STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215297	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South River Healthcare Center	144 Washington Road Edgewater, MD 21037

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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. 50385 Based on observations and staff interviews, it was determined the facility failed to provide a resident with an environment that promotes a dignified existence. This was evident for 1 (Resident #349) of 8 residents reviewed for dignity. The findings include: On 12/2/24 at 8:25 AM, an observation was made of Resident #349's room. A clear plastic bag was lining the commode. Inside the bag was a yellow-colored liquid with a piece of toilet paper inside. This Surveyor took a picture of the commode. On 12/2/24 at 8:27 AM, an interview was conducted with Registered Nurse (RN) #3. When asked why the resident had a plastic bag over the commode, RN #3 stated they were not sure but stated that the resident does things their way. On 12/3/24 at 10:30 AM, an interview was conducted with RN #7. When asked why there was a bag over the commode, the nurse stated they used bags to dispose of the waste when Resident #349 had a stomach infection recently and kept using a plastic bag to line the commode even after the resident was cleared from the infection.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 51589 Based on observations and staff interviews, it was determined that the facility failed to ensure the call bells were within reach of a resident. This was evident in 1 (Resident #79) of 1 resident reviewed for access to the call system during the recertification survey. The findings include: On 12/2/2024 at 8:33 AM, Resident #79's call bell was observed by surveyors on the floor next to their bed. Further observation on 12/4/2024 at 8:36 AM again revealed Resident #79's call bell on the floor. Geriatric Nursing Assistant (GNA) #11 was interviewed by surveyors on 12/4/2024 at 8:40 AM. GNA #11 confirmed the call bell was on the floor and picked up the call bell and placed it next to the resident. Resident #79's call bell was observed by surveyors on 12/5/2024 at 8:58 AM to be on the floor behind their bed. Licensed Practical Nurse (LPN) #15 was interviewed at 8:59 AM and stated expectations that the call bell is always within reach of the resident. LPN #15 then picked up the call bell and placed it next to the resident. LPN #15 further stated that there was no clip for the call bell and would get one. On 12/5/2024 at 10:56 AM, Registered Nurse Unit Manager (RN) #8 was interviewed about the facility's call bell policy. RN #8 stated it is expected that call bells to always be within reach of residents. Concerns about Resident #79's call bells were addressed by surveyors with the Director of Nursing (DON). The DON acknowledged the concerns and stated that facility's expectations are that call bells should be accessible to residents.

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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** 49815 Based on record review and interview, it was determined that the facility staff failed: (1.) to provide documentation whether a Resident had an advance directive and/or wished to formulate an advance directive and (2.) to ensure the accuracy of the Medical Orders for Life-Sustaining Treatment (MOLST) in place. This was found to be evident for 2 (Resident #32 and #23) out of 12 residents reviewed for the MOLST and advance directives. The findings include: 1. The surveyor observed Resident #32 on 12/2/2024 at 9:45 AM in bed. Resident #32 was alert and oriented to person, place and time. On 12/3/2024 at 2:00 PM the surveyor conducted a record review of Resident #32's medical record. Resident #32 was admitted to the facility on [DATE]. An advance directive is a legal document that specifies a person's wishes for end-of-life healthcare. It also specifies who should make healthcare decisions on your behalf if you are unable to do so yourself. During the record review of Resident #32's medical record it revealed that there was no documentation on admission to determine if Resident #32 had an advance directive and/or determine whether the Resident wished to formulate an advance directive. Further review of Resident #32's medical record revealed that a Social History Assessment - Maryland v7 form was not present and completed for Resident #32. The documentation on advance directives was found in the Social History Assessment - Maryland v7 form for other residents that were reviewed for advance directives. The surveyor interviewed the Director of Nursing (DON) on 12/4/2024 at 8:33 AM and asked the DON for documentation of advance directives for Resident #32. The surveyor conveyed to the DON that there was not a Social History Assessment for Resident #32 in the medical record. On a follow up interview with the Director of Nursing (DON) on 12/4/2024, the DON stated that Resident #32 did not have documentation of advance directives because when Resident #32 was admitted to the facility the resident was not able to make own decisions. The DON provided no additional information. 45733 2. MOLST is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review, on 12/02/24 at 01:36 PM, of Resident # 23's MOLST front page revealed that the decision-making section was blank, but the facility staff had accepted an Advance Directive that was on file since 2021. However, the option of the patient's health care agent as named in the patient's advance directive should have checked. During the interview, on 12/03/24 at 01:06 PM, the Director of Nursing and the Administrator stated that Doctor staff # 24 had completed the MOLST form and did not check the correct option box as an omission. Additionally, the copy of the Advance Directive had been directing this Resident's care decision since 2021. Additionally, a copy of the Advance Directive had been directing this resident's care. The surveyor informed both that the above omission was a concern.

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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** 42828 Based on observations and staff interview during facility environmental observations, it was determined that the facility staff (1.) failed to provide housekeeping and maintenance services necessary to maintain a safe homelike interior and (2.) failed to exercise reasonable care for the protection of the resident's property from the wandering residents. This was evident for 1 of 8 rooms and 1 (Resident #67) out of 3 residents observed during the annual survey. The findings include: 1a. On 12/2/24 at 1 PM surveyors conducted an environmental tour which revealed: - room [ROOM NUMBER]: the baseboard on the wall adjacent to the resident's closet had visible damage- jagged edges where pieces of the baseboard were missing. - Circular shaped brown stains on two ceiling tiles in the shower room on the 200 unit One of the stained areas measured 6 inches in diameter and the other area measured 2 inches in diameter. - A structural wall to the left upon entrance into the shower room on the 200 unit with two capped copper pipes 1/2 inch in diameter, projected out of the wall. The copper pipes measured approximately 4 to 6 inches in length, sticking out of the wall. On 12/4/24 at 7:45 AM surveyors and the Director of Nursing (DON) conducted a tour of the shower room on the 200 unit and identified the stained ceiling tiles and 2 copper pipes projected out of the wall. The surveyor expressed concern about lack of resident safety with the copper pipes exposed and protruding out of the wall. The DON confirmed that there was daily resident use of that shower room and stated she will notify the Maintenance Director to address the identified concerns. 49815 1b. During the tour of the facility on 12/2/2024 at 8:15 AM to 10:45 AM the surveyor observed the following items in need of repair: the floor tile missing around sink area and baseboards marred and missing in Resident #29's room; the baseboard in bathroom not secured to the wall, marred walls and sink counter warped in Resident #34's room; sink counter top not secure to base and marred walls in bathroom in Resident #2's room; cracked lampshades and marred bathroom walls in Resident #21's and 32's room. In addition, the surveyor observed missing baseboard and floor tile in the Spa/Shower Room on Unit 200. In an interview with the Nursing Home Administrator (NHA) at 7:30 AM on 12/11/2024 the surveyor addressed the marred walls, unsecured and missing baseboards, missing floor tiles, and unsecured and warped sink counter tops in the resident rooms. The NHA stated that she was aware