STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215278	A. Building B. Wing	03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Meadows Retirement Com.	11630 Glen Arm Road Glen Arm, MD 21057

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51213 Based on medical record review and staff interviews, it was determined that the facility failed to revise the interdisciplinary care plan to meet the residents' needs. This was evident for 1 (Resident #28) of 19 residents reviewed during the re-certification survey process. The findings include: A care plan is a personalized guide designed to meet the specific needs of each resident. It is used to assess, plan, implement and evaluate the effectiveness of the care provided to the resident. On [DATE] at 9:14 AM a review of the electronic health records revealed that Resident #28 went out with their family on [DATE] at 4 PM and returned to the facility later that evening at 9 PM in stable condition. On [DATE] cough medicine was ordered as well as a chest x-ray for Resident #28. On [DATE] the progress note written by Staff # 24 RN stated that at 7:15 PM Resident #28 was observed to be congested and had a dry cough. Resident #28 was not able to cough out their mucus, so Staff #24 performed oral suction on the resident. When Staff # 24 returned to Resident # 28's room to give the resident's night medications, Staff #24 noted Resident #28 had difficulty breathing. Oxygen was applied and 911 was called. Resident was a do not resuscitate (DNR) option B. Resident # 28 expired prior to the ambulance arriving. On [DATE] at 12:16 PM during an interview with Staff #10, the Corporate Extended Care Services Support Manger, was asked if documentation could be provided of what happened to Resident #28 from ,d+[DATE] -[DATE] from orders, progress notes and the care plan. On [DATE] at 1:15 PM during an interview with the Assistant Director of Nursing (ADON), documentation for chest x-ray results and an order for cough medicine were received for Resident #28. The ADON was then asked if documentation could be provided that the care plan was updated to reflect Resident # 28's resent respiratory issues. On [DATE] at 1:20 PM further record review revealed that Resident #28's care plan did not address Resident #28's respiratory issues. Resident #28's care plan was last updated on [DATE]. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:31 PM during an interview with Staff #10, documentation was provided for an order for oxygen, (prn) as needed, for Resident #28 from [DATE]. Staff #10 was asked, would it be your expectation that when Resident #28 had respiratory changes on [DATE] and was started on cough medicine, prn oxygen, and had a chest x-ray ordered that the care plan would be updated to reflect the resent respiratory changes? Staff #10 stated yes that would be my expectation.

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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 51213 Based on medical record review and interviews with staff, it was determined that the facility staff failed to develop a baseline care plan and failed to provide residents/representatives with a copy of their baseline care plan and medication list. This was evident for 1 (Resident #15) of 12 residents reviewed for care plans during the re-certification/complaint survey. The findings include: A care plan is a personalized guide designed to meet the specific needs of each resident. It is used to assess, plan, implement and evaluate the effectiveness of the care provided to the resident. On 3/31/25 at 8 :17 AM, record review revealed that Resident #15 did not have a baseline care plan in their electronic health records. On 3/31/25 at 9:46 AM during an interview with the Director of Nursing (DON), the DON was asked if a copy of Resident #15's baseline care plan could be provided. The DON stated currently I did not see a base line care plan for the resident but let me check with Social Work because the resident's daughter lives out of town, and I will get back with you. But right now, I do not see the baseline care plan in the resident's record. The DON was asked who completes the baseline care plan. The DON stated, the nurse does the baseline care plan and has the patient/representative sign the care plan. Then the baseline care plan will be scanned into the resident's electronic health record. On 3/31/25 at 1:04 PM The ADON and the Administrator were interviewed and asked if they could provide documentation that Resident #15 had their baseline care plan completed. The ADON and the Administrator said no we cannot. The baseline care plan was not in the residents' electronic health records.