STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Care Services at Mercy Medical Center	301 Saint Paul Place Baltimore, MD 21202

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42507 Based on observation and interview, it was determined the facility staff failed to treat each resident in a dignified manner by: 1) leaving a breakfast tray in the resident's closet, 2) leaving urinals hanging on the trash can in the resident's room, and 3) serving breakfast on a bedside table that had a urinal containing urine. This was evident for 2 (Resident #4, #12) of 27 residents reviewed during the survey. The findings include: 1) During an initial observation of Resident #4 on 3/25/2024 at 8:45 AM, surveyor observed a breakfast tray dated 3/25/2024 and pillows in two transparent bags in the resident's closet. NPO (nothing by mouth) signage was noted on the resident's room door. Resident #4 stated s/he did not know why and/or who placed the breakfast tray in the closet. On 3/25/2024 at 8:55 AM, the charge nurse, Registered Nurse (RN #17) was notified of surveyor's observation. RN #17 went into Resident #4's room and validated surveyor's findings. RN #17 stated the pillows in the two transparent bags were extra pillows. RN #17 further stated that the breakfast tray should not be in the closet and immediately took the tray out of Resident #4's room. On 3/25/2024 at 9:49 AM, the above concerns were reviewed with the Director of Nursing (DON) and the Administrator. The Administrator confirmed that the breakfast tray should not be in the resident's closet. She stated that staff should have taken the tray out of the room and placed it in the pantry with a sign on it and/or ordered a new tray for the resident. 2) On 3/26/2024 at 9:45 AM, surveyor observed three (3) open urinals hanging on a trash can by the foot of Resident #4's bed. In an interview, Resident #4 stated s/he was using the urinals when s/he first came to the unit and was not getting out of bed. Resident #4 further stated that s/he no longer used the urinals and staff should have kept them in the bathroom and not on the trash can. On 3/28/2024 at 2:33 PM, in an interview with the Administrator, she was made aware of surveyor's observation of urinals placed on the trash can. The Administrator stated that she was going to re-educate the staff on paying attention when they go into patients' rooms and make sure things like that were not happening. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/29/2024 0 at 7:45 AM, in a follow up interview with the Administrator, she stated that she spent last evening going into the residents' rooms looking for urinals and making sure there were no urinals on the trash cans. The Administrator added she was working on figuring out how they could hang the urinals on the bed rails instead of using the trash cans as observed in some of the residents' rooms. 3) During an observation of Resident #12 on 3/26/2024 at 8:50 AM, surveyor observed a urinal with 1/3 (one third) full yellow colored urine and a breakfast tray on a bedside table across the resident's bed. When asked if the resident had used the urinal prior to breakfast, s/he replied yes. Resident #12 stated that the urinal was on the table when staff served her/him breakfast. On 3/26/2024 at 9:07 AM, Surveyor notified Resident #12's nurse, Licensed Practical Nurse (LPN #9), who accompanied the surveyor to the resident's room and validated the finding. LPN #9 stated that the urinal should not be on the table with the breakfast tray. LPN #9 further stated that she had not made her way into the resident's room. She apologized to Resident #12 and immediately removed the urinal from the bedside table and took it to the bathroom. On 3/28/2024 at 2:33 PM, Surveyor reviewed her observations with the Administrator. She stated that she was going to re-educate the staff on paying attention when they go into residents' rooms and be mindful when passing out trays, so that meals are not served next to residents' urinals and/or urine.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on observation and interviews it was determined that the facility failed to maintain a comfortable homelike environment as evidenced of a resident having stained ceiling tile, rust near the trim in a resident's bathroom, fluid stains on the wall in a resident's room, and damaged drywall in a resident's room. This deficient practice was evidenced in 4 rooms of 8 rooms assessed for a homelike environment during the survey. The findings include: On 03/25/24 at 8:39 am during observation rounds upon entering room [ROOM NUMBER] the surveyor observed a stained ceiling tile in the resident's room. Nursing Tech #11 confirmed the surveyor's findings. On 03/25/24 at 8:46 am the surveyor observed discolored tile behind the commode near the trim in room [ROOM NUMBER] bathroom. Director of Nursing #2 confirmed the surveyor's findings. On 03/25/24 at 9:18 am during observations rounds Resident # 8 was in their room sitting in the chair. The surveyor observed the drywall behind the chair was damaged. Administrator #1 confirmed the surveyor's findings. On 03/28/24 at 2:45 pm during an interview with Director of Maintenance #19 who indicated they try to do a weekly check on every floor. When there are maintenance issues they have a ticket system. If the issue is not an emergency the ticket will be assigned to a technician and after the repair is completed an email is sent to the requester. The requester has the option to direct the ticket response to the Director or Administrator. They have staff available 24 hours a day. They have a preventive maintenance schedule for equipment. The maintenance department was not aware of the issues on the unit. On 04/02/24 at 11:57 am during an interview with LPN #33 concerning the process of reporting maintenance problems he/she verbalized, normally if a patient tells the nurse about a maintenance issue the nurse will tell the Patient Service Representative (PSR) and a ticket will be put in and the staff or the PSR can put a ticket in and the problem is continuity as they only work 3 days a week.

