was determined that the facility failed to provide appropriate treatment to maintain an individual's limited range of motion. This finding was evident for 1 (Resident# 6) of 1 resident reviewed for range of motion. The findings include: On 8/8/24 at 8:15 AM the surveyor observed Resident #6 sitting in a wheelchair in his/her room using the left hand to stabilize the right arm which was flaccid. On 8/13/24 at 9:31 AM while in the hallway, the surveyor again observed Resident #6 sitting in a wheelchair using her/his left hand to support the right arm which was pressed against the inside of the wheelchair. The surveyor enquired from Staff #18 whether Resident # 6 should have an arm support. Staff # 18 replied yes and proceeded to the resident's room, retrieved a splint and placed it on Resident #6's right arm. A review of Resident #6's medical record on 08/13/24 at 08:31AM revealed that the resident was admitted to the facility on [DATE] with diagnoses including Cerebrovascular Disease, Flaccid Hemiplegia Affecting Right Dominant Side and Muscle Weakness and Aphasia. Additional review also revealed: - A physician order dated 6/12/24 that stated - PT (Patient) to wear Comfy Grip Splint during the daytime every day related to Flaccid Hemiplegia Right Dominant side. Wash and dry splint as needed; -A careplan intervention initiated on 12/13/22 that stated - Apply splint to right hand for contracture management- assess skin prior to application and upon removal for skin breakdown. On 08/14/24 at 10:49 AM the surveyor notified the DON of the findings. The DON provided no additional information.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49148 Based on review of the daily staffing sheets and interviews with staff, it was determined that the facility failed to have a Registered Nurse (RN) providing services for at least 8 consecutive hours a day, 7 days a week. This was found to be evident 4 out of 19 days reviewed for sufficient and competent nursing staff during the annual survey. The findings include: During the entrance conference on 8/6/24, the Director of Nursing (DON) confirmed that the facility did not have any Federal or State nursing staffing waivers. On 8/22/24 at 8:34 AM, the Surveyor reviewed the daily staffing sheets from 7/22/24 through 8/5/24. On 7/28/2024, there was no RN coverage for 24 hours. On 8/27/24 at 11:05 AM, the Surveyor conducted an interview with Staff Scheduler #30. During the interview, the Surveyor was informed that finding RN coverage for the weekend shifts are a challenge and that most of the time there is no RN coverage on the weekends. Staff Scheduler #30 also informed the Surveyor that there is a weekend supervisor that will start soon, and that person is an RN. During additional review of daily staffing sheets on 8/27/24 at 12:00 PM, the Surveyor discovered that on 8/10/24, 8/11/24, and 8/17/24, all weekend shifts, there was no RN coverage for 24 hours at the facility. On 8/27/2024 at 12:23 PM, an interview was conducted with the DON. The DON confirmed that there is a problem with weekend RN coverage and acknowledged a need for a RN for at least 8 consecutive hours a day. The Surveyor and DON established that on 7/28/24, 8/10/24, 8/11/24, and 8/17/24, there was no RN coverage those days for 24 hours.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49148 Based on observation and interview with residents and facility staff, it was determined that the facility failed to ensure that food was delivered to residents at an appropriate and palatable temperature. This was evident for 1 out of 1 observation of test tray temperatures. This practice has the potential to affect all residents who eat food prepared by the facility. The findings include: On 8/08/24 at 10:00 AM, the Surveyor conducted an interview with Resident #74. During the interview, the resident stated that the food is lukewarm and not palatable. In addition, the Surveyors received complaints from resident families stating that the food is cold by the time it reaches their loved one. On 8/15/24 at 11:40 AM, the Surveyor observed preparation for the lunch tray line. The Certified Dietary Manager (CDM) #6 was present during the Surveyor's observation of the tray line. The first tray was prepared at 12:00 PM. Trays were prepared accordingly, placed in a meal cart, and immediately taken to the appropriate unit. The Surveyor