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42782 Based on medical record review and interview it was determined that the facility staff failed to update a person-centered care plan for a resident who was wearing a safety device to help prevent them from leaving the facility unattended. This deficient practice was evidenced in 1 (Resident #86) of 3 resident records reviewed for WanderGuard care plans during the revisit survey. The findings include: A WanderGuard is a wander management solution used in senior living communities and other healthcare facilities to help protect residents who are at risk of wandering and leaving the premises. It utilizes technology like wearable bracelets, sensors, and a central platform to monitor resident movement and alert staff if a resident approaches a monitored area or attempts to leave the safe zone. On 05/22/25 at 8:20 am the surveyor reviewed Resident #86's electronic medical record (EMR) which revealed an order was written on 04/08/25 for the resident to wear a WanderGuard to help prevent the resident from leaving the facility unattended. Further review of the EMR revealed there was no nursing documentation to indicate why the device was applied, the location of the device, or an active plan of care for the nursing staff to care for the resident while wearing the safety device. A review of the resident's treatment administration record (TAR) revealed the site of the safety device was not documented, but as of 04/08/25 the staff signed off the device was on the resident. At 11:15 am the surveyor reviewed the resident's care plan in the Matrix Care EMR; there was not an active care plan for the WanderGuard safety device. On 05/22/25 at 11:10 am during an interview with the Director of Nursing (DON) the surveyor reported after reviewing Resident #86's EMR in PointClickCare and Matrix, the resident did not have a care plan for wearing a Wander-Guard safety device to help prevent elopement. The surveyor asked if Resident #86 should have a care plan. DON verbalized the resident should have a care plan for wearing the Wander-Guard safety device. On 05/22/25 at 12:21 pm the Director of Nursing provided the surveyor an inactive Behavioral care plan for Resident #86 that was last dated 08/14/24. The care plan did not indicate that the resident was currently wearing a WanderGuard and there were no updated interventions included. On 09/26/23 it was documented for the WanderGuard to be applied to the back right side of the resident's wheelchair.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on record review and interview with facility staff, it was determined the facility failed to implement measures to prevent pressure ulcer development and improvement on the right heel of a resident. This was evident for 1 (Resident #5) of 16 residents reviewed during the recertification/complaint survey. The findings included: A pressure ulcer also known as pressure injury, bed sore, or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying skin. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (partial thickness loss of skin presenting as a shallow open ulcer), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with exposed tendon, muscle or bone) to Unstageable (the depth of tissue damage cannot be determined due to the presence of slough or eschar (both are types of dead skin that prevent healing). On 3/27/25 at 1:43 PM review of Resident #5's medical record revealed the resident was admitted to the facility on [DATE]. Further review of the resident's medical record revealed the following progress notes and care plans: - 8/6/24 progress note (the resident's admitted): The resident an [AGE] year old fe/male, transferred via stretcher from [hospital]. S/P (status post, meaning after a treatment, diagnosis or event) hospital stay related to a stroke with some right weakness. Skin intact, with multiple discoloration noted to BLE (bilateral lower extremities) and a scab to right ear. - 8/6/24 care plan: Resident #5 is at risk for pressure ulcers related to decreased mobility and occasional incontinence. Resident #5's skin will remain intact with no new open areas caused by pressure or friction through review date (Goal: 11/4/24). - 8/18/24 progress note: [Resident #5] alert with baseline confusion; today with generalized weakness and bilateral lower extremities generally weak. - 8/20/24 progress note: The resident remains a one person assist with ADLs (activities of daily living: the basic, essential self-care tasks people need to perform to maintain their health, safety, and well-being, such as bathing, dressing, eating, and toileting) and two person assist with transfer (the movement of a patient from one location or level of care to another). - 8/30/24 progress note: Skin dry and intact. Discoloration to both upper extremities, edema noted to left arm. - 9/1/24 progress note: Resident was noted with an open blister to his right heel. First aid administered, the heel was cleansed, pet dry, xeroform applied and cover with dry dressing. POA and MD made aware. Will continue to monitor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/3/25 care plan updated: Resident [#5] has developed a stage 2 to right heel presenting as an open blister. - 9/5/24 progress note: Skin dry and intact, skin tear to right heel. - 9/5/24 progress note: ***Correction/Addendum (to above 9/5/24 progress note)***: wound is a blister, stage 2 pressure injury. Monitor closely to determine necessity for addition of Prostat (a liquid supplement). Skin update. Per nursing the wound seems to have had significant healing already. As wound appears to be healing well, will withhold recommending nutrition supplementation at this time. Upon further assessment from wound nurse, may recommend 30cc Prostat BID (two times a day), if deemed