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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** 42507 Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative (RP) in writing of a transfer/discharge of a resident along with the reason for the transfer and failed to send a copy to the ombudsman. This was evident for 2 (#7, #17) of 2 residents reviewed for hospitalization during a recertification survey. The findings include: 1) Review of the medical record for Resident #7 on 4/1/2024 at 12:00 PM revealed Resident #7 was originally admitted to the facility on [DATE] from the hospital. Further review of the medical record revealed that Resident #7 was transferred back to the hospital emergency department (ED) on 2/24/2024 for a change in mental status. However, there was no documentation and/or evidence in the record indicating that the facility staff notified the resident/resident's representative (RP) in writing of the reason for the transfer/discharge to the acute care facility on the above date/time the resident was transferred out. On 4/1/2024 at 12:50 PM, surveyor requested from the Administrator to see written notification for the reason of transfer to the hospital given to the resident or their RP and a copy of the bed hold policy given to the resident or their RP. On 4/1/2024 at 1:11 PM, an interview was completed with the Administrator. Administrator stated that she did not know of any written form to notify residents that they were going to the hospital, or any written forms that were given to residents or resident representatives (RP), or any written notice of why the resident was being sent out. Regarding the transfer notice, the Administrator confirmed that they did not provide in writing the reason for transfer to the hospital either to the resident and/or resident representative. She further stated that she was not aware of the facility staff notifying the ombudsman when residents were transferred out. Administrator stated that the only expectation was for staff to write a progress note regarding the reason for the transfer and if the family/RP was notified. On 4/2/2024 at 8:35 AM, a review of the transfer progress note written by nursing on 2/24/2024 revealed the following documentation PT. (patient) was transferred to ED for consultation. Sister made aware via telephone. However, there was no indication/documentation that the resident, RP (patient's sister), and/or ombudsman was notified in writing of the reason for the transfer to the hospital. 42782 2) On 04/01/24 at 11:56 am A review of Resident #17's electronic medical record (EMR) revealed the resident was transferred to the hospital on 12/26/23. On 04/01/24 at 12:43 pm The surveyor requested to review the transfer summary sent to the resident or responsible party. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Administrator #1 on 04/01/24 at 1:15 pm when a patient goes out the discharge summary is sent with the patient, not a transfer summary. The surveyor asked to review the transfer summary. On 04/01/24 at 1:17 pm Administrator #1 made the surveyor aware there was not a transfer summary or discharge summary available for the surveyor to review.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative in writing of the bed-hold policy upon transfer of a resident to an acute care facility. This was evident for 2 (#7, #17) of 2 residents reviewed for hospitalization during a recertification survey. The findings include: The bed-hold policy describes the facility's policy of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . 1) Review of the medical record for Resident #7 on 4/1/2024 at 12:00 PM revealed Resident #7 was originally admitted to the facility on [DATE] from the hospital. Further review of the medical record revealed that Resident #7 was transferred back to the hospital emergency department (ED) on 2/24/2024 for a change in mental status. Medical record documentation revealed that Resident #7's responsible party (RP) was notified of the transfer via telephone, however, there was no written documentation that the resident/responsible party was notified in writing of the bed-hold policy. On 4/1/2024 at 12:50 PM, surveyor requested from the Administrator to see written notification for the reason of transfer to the hospital given to the resident or their RP and a copy of the bed hold policy given to the resident or their RP. On 4/1/2024 at 1:11 PM, an interview was completed with the Administrator. Administrator stated that she could not find any documentation or copies of the bed hold policy given to residents when they went to the hospital. The Administrator added that she did not know of any written form to notify residents that they were going to the hospital, or any written forms that were given to residents or resident representatives (RP), or any written notice of why the resident was being sent out. She confirmed that the facility did not have a bed hold policy because their patients were mostly short-term stay. She added that their patients were Medicare part A and B and private pay and added that they were not licensed for Medicaid patients for about 3 years now. On 4/2/2024 at 8:35 AM, a review of the transfer progress note written by nursing on 2/24/2024 revealed the following documentation PT. (patient) was transferred to ED for consultation. Sister made aware via telephone. However, there was no indication/documentation that the resident and/or RP (resident's sister) was notified in writing of the bed hold policy. 