was informed that the meal trays are delivered to each specific unit in an order based on the hallway and room numbers. This pattern continued until every resident had a tray. A test tray was requested by the Surveyor to be included on the last meal cart. On 8/15/24 at 1:00 PM, the final tray was placed on the meal cart. CDM #6 retrieved a temperature gauge and rolled the meal cart directly to the nursing unit. The meal cart arrived to the unit at 1:05 PM and 3 staff members assisted with passing out the lunch trays. The test tray was the last tray on the cart. CDM #6 performed the temperature testing: chicken breast, 119 degrees Fahrenheit; rice 126 degrees Fahrenheit; potato 117 degrees Fahrenheit; and peas 120 degrees Fahrenheit. The Surveyor interviewed CDM #6 at the end of the test tray process, around 1:10 PM, who stated that his expectation is for meal trays to be delivered to units timely and hot foods to be maintained at a temperature palatable for the residents. CDM #6 informed the Surveyor that several changes have been made to make sure the hot food is palatable for the residents. The kitchen staff have been educated on setting steam table temps, getting additional plates for the induction heater and prewarm them, keeping the food covered while on the steam table, and maintain warm plate pellets.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on observation and interview with facility staff, it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents who eat the food prepared in the facility's kitchen. The findings include: During a tour of the facility's kitchen conducted on [DATE] at 8:30 AM, the Surveyor inspected the main walk-in refrigerator. The Surveyor observed a shelf containing an opened and unlabeled 1-gallon tub of Sysco mayo, a 1-gallon tub of Sysco mustard with a received date of ,d+[DATE] on the lid, and 1 gallon tub of Kens Homestyle Ranch with a received date of ,d+[DATE]. During a continued tour of the kitchen, the Surveyor observed the dry goods storage pantry. The Surveyor noted an opened and unlabeled 28 oz box of Quaker Cream Of Wheat with a use first label, Ralson Foods Quick oats with a use first label, tub of Goldmetal Chocolate Fudge icing with a use first label, 26 oz pack of Idahoan classic mashed potatoes wrapped in plastic wrap, 12 inch flour tortilla package (12ct), 24 oz of orange Jello wrapped in plastic wrap, and 24 oz pack of lime Jello with a use first label wrapped in plastic wrap. In addition, the Surveyor observed the main walk-in freezer. There was a box of Iced Crown Danish variety pack of 24 apple, 24 cherry, and 24 raspberry which were labeled opened on [DATE] with a use by date of [DATE]. There were personal items such as a grocery bag with personal food items and a bouquet of [NAME] on the shelf of the freezer alongside other frozen foods. Located in the back of the freezer, just below the ceiling, was a two-condenser fan unit. There were tiny mounds of ice on the ceiling of the freezer in front of the left condenser fan. Behind the right condenser fan, was a pipe with ice buildup and icicles. At the back of the freezer, directly below the condenser fan unit and the pipe, was several large mounds of ice going across the floor which made that area slippery. On [DATE] at approximately 9:30 AM, during a walk through the kitchen, the Surveyor reviewed the unlabeled and expired food items with Certified Dietary Manager (CDM) #6. CDM #6 immediately removed the unlabeled and expired food items. He removed the personal items from the freezer and stated, personal items should never be in here. CDM #6 confirmed the Surveyors findings of ice buildup in the walk-in freezer and stated that, he has to remove the ice buildup a couple times a week. Surveyor reviewed the concern that if working properly, there should not be ice buildup in the walk-in freezer. On [DATE] at 10:20 AM, CDM #6 provided the Surveyor with a copy of the Labeling and Dating Foods (Date Marking) procedure which stated that once a package is opened, it will be re-dated with the date the item was opened (all ready to eat, potentially hazardous food will be re-dated with the use by date) and shall be used by the safe food storage guidelines or by the manufacturer's expiration date. CDM #6 stated that he will review the labeling and dating procedure with his staff through an education in-service.