appropriate. Continue to monitor as needed/per plan of care. On 3/27/25 at 2:11 PM, the surveyor requested printed copied of any and all wound notes, assessments, evaluations, and new physician orders for Resident #5 between the dates of 8/30/24 through 9/10/24. On 3/28/25 at 7:50 AM the surveyor reviewed Wound Assessment Reports and Skin and Wound Notes from the Wound Nurse Practitioner (WNP #29). Of note, the first noted assessment and documentation from WNP #29 was dated 9/11/24 although per the facility's nursing staff's documentation, the resident was noted on admission (8/6/24) to be at risk for developing pressure ulcers, to have an open blister to his/her right heel on 9/1/24, and it to have developed to a Stage 2 pressure ulcer on his/her right heel on 9/3/24. Further review of the Skin and Wound Note from WNP #29 dated 9/11/24 documented in the Wound Assessment section: Location: Right heel, Wound Status: New, Primary Etiology (the cause or origin of): Pressure, and Stage/Severity: Unstageable. Additionally, on the Wound Assessment Report with the same date, 9/11/24, it was noted that the unstageable, right heel pressure ulcer was acquired in house, in other words, the resident was not admitted into the facility on [DATE] with this pressure ulcer. In an interview with the DON on 3/28/25 at 7:55 AM, he verified and confirmed that 9/11/24 is the first wound note from WNP #29. The surveyor shared concerns that the resident was not seen by the WNP #29 until 9/11/24 at which time the pressure ulcer had worsened from a Stage 2 (on 9/3/24) to an Unstageable pressure ulcer, which the DON verified and confirmed. On 3/28/25 at 11:05 AM the Extended Care Services Support Manager (ECSSM #10) provided the surveyor with 2 physician orders between the dates of 8/30/24 through 9/10/24 for Resident #5, both of which were dated 9/11/24: 1) Apply Heel Boots while in bed every night and remove in the AM 2) Apply Skin Prep to heel every evening. In an interview with ECSSM #10 on 3/28/25 at 1:35 PM, the surveyor shared concerns that Resident #5 was noted with an open blister on his/her right heel on 9/1/24, a documented Stage 2 pressure injury on 9/3/24, and was not seen by the Wound Provider and did not have any new interventions (as evidenced by physician orders) implemented until 9/11/24. The ECSSM #10 verified and confirmed the concerns stating, It is a big concern, I understand.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on medical record review and staff interviews, it was determined that the facility staff failed to have a system to monitor and respond to changes in residents' weights. This was evident for one (Resident #21) of 1 resident reviewed for nutrition during the recertification/complaint survey. The findings include: On 3/24/25 at 12:53 PM, the surveyor reviewed Resident #21's medical records for nutrition. The review revealed that the resident's body weight was documented as below: - 1/2/25: 183.4 lb. (pound) - 1/13/25: 183.4 lb. - 1/22/25: 165.8 lb. - 2/07/25: 204 lb. - 2/08/25: 184.4 lb. - 3/01/25: 180.2 lb. - 3/05/25: 181.2 lb. Further review of Resident #21's medical record revealed that there was no documentation regarding the weight of 1/22/25 (165.8 lb, losing 8.3 % within 9 days). There was no documentation about his/her weight of 2/07/25 (204 lb, about 23% gain from 1/22/25). The progress note written by the Dietitian (Staff #8) on 2/13/25 said, Wt clarification. Re-weighed in February with usual wt range at 184.4 lb. Wt has ranged 180-185 lb x 90 days with a noted wt loss from Sept to [DATE] from 191 to 180 lb. Suspected entry/weight error on wts of 204 lb on 2/7 and 165.8 on 1/22. During a phone interview with Staff #8 on 3/27/25 at 1:19 PM, the staff stated that the facility staff monitored residents' body weight monthly or weekly (based on the provider order). She said if any significant weight changes were noted, the facility staff discussed them in their risk meeting and provided interventions like starting supplements, changing diet orders, etc. Staff #8 also stated that the nursing staff performed the weight measurement, and she expected any variation to be noted within 48 hours. If it happened, it would be documented in residents' medical records. During an interview with the Licensed Practical Nurse (LPN #6) on 3/27/25 at 1:37 PM, she stated that the nurse aide measured residents' weight, and nurses put them in medical records. She confirmed that while they put the weight in, they would see residents' previous body weight: if any difference is noted, they can reweigh them immediately without obtaining new order and report to the Director of Nursing (DON). LPN #6 said, DON will do the next step. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with DON on 3/27/25 at 2:43 PM, he stated when the body weight concern was noted, they did re-weigh, notified the dietitian and provider, document, and intervention started. The surveyor reviewed Resident #21's body weight record with him. He verified that there was no documentation to support the facility staff monitoring/responding to his/her body weight fluctuation. The DON validated the above concern.