42782 2) On 04/01/24 at 11:56 am a review of Resident #17 electronic medical record (EMR) revealed the resident was transferred to the hospital on 12/26/23. On 04/01/24 at 12:43 pm the surveyor requested to see the Bed Hold policy and the form provided to the resident before he/she was transferred to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/01/24 at 1:17 pm during an interview with Administrator #1 who verbalized they do not have a bed hold policy. When a patient goes out, they don't save their bed. The patient goes to the next available bed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on observation, medical record review, and interview, it was determined the facility staff failed to: 1) review and revise resident care plans to reflect accurate and current interventions, and 2) ensure the full interdisciplinary team including residents and/or their responsible parties were invited to the care plan meetings and 3) have care plan meetings for residents who had been in the facility 21 days or more. This was evident for 4 (#4, #12, #13, #15) of 27 residents reviewed during a recertification survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Tube feeding is a way of getting your body the nutrition it needs. Tube feed is a liquid form of food that's carried through your body through a flexible tube (feeding tube). The nutrients within the tube feed are similar to what you would get from normal food. They are also digested in the same way. Tube feeds contain all the nutrients you need daily, including carbohydrates, proteins, fat, vitamins, minerals, and water. 1) On 3/25/2024 at 8:45 AM, an initial observation was made of Resident #4 in their room. The resident was lying in bed, awake, alert, and oriented to person, place, time, and situation. Resident #4 had a gauze dressing to the left upper quadrant of the abdomen and stated that s/he had a feeding tube that was discontinued. On 3/29/2024 at 12:37 PM, review of Resident #4's care plan revealed a care plan focus for The resident requires tube feeding r/t protein calorie malnutrition. Jevity 1.5 continuous tube feedings at 25 ml hour with 40 ml water flushes q 4 hours . initiated on 3/18/2024 with goals and Interventions/Tasks. However, Resident #4 was no longer receiving tube feedings and did not have a feeding tube in place anymore. On 3/29/2024 at 12:53 PM, a review of Resident #4's active orders were completed. There were no physician active orders for tube feeding. On 3/29/2024 at 1:00 PM, in an interview with the Administrator, she confirmed that Resident #4's feeding tube was discontinued sometime last week because the resident was not tolerating tube feedings. On 3/29/2024 at 1:16 PM, an interview was completed with Resident #4's nurse, RN #2 who is also the Director of Nursing (DON). RN #2 confirmed that Resident #4's feeding tube was discontinued about a week ago and the resident was taking oral stuff. Regarding care plan revision/updates, DON stated that during daily rounds with the multidisciplinary team residents' care plans were discussed and the MDS (Minimum Data Set) coordinator was responsible for revising/updating residents' care plan. Surveyor reviewed with DON Resident #4's care plan and DON acknowledged that the care plan should have been revised to reflect that the resident no longer had a feeding tube/tube feeding. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/29/2024 at 2:56 PM, a follow up interview was completed with the Administrator. She stated that care plans were updated/revised quarterly and as needed by the MDS coordinator. Administrator further stated that nurses verbalize changes in residents' condition during morning rounds with the interdisciplinary team, and MDS coordinator revises and updates their care plans. The surveyor reviewed Resident #4's care plan with the Administrator: She verified and confirmed that the care plan focus for tube feeding should have been updated and resolved after the resident's feeding tube was discontinued on 3/21/2024. However, the Administrator added that the interdisciplinary team rounds did not hold because the surveyors were in the building, which was the reason why the care plan was not updated. 