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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 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49148

Based on record review and interview with staff, it was determined that the facility failed to maintain complete and accurate medical records in accordance with acceptable professional standards. This was evident for 3 (Resident #64, Resident #34, and Resident #44) out of 56 resident records reviewed during the annual survey.

The findings include:

Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options.

Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped.

Do Not Resuscitate (DNR) is an order placed in a person's medical record by a doctor informs the medical staff that CPR should not be attempted.

Do Not Intubate (DNI) is an order placed in a person's medical record by a doctor informs the medical staff that chest compressions and cardiac drugs may be used, but no breathing tube will be placed.

1) On [DATE] at 10:40 AM, during a review of Resident #64's paper medical record, the Surveyor discovered two MOLST forms in the resident's chart. The first MOLST form was dated [DATE] with code status of Do Not Resuscitate (DNR). The second MOLST form was dated [DATE] with a code status of Cardiopulmonary Resuscitation (CPR).

On [DATE] at 10:45 AM, during a review of Resident #34's paper medical record, the Surveyor discovered two MOLST forms in the resident's chart. The first MOLST form was dated [DATE] with code status of DNR. The second MOLST form was dated [DATE] with a code status of Do Not Intubate (DNI).

On [DATE] at 10:15 AM, the Surveyor conducted an interview with Licensed Practical Nurse (LPN) #16. LPN #16 stated that the nursing staff go to the paper chart for the MOLST form and code status. There should be one MOLST form in the resident's paper medical record and the old MOLST should be voided out. The Surveyor and LPN #16 confirmed two MOLST forms in Resident #64's and Resident # 34's paper chart.

During an interview conducted on [DATE] at 10:25 AM with the Director of Nursing (DON) #2, the Surveyor expressed the concern that there were two MOLST forms in Resident #64's and Resident #34's paper chart. The Surveyor was informed that the nursing staff should look at the MOLST form with the most recent date if two are in the resident's chart. However, it is best practice to void the old MOLST to avoid mistakes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:00 AM, during an interview with Unit Manager #10, the Surveyor was informed that the process for updating a MOLST form is that once a new MOLST form is created and reviewed by the physician, the old MOLST form should be voided by writing VOID across the form and place it in the paper chart behind the new MOLST form. The new MOLST form should then be uploaded into the electronic medical record. 2) On [DATE] at 9:45 AM, a review of Resident #34's electronic medical record revealed a nursing note written by LPN #16 which stated that the resident sustained a fall on [DATE] at 5:15 AM. The Surveyor identified another nursing note with the effective date and time as [DATE] at 3:45 AM, created on [DATE] at 11:06 AM by Registered Nurse (RN) #33 stating that Resident #34 sustained a fall. Morse fall scale is a fall risk assessment tool that predicts the likelihood that a patient will fall. Additional review of Resident #34's electronic medical record revealed a fall incident report, a Morse fall scale, and a skin and wound total body assessment documented on [DATE] for the fall sustained on [DATE] at 5:15 AM. On [DATE] at 10:11 AM, during an interview with LPN #16, the Surveyor discovered that the Geriatric Nursing Assistant (GNA) from the night shift on [DATE] informed LPN #16 that Resident #34 sustained a fall on [DATE] at 5:15 AM. On [DATE] at 11:05 AM the Surveyor conducted an interview with DON #2. DON #2 informed the Surveyor that RN #33 was suspended for not completing the fall protocol for Resident #34 immediately after his/her fall on [DATE] at 5:15 AM. 3) On [DATE] at 12:17 PM, a review of Resident #44's electronic medical record revealed that the resident sustained a fall on [DATE]. Further review of Resident #44's electronic medical record revealed that Resident #44 complained of bilateral hip pain on [DATE] and was transferred to the local hospital emergency room (ER) for further management of a left femoral fracture. Subsequently, Resident #44 had surgery for a comminuted intertrochanteric fracture involving the left femur. On [DATE] at 9:11 AM, a review of Resident #44's electronic medical record revealed a consultant Pain Management note written by Certified Registered Nurse Practitioner (CRNP) #32 on [DATE] at 8:42 PM regarding a session with Resident #44 on [DATE], the day after Resident #44's fall. According to the assessment note, Resident #44 had no recent acute incidents, trauma, or reported injury. There was no documentation of pain, the left femur fracture, or the surgical procedure related to the fractured femur from the fall sustained on [DATE] in subsequent pain management encounters on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. Assessment findings on these dates reported no recent acute incidents, trauma, or injury and no significant change since the last assessments. On [DATE] 07:45 AM, DON #2 was made aware of the concern regarding inaccurate pain management assessment documentation for the pain management notes written on [DATE]-[DATE] by CRNP #32.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50504 Based on medical record review, observation and interview, it was determined that the facility failed to provide a safe, sanitary environment to prevent the development and transmission of disease and infection. This was evident for 2 (Resident #72 and Resident # 22) out of 56 residents observed for Infection Control. The findings include: Droplet precautions are a set of measures used to prevent the spread of infections caused by germs that spread through coughing, sneezing or talking. 1) Review of record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Major Depressive Disorder, Muscle Weakness, Unsteadiness on Feet. Resident #72 had a history of falls, and his/her plan of care included an intervention dated 08/05/24 which stated - during periods of significant restlessness and attempting to get out of chair without assistance, offer period of mats on the floor for (NAME) to rest on or engage in activities with supervision. On 7/27/24 Resident #72 tested Positive for Covid-19 and was placed on droplet precautions. During rounds on 08/07/24 at 11:AM the surveyor observed Resident #72 lying on a mat on the floor in the dayroom. The dayroom's door was open and there was no signage on the door to indicate that Resident #72 was on droplet precautions. Further, another Resident # 30 who was not diagnosed with Covid-19 was in the dayroom sitting on a wheelchair. Both Resident # 72 and Resident # 30 were not wearing masks. The surveyor's observation was brought to the attention of Staff #25 who immediately removed Resident # 30 from the dayroom, closed the door and placed the droplet precautions signage on the door. On 08/07/24 at 01:41PM the DON was notified of the surveyor's observation. The DON stated that the signage was usually on the door, and someone must have removed it. 2) Review of Record revealed Resident #22 was admitted on [DATE] with diagnoses including Dementia, Difficulty walking, Need for Assistance for Personal Care, Dysphagia and Chronic Diastolic (Congestive) Heart Failure. Resident #22's physician orders dated 02/01/20 included Oxygen via nasal cannula at 2 liters every 24 hours as needed for Shortness of Breath. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 03:27 PM upon entering Resident #22's room, the surveyor observed the resident's nasal cannula lying on the floor while the oxygen concentrator was in use. Resident#22 was not in respiratory distress. Further inspection revealed that the nasal canula was not dated and the humidifier bottle was not dated or labeled with the resident's name. Staff #13 confirmed the findings and removed the nasal canula and humidifier bottle from Resident #22's room stating, they would be replaced. Staff #13 stated that nasal cannulas and humidifier bottles are changed once a week on Fridays and should be dated and labelled with resident's name and the date changed. The Assistant Director of Nursing was notified of the findings on 08/09/24 at 08:05 AM and confirmed that it is the facility's policy for nasal cannulas and humidifier bottles to be changed weekly and labelled with resident's name and date changed.