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 49304 Based on medical record review and interview with facility staff, it was determined that the facility failed to provide behavioral health monitoring to ensure a resident's highest practicable mental and psychosocial wellbeing. This was found to be evident for 1 (Resident #8) out of 5 residents reviewed for unnecessary medications during the recertification/complaint survey. The findings include: The Centers for Medicare & Medicaid Services (CMS) defines a psychotropic medication in the regulations at S483.45(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) requiring careful consideration and monitoring. Review of Resident #8's medical record on 3/26/25 at 8:37 AM revealed the resident had resided at the facility for several years and whose diagnoses included but were not limited to: bipolar disorder, Parkinson's disorder, history of falling, muscle weakness (generalized), and unsteadiness on feet. Further review of Resident #8's medical record revealed the resident's current psychotropic medications included Seroquel (an antipsychotic) 25 mg (milligrams) two times a day, Divalproex sodium ER (Extended Release) 500 mg tab two times a day, and Mirtazapine (an antidepressant) 15 mg daily. However, additional review of the resident's physician orders did not reveal any orders related to behavior or side effect monitoring. On 3/28/25 at 12:09 PM in an interview with the Director of Nursing (DON) when asked if a resident is ordered a psychotropic medication, is there any required behavior monitoring, he stated, Yes. During the interview the DON stated there is behavior monitoring for any resident on a psychotropic medication and he verified and confirmed that there would be a physician order that nurses document on every shift and that documentation would be observed in the resident's MAR (medication administration record). Additionally, the Extended Care Services Support Manager (ECSSM #10) said yes, any resident on a psychotropic medication should have a behavior monitoring order. The surveyor handed the printed physician orders for Resident #8 (that were provided to the survey team on 3/27/25 at 1:45PM by ECSSM #10) to the DON and ECSSM #10. They were asked if Resident #8 had the order for behavior monitoring that they had both just stated was required for residents on psychotropic medications and they both stated, No. The DON verified and confirmed that this resident did not but should have a behavior monitoring order.

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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. 43096 Based on a review of the resident medical records and interview with facility staff, it was determined that the facility failed to ensure that drug records were maintained in a manner that allowed for reconciliation of dispensed and administered medication. This was evident for 1 (Resident #84) out of 2 residents reviewed for administration of narcotic medication during the recertification/complaint survey. The findings include: Oxycodone is a narcotic medication used to treat moderate to severe pain. It is at high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol or other illicit drugs such as heroin and cocaine. A controlled medication utilization record (known as a count sheet) is a form to record controlled medication dispense. It documents the details for each use of any controlled substance amount removed from its original containers, including date, time, the dose given, the signature of the nurse administering medication, the amount remaining, wasted, and the signature of who checked. On 3/24/25 at 1:06 PM, the surveyor reviewed Resident #84's medical record. The review revealed that the resident was admitted to this facility in February 2025 for right digital radial fracture recovery. He/she was on Oxycodone 2.5mg by mouth every 6 hours as needed for pain. Further review of Resident #84's Medication Administration Record (MAR) for March 2025 and controlled substance records revealed: - Controlled substance records documented as given, but no documentation in MAR: 3/04/25 at 3:40 (not documented AM/PM), 3/06/25 at 6 AM, 3/08/25 at 5:45 AM, 5 AM, 5 AM (handwritten note present as error, however the remained dose counted as used), 3/09/25 at 9 PM, 3/12/25 at 4:30 PM, 3/13/25 at 5 PM, 3/18/25 at 9:00 (without AM/PM), 3/19/25 at 4:30 AM, and 3/22/25 at 8:54 PM. Also, there were discrepancies noted about documentation for 3/17/25 : - MAR documented as given at 4:45 AM, 2:37 PM, 10:42 PM - Controlled substance records documented as given at 7:45 AM, 4:45 PM, 4:45 AM, 2:40 PM, and 9:45 (without recording AM/PM). These records were not documented chronologically. During an interview with Licensed Practical Nurse (LPN #2) on 3/26/25 at 9:35 AM, she explained that when the facility nurses administer controlled medication to residents, they are supposed to verify the order, conduct pain assessment, administer medication, and document. LPN #2 confirmed that they needed to document both the MAR and the controlled sheet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 3/26/25 at 10:47 AM, the surveyor reviewed Resident #84's MAR and controlled sheet, which showed discrepancies in Oxycodone use. The DON stated that two documents should match. He validated the surveyor's concern.