2) In an interview with Resident #12 on 3/26/2024 at 8:48 AM, Resident #12 stated that s/he has not attended any care plan meetings and/or seen the social worker since being admitted in the facility. On 3/28/2024 at 12:00 PM, a review of Resident #12's medical record failed to reveal any documentation that Resident #12 or his/her family had been invited to a care plan meeting. In an interview with the facility social worker (SW #16) on 3/28/2024 at 12:26 PM regarding care plan meetings, SW #16 stated that normally she meets with the patients and their family within 2 to 3 days after admission. However, SW #16 stated and confirmed that she has not met with Resident #12 and/or had any care plan meetings with the resident or their family since his/her admission to the facility. SW #16 added that the Patient was missed. On 3/28/2024 at 2:33 PM, in an interview with the Administrator, she was made aware of Resident #12 not having been seen by the Social Worker and/or invited to a care plan meeting since admission. Administrator stated that SW #16 had already informed her about it. 42782 3) On 03/25/24 at 1:42 pm while interviewing Resident #13, he/she verbalized not having a care plan meeting. The resident was admitted to the facility on [DATE]. 4) On 03/26/24 at 9:57 am during an interview with Resident #15, he/she did not recall whether a care plan meeting took place. The resident was admitted to the facility on [DATE] and was due for a care plan meeting. On 03/28/24 at 10:27 am during an interview with Administrator #1 they did not have a care plan meeting for Resident #13 as he/she doesn't have family that's willing to communicate with the facility staff. They had an initial meeting when the patient is admitted to the facility. On 03/28/24 at 12:26 pm during an interview with Social Worker #16 revealed residents come in initially he/she would reach out within 2-3 days. The day before the meeting she calls to make sure they attend by phone or in person. Social Worker #16, MDS, the assigned nurse, rehab manager, and the resident & Responsible Party as Physicians are not able to attend. A follow-up meeting depends on what they discuss; it depends on the situation. Social Worker #16 confirmed Resident #13, and #15 did not have care plan meetings.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on record review and interview it was determined that the facility failed to provide person centered Activities that incorporated the resident's interests. This deficient practice was evidenced in 3 (#8, #13, and #170) of 3 residents who verbalized they didn't know the facility offered Activities. The findings include: On 03/25/24 at 1:38 pm during an interview with Resident #13, he/she verbalized the facility does not offer Activities. Nobody told him/her that they have Activities for the patients. 03/26/24 09:40 am during an interview with Resident #170 he/she verbalized not knowing the facility offered Activities. On 03/26/24 at 9:55 am during an interview with Resident #8 he/she verbalized not being aware if the facility offers Activities for them. On 03/28/24 10:48 am during an interview with Patient Service Representative #18 who verbalized they do not have Activities at this time. On 03/28/24 10:57 am During an interview with Administrator #1 who reported they have volunteers 3 times a week who can do Activities with the patients. They were working with the resident in room [ROOM NUMBER]. Generally, the patients are short term but recently they had been having long term care patients.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42507 Based on observation, resident, and staff interviews, it was determined that the facility failed to develop, prepare, and distribute menus that reflect a resident's nutritional wishes. This was evident for 1 (#7) of 27 residents in the facility reviewed during a recertification survey. The findings include: In an interview with Resident #7 on 3/25/2024 at 1:31 PM, the Resident stated that the food was not for me because I don't eat meat, but they serve me food with meat. Resident #7's sister who was present in the room confirmed that the resident is a vegetarian, but they keep giving him/her meat products. Resident #7 added that s/he has seen the dietitian once since being in the facility. On 3/29/2024 at 11:59 AM a surveyor observed Resident #7 sitting in a chair in front of the nurses' station with his/her lunch tray. The surveyor asked Resident #7 if s/he was going to eat his/her lunch. Resident #7 replied, No, it's terrible, and I'm a vegetarian and they keep giving me meat. The surveyor observed chopped chicken and carrots on Resident #7's lunch tray and the resident's meal ticket read Chopped 60 GM CHO, ConstCho, Veg. The meal ticket also read Chopped Manicotti in which chopped had a line through it and Chicken was written over it, along with wax beans. Resident #7's meal ticket and the food on his/her tray was not the same. In an interview with the Clinical Nutrition Manager (Staff #23) on 3/29/2024 at 1:07 PM, she stated that she oversees the other dieticians and was not directly involved with the residents. Staff #23 further stated