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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. 49148 Based on observation and interview with staff, it was determined that the facility failed to ensure that the walk-in freezer was in safe operating condition that prevented ice build-up including ice frozen to the floor. This was found to be evident for the walk-in freezer in the kitchen. The findings include: On 8/13/24 at 8:30 AM, the Surveyor conducted a follow up tour of the kitchen. During the tour, the Surveyor observed the walk-in freezer. Located at the back of the freezer, just below the ceiling, was a two-condenser fan unit. There were tiny mounds of ice on the ceiling of the freezer in front of the left condenser fan. Behind the right condenser fan, was a pipe with ice buildup and icicles. At the back of the freezer, directly below the condenser fan unit and the pipe, was several large mounds of ice across the floor which made that area slippery. On 8/13/24 at 9:45 AM, Certified Dietary Manager (CDM) #6 confirmed the Surveyors findings in the walk-in freezer. CDM #6 stated that, he has to remove the ice buildup a couple times a week. He informed the Surveyor that a repair man came out a year ago to assess the freezer and said that the freezer was working properly and that it was just condensation near the fans. The Surveyor reviewed the concern that if working properly, there should not be ice buildup in the walk-in freezer. On 8/14/24 at 12:08 PM, Administrator #1 informed the Surveyor that Southern Maryland Refrigeration is the vendor that the facility utilizes for repairs. The vendor came out to assess the freezer about a year ago. Surveyor requested documentation of the most recent maintenance company service call for the walk-in freezer and a copy of the workorder. As of 8/29/2024 at 1:40 PM, Administrator #1 did not provide any recent documentation of service calls or repairs to the walk-in freezer in the kitchen prior to 8/13/24. The Director of Maintenance, #31, informed the Surveyor that the workorder for the walk-in freezer had been submitted and being serviced.