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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. 43096 Based on a review of medical records and interviews with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was true for 1 (Resident # 13) of 5 residents reviewed for unnecessary medication review during the recertification/complaint survey. The findings include: During a review of Resident #13's medical record on 3/28/25 at 1:00 PM, the surveyor noted that the consultant pharmacist recommended on 2/21/25 as below: - His/her fingerstick have been fairly elevated (200s and 300s). Please consider increasing his/her Lantus to 20 unit. It might be worth further increasing his/her basal insulin to try and taper off of the [Diabetic medication name]. - He/she gets QID (four times a day) fingerstick and is noted as a hospice patient. He/she also refuses the fingerstick often. For comfort reason, please consider changing fingerstick to twice daily. However, the recommendation paper had no physician's response, signature, or date. During an interview with the Director of Nursing (DON) on 3/28/25 at 2:15 PM, he explained that the facility received Monthly Recommendation Report (MRR) from the pharmacy, communicated with providers with communication board, filled out the MRR note with their response, signature, and date, changed order (if needed), and uploaded them in residents' medical record. He stated that he expected the MRR to be reviewed within 72 hours. The surveyor reviewed Resident #13's MRR for February 2025 with the DON. He agreed that the facility failed to respond to MRR timely.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on observation and interview with facility staff, it was determined the facility failed to: 1) ensure expired food items were discarded 2) ensure the ice machine's filtration cartridge was replaced timely and 3) ensure required temperature levels were consistent for dishwashing sanitization. These deficient practices have the potential to affect all facility residents. The findings include: On [DATE] at 7:53 AM, the surveyor conducted an initial tour of the facility's kitchen. On [DATE] at 7:59 AM the surveyor observed the following: - Hulled sesame seeds with the following label: [DATE] 6:20 PM, [DATE] 6:20 PM - Ground ginger with the following label: [DATE] 1:01 PM, [DATE] 1:01 PM - Ground coriander with the following label: [DATE] 11:22 AM, [DATE] 11:22 AM - Ground cardamom with the following label: [DATE] 11:49 AM, [DATE] 11:49 AM - Ground marjoram with the following label: [DATE] 7:59 AM, [DATE] 7:59 AM - Whole poppy seeds with the following label: [DATE] 12:00 PM, [DATE] 12:00 PM - Whole cloves with the following label: [DATE] 3:09 PM, [DATE] 3:09 PM - Pork raw with the following label: [DATE] 4:55 PM, [DATE] 4:55 PM - Frozen open box (cookies) with the following label: [DATE] 6:10 PM, [DATE] 6:10 PM On [DATE] at 8:36 AM the surveyor observed the ice machine's filtration cartridge with the following label: Installed: [first initial and last name] of Maintenance Manager #31and Replace: [DATE] (6 months after installation). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 9:03 AM the Certified Dietary Manager (CDM #30) was interviewed. When asked what food items needs to be labeled, he stated anything that has been opened. When asked to describe the labeling process, he stated, opened items are labeled with the opened and use by date. If you do not use it by then, you have to get rid of it. He also stated we put receiving labels on everything. When asked who is responsible for labeling, he stated Everyone, if you open it, it's your responsibility to put a label on it. When asked who is responsible for disposing expired food items, CDM #30 stated, Everyone in the kitchen. When asked who is ultimately responsible for ensuring the process as described above was completed, he stated, me, Director of Dining Services. During the interview, the surveyor conducted a dual observation of the concerns (from the surveyor's initial tour) with CDM #30. While observing the spices he stated, Spices, the rule of thumb is 1 year. [After looking more closely at the label] Oh, it has been a year, so we will just get rid of this. When the other expired spices were observed, CDM #30 stated, Yup, so these probably all just need to go, so we can dispose of these and gathered all the expired spices and threw them into the trash. Additionally, when the surveyor and CDM #30 looked at the pork, he stated that pork is not raw, but we can throw it out. The next dual observation was of the frozen cookies and CDM #30 stated we made those cookies and after looking at the label stated, These have a longer life than that. He walked over to the