that Registered Dietitian (RD #29) was the assigned dietitian to Resident #7's unit (TCU- Transitional Care Unit) but she was off for the day. In an interview with the facility Patient Service Manager (Staff #15) on 3/29/2024 at 1:39 PM, she was made aware of Resident #7's food concern of getting meat products and surveyor's observation of the resident's lunch tray/meal ticket earlier on. Staff #15 stated that the facility has a meal concierge (MC) who comes to the floor and uses their tablets to take meal orders from the residents. This then goes to the diet office for review and modification prior to going to the tray line. However, Staff #15 stated that the above error should have been caught by the server in the kitchen before the tray got to the unit. She added that the MC should have caught it when the meal tray was served to the resident on the unit because they are expected to call out what is on the meal ticket and compare it to what is on the tray when they lift the lid off. Staff #15 added that she was going to follow up with Resident #7 and re-educate staff. In an interview with the Administrator on 3/29/2024 at 2:56 PM, surveyor shared the above food concerns. On 4/2/2024 at 10:33 AM, an interview was completed with TCU dietitian (Staff #29). Surveyor informed Staff #29 of Resident #7's food concern of being served meat products and surveyor's lunch tray observation on 3/29/2024. Staff #29 stated she was going to follow up.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42782 Based on observations and interviews it was determined that the facility staff failed to use safe food practices while preparing lunch trays for the Transitional Care Unit and failed to store edible produce in the produce refrigerator located in the kitchen. This deficient practice was discovered during the survey. The findings include: On 03/25/24 at 12:51 pm during the initial walk through of the kitchen, the surveyor observed molded zucchini and squash in a box on the bottom shelf located on the right side of the produce refrigerator. There was a large plastic bag of wilted lettuce next to the box of molded vegetables. Chef #15 and Dietary Manager #15 were present when the surveyor discovered the spoiled food. On 03/29/24 at 11:18 am while in the kitchen, the surveyor observed Food Server/Menu Concierge #24 preparing lunch plates for the Transitional Care Unit. While plating the food he/she went into the under carriage with the same gloves that he/she used to plate the patient's food. Chef #15 was made aware. On 03/29/24 at 11:26 pm the surveyor observed Food Server/Menu Concierge #24 go into the under carriage again with the same gloves being used to plate the residents' food. Chef #15 was made aware. On 03/29/24 at 2:32 pm during an interview with Patient Service Manager #15 who verbalized Food Server/Menu Concierge #24 should have changed gloves after going into the under carriage and they always strive for excellence in the kitchen. They receive lettuce every 3 days, and it should have been rotated out. The zucchini and squash should have been rotated out as well.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215283	A. Building B. Wing	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Care Services at Mercy Medical Center	301 Saint Paul Place Baltimore, MD 21202

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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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42507 Based on observation, medical record review, and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. Furthermore, the facility staff failed to assure the completeness and accuracy of documentation related to the route of medication administration. This was evident for 1 (Resident #4) of 27 residents reviewed during the recertification survey. The findings include: On 3/25/2024 at 8:45 AM, an initial observation was made of Resident #4 in their room. The resident was lying in bed, awake, alert, and oriented to person, place, time, and situation. Resident #4 had a gauze dressing to the left upper quadrant of the abdomen and stated that s/he had a feeding tube that was discontinued. On 3/29/2024 at 10:39 AM, a review of active orders for Resident #4 revealed the following orders: Doxepin (Sinequan) capsule 25 mg: 25 mg J-Tube, daily, First dose (after last modification) on Sun 3/10/24 at 0900. Doxepin is a medication used to treat depression and other related disorders. Jejunostomy tube (J-tube) is a soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine. The tube delivers food and medicine until the person is healthy enough to eat by mouth. On 3/29/2024 at 11:15 AM, review of Medication Administration Record (MAR) for March 2024 was completed. Staff documentation revealed that Resident #4 was given Doxepin 25 mg capsule via J-tube daily from 3/10/2024 through 3/29/2024. However, based on observation and interview conducted on 3/25/2024, Resident #4 