kitchen's labeling system, Menu Pilot, and after checking stated, Oh, it is a month and disposed of the frozen cookies. On [DATE] at 9:19 AM the surveyor conducted an interview and dual observation of the ice machine's filtration cartridge with CDM #30. When asked how often the cartridge is replaced, he stated monthly. The surveyor then pointed to the label and CDM #30 stated, Oh that cartridge, yearly. The surveyor pointed out the label which stated Replace: [DATE] (6 months after installation) and CDM #30 stated maintenance, not Ecolab, replaces that cartridge and called maintenance to the kitchen. Maintenance Manager #31 (the same facility staff member whose initials are on the label as having last installed it) arrived and in an interview with him, he stated yes, it [ice filtration cartridge] should have already been replaced. On [DATE] at 9:26 AM at the end of the interviews and dual observations, the surveyor shared the concerns of the expired foods and timely replacement of the ice filtration cartridge with CDM #30 who verified and confirmed understanding of the concerns. CDM #30 was interviewed on [DATE] at 9:17 AM. When asked how dishes are cleaned and sanitized, CDM #30 stated the dishwashing machine was a high temperature machine. Dishwashing machines use either heat or chemical sanitization methods. For heat sanitization, the wash temperature must register between , d+[DATE] degrees Fahrenheit (F) and the final rinse temperature must register 180 degrees Fahrenheit (F). These temperatures ensure proper and effective sanitization. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:11 AM the surveyor observed dishwashing with Dishwasher #31 who rinsed and ran dish trays through the machine while CDM #30 removed the trays as they finished and put the dishes away in storage bins. The first temperatures observed were as follows: Wash- 137 F and Final rinse- 176 F. The surveyor shared the concern about the machine's final rinse temperature not hitting 180 F and CDM #30 stated the machine was just turned on and so it might need to warm up. The next few rounds of dishes, the machine did register the 180 F or higher for the final rinse. However, at 10:22 AM when a load of silverware was being run through the machine, the final rinse temperature registered 176 F. During all of the abovementioned observations, neither Dishwasher #31 or CDM #30 were noted to be looking at or even in the direction of the temperature gauge on the dishwashing machine. Dishwasher #31 was going to put another tray of dishes through when upon surveyor intervention, CDM #30 was notified of the 176 F for the final rinse temperature and verified and confirmed it was not 180 F. He stated that this was just fixed a month ago and that they had fixed the heater. CDM #30 then instructed Dishwasher #31 to run the silverware back through and the final rinse temp registered 182 F. After observations in an interview with CDM #30 when asked how he ensures the dishwasher is consistently hitting the required temperatures he stated, the dishwashers have been trained to look at the gauges as they run a load through. If it does not hit temperatures, they would run the load back through. On [DATE] at 10:27 AM the surveyor reviewed the [DATE] dishwasher temperature log entries. For each day of the month, there are 3 readings documented. Between [DATE]st-30th, 38 out of 90 final rinse temperatures documented less than the required 180 F final rinse temperature. For these 39 readings the final rinse temperature ranged from ,d+[DATE] F. There were 6 documented readings in the 150's, 9 documented readings in the 160's and 23 documented readings in the 170's. At this time the surveyor again shared their concern that the final rinse temperature was not consistently reaching 180 degrees Fahrenheit. CDM #30 verified and confirmed understanding of the concerns. The Nursing Home Administrator was made aware of the surveyor's findings prior to the [DATE] exit conference and acknowledged and confirmed understanding of the concerns.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 43096 Based on review of pertinent documentation and interview with staff it was determined that the facility failed to have a transfer agreement with a local hospital. This was found to be evident during the extended survey. The findings include: On 3/31/25 at 2:29 PM, the surveyor requested to provide a Transfer Agreement. The Nursing Home Administrator (NHA) confirmed that they did not have an agreement between the facility and a local hospital. During an interview with the NHA on 3/31/25 at 2:38 PM, the surveyor informed him of the federal regulation regarding transfer agreements. NHA validated it.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43096 Based on staff interviews, review of pertinent documentation, and survey findings, it was determined that the facility staff failed to ensure that an effective Quality Assurance Performance and Improvement (QAPI) program was in place to identify quality concerns and have a system in place to correct identified concerns. This was found to be evident while conducting the facility's recertification/complaint survey. The findings include: The facility's annual and complaint surveys, including investigations of self-reported incidents, conducted from 3/24/25 to 3/31/25, identified non-compliance regarding Resident Abuse, free of accident hazards (elopement), and pharmacy service (related document of controlled medication use), and so on. During an interview with the Nursing Home Administrator (NHA) on 3/31/25 at 2:03 PM, he brought the QAPI binder and reviewed it with the surveyor team. NHA stated that the facility had QAPI meetings monthly and discussed issues like pressure ulcers, infection, falls, psychoactive medications, depression, implementation functions, medication errors, and deficiencies outstanding from the previous survey. The surveyor asked whether they discussed residents' elopement in their August 2024 QAPI meeting. NHA stated they discussed it at the monthly risk meeting: he showed two pages of printed risk meeting reports filed in the QAPI binder. The risk meeting report included the number of incidents per category, such as elopement, infection, and weight loss. However, it did not contain details of what they discussed or a corrective action plan. On 3/31/25 at 2:14 PM, the surveyor continuously interviewed NHA. The surveyor shared the facility's self-reported incident regarding Resident #16's elopement on 7/29/24, MD00208131, and questioned what the facility discussed about this issue. NHA explained that there was no monitoring for the elopement because they did not specify any of that in QAPI. The surveyor shared the facility's follow-up report for MD00208131, which mentioned that the facility would QAPI about this incident. NHA flipped through the QAPI binder and stated, I'm not seeing it. The surveyor asked what the goal for QAPI was. NHA said, What's wrong and how we fix it. The surveyor also asked if the facility team discussed employee-to-resident abuse after the facility reported the incident, MD00209055, on 8/23/24. NHA said no. The surveyor asked about the facility discussing the controlled medication documentation issue regarding the self-reported incident, MD00212528, which occurred on 12/07/24. NHA said, We didn't QAPI about that issue. The surveyor informed him that the surveyor team noted that the same issue still occurred (controlled medication was not appropriately documented by two nurses) while the surveyor teams conducted this annual survey. NHA verified and confirmed the facility's failure to identify quality concerns and to have a system in place to correct identified concerns.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49304 Based on review of facility records and interview with facility staff, it was determined the facility staff failed to ensure the required committee members consistently attended monthly Quality Assessment and Assurance (QAA) meetings. The findings include: On 3/24/25 during the Entrance Conference with the Nursing Home Administrator (NHA), he provided the survey team a binder that included the QAA committee information and noted the committee members as: Medical Director, Healthcare Administrator, Director of Nursing, MDS Coordinator, Assistant Director of Nursing, Rehab Manager, Social Worker/Admissions, Community Life Director, Director of Environmental Services, Laundry Manager, Director of Food Services, Human Resources Manager, Dietician and GNA designee. On 3/31/25 at 2:22 PM review of the facility's QAA monthly attendance records for 2/2024 to 2/2025 revealed the following: 1. The Medical Director failed to attend 1 of 12 meetings (June 2024). 2. The Director of Nursing failed to attend 2 of 12 meetings (March 2024, July 2024). 