no longer had a feeding tube and was taking food and medications orally. On 3/29/2024 at 1:00 PM, in an interview with the Administrator, she confirmed that Resident #4's J-tube was discontinued sometime last week because the resident was not tolerating tube feedings. On 3/29/2024 at 1:16 PM, an interview was completed with Resident #4's nurse, RN #2 who is also the Director of Nursing (DON). RN #2 confirmed that Resident #4's J-Tube was discontinued about a week ago and the resident was taking oral stuff. She further stated that Resident #4 took all their medications orally except for IV (intravenous) meds. The surveyor reviewed the resident's active orders and MAR with RN #2. RN #2 verified and confirmed that the staff were documenting that Resident #4 was getting Doxepin via a J-Tube that was no longer there. RN #2 stated the order for Doxepin 25 mg J-Tube daily should have been modified to reflect the oral route of administration as the resident no longer had a J-Tube in place and was taking the medication by mouth. RN #2 further stated that she was going to have the pharmacist modify the order and change the route of administration for Doxepin. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/29/2024 at 2:56 PM, a follow up interview was completed with the Administrator. Surveyor reviewed the active order for Doxepin and the MAR for March 2024. The Administrator confirmed that the patient no longer had a J-tube, and his/her medications were administered orally. She stated that staff should have made sure the order for Doxepin was revised/changed to reflect the proper route (oral) of administration when the resident's J-Tube was removed. The Administrator provided surveyor with a copy of progress notes written by nursing on 3/21/2024 that validated that the resident no longer had a J-tube: Patient returned to the unit from surgical oncology. G-tube removed by surgeon and dry dressing applied to site Patient tolerated PO (by mouth) intake with no n/v (nausea/vomiting) reported.

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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. 42782 Based on observations and interviews it was determined that the facility staff failed to maintain infection control practices as evidenced by urinals hanging over residents' trash cans, a resident's wound vac machine was on the floor, and a urinal was on the bedside table near a resident's water and food tray. This was evident for 3 (Resident #170, #15, #171) of 27 residents reviewed during the survey. The findings include: On 03/25/24 at 8:24 am during observation rounds the surveyor observed a partially filled urinal hanging over the trashcan in Resident # 170's room. The surveyor also observed Resident #170's wound vac was on the floor near the end of the bed on the right side. Quality Assurance Director #4 confirmed the surveyor's findings. On 03/25/24 at 8:42 am while speaking to Resident #15 in his/her room the surveyor observed a leg brace on the floor in front of the chair and a urinal on the bedside table next to 2 cups of water and the breakfast tray. Nursing Tech #11 confirmed the surveyor's findings. On 03/25/24 at 9:11 am During observation rounds while the surveyor was in Resident #171 room, the surveyor observed a urinal hanging over the trashcan. On 04/02/24 at 9:30 am During an interview, Administer #1 made the surveyor aware the expectation would be that the urinals be emptied readily, and the staff be mindful the trashcan is not the ideal place to put the urinal. The staff should avoid placing a urinal beside someone's food. Even though the wound vac is a closed system the vac should have been supported on the bed or on the resident's walker.

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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. 42782 Based on observation and record review it was determined the facility staff failed to ensure the dishwasher reached the final rinse temperature of 180' Fahrenheit. The findings include: On 03/25/24 at 1:01 pm while in the kitchen the surveyor asked Dietary Manager #13 to run the dishwasher to assess the final rinse temperature. The surveyor heard the dishwasher making a loud noise and the final rinse maximum temperature was 132' Fahrenheit (F). Patient Service Manager #15 verbalized the machine was down before it was tuned on and it needed time to reach the required temperature. He/she also verbalized the machine was making noise. Dietary Manager #13 verbalized the dishwasher was broken. On 03/25/24 at 1:04 pm the surveyor received a copy of the Dish Machine Temperature Log as requested. A brief review of the temperature log revealed the last documented final rinse temperature was 135'F on 03/25/24 at 11:00 am. On 03/25/24 at 2:10 pm further review of the Dish Machine Temperature Log revealed at least one shift during the entire month of March 2024, the final rinse temperature did not reach the required 180F temperature.