3. The Infection Preventionist failed to attend 3 of 12 meetings (May 2024, September 2024, December 2024). On 3/31/25 at 2:35 PM in an interview with the NHA, he reviewed each month's attendance sheets for the QAA committee. During the interview, he verified and confirmed the surveyor's above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on interviews with facility staff and a review of resident records, it was determined that the facility failed to 1) ensure that each resident was offered an influenza immunization during an active flu season and 2) monitor/document each eligible resident's pneumococcal vaccine status. This was evident for 2 (Residents #15 and #84) of 5 residents sampled for immunization review during the recertification/complaint survey. The findings include: Pneumococcal vaccine help prevents pneumococcal disease, which is any type of illness caused by streptococcus pneumonia bacteria. The Centers for Disease Control and Prevention (CDC) recommends a pneumococcal vaccine for age [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions or risk factors. (Centers for Disease Control and Prevention- vaccines and preventable disease) Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people [AGE] years and older, pregnant people, and people with certain health conditions or a weakened immune system are at the greatest risk of flu complications. Influenza (Flu) vaccines can prevent influenza. (Centers for Disease Control and Prevention- vaccines and preventable disease) The surveyor reviewed randomly selected five residents' immunization records on 3/27/25. The review revealed that: 1)Resident #84, who was admitted to the facility in February 2025, did not have Flu immunization records for this season and no record for the Pneumococcal vaccine. During an interview with the Assistant Director of Nursing (ADON, also Infection Control Preventionist) and Staff #10 (corporate support manager) on 3/26/25 at 1:51 PM, ADON stated that the facility staff updated newly admitted residents' vaccination (including Flu and pneumonia, and COVID-19) status. She said sometimes it took longer to update their vaccination status due to the communication process: if the residents' responsible party was unreachable and/or took time to consent. The surveyor asked if the process was delayed due to communication issues the facility staff expected to see any documentation in the resident's medical records. Staff #10 said they should document residents' vaccination status in their medical records. In an interview with ADON on 3/27/25 at 12:30 PM, the surveyor reviewed Resident #84's vaccination status with her. ADON stated that the resident's Flu immunization status should be updated. Also, she said if residents had not received it yet, the facility staff supposed to offer it. Also, she validated that no Pneumonia vaccination status was documented in Resident #84's medical record. 2) Resident #15's medical record review revealed that pneumonia vaccination status was not documented. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with ADON on 3/27/25 at 12:30 PM, she stated that since the resident only consented Flu vaccine, the pneumonia vaccination status was not updated. The surveyor asked to provide evidence to support that the facility offered education regarding immunization's benefits and potential side effects. ADON brought a copy of the "Vaccine Informed Consent & Screening Form" signed by Resident #15's responsible party via telephone consent on 10/14/24. However, the consent form checked only for Flu: Covid, RSV, PNA (pneumonia), RZV (shingles), and other check boxes were remained blank. The surveyor informed ADON there was no documentation to support Resident #15 receiving education for the Pneumonia vaccine. ADON validated it.

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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. 43096 Based on medical record review and staff interviews, it was determined that the facility failed to ensure employees' COVID-19 vaccination status. This was evident for 1 (Registered Nurse, RN #14) of 5 employees' immunization records reviewed during the recertification/complaint survey. The findings include: A COVID-19 vaccine is intended to provide acquired immunity against severe acute respiratory syndrome coronavirus 2, the virus that causes coronavirus disease. During a portion of the infection control task on 3/27/25 at 11:00 AM, the surveyor randomly selected five employees to review their immunization records. The review revealed that the employee health file of RN #14 (hired in November 2024) did not have his/her COVID-19 vaccination record. In an interview with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and corporate supporting manager (Staff #10) on 3/27/25 at 2:07 PM, ADON stated that the Human Resources department managed employees' health files, including their immunization data. The surveyor asked whether the facility monitored/tracked employees' COVID-19 vaccination status. ADON stated that since the facility no longer offered the COVID-19 vaccine, they did not have to keep their records. On 3/28/25 at 10:21 AM, Staff #10 confirmed that the facility did not have documentation to support RN #14's COVID-19 vaccination status. The surveyor informed her about the federal regulation regarding the COVID-19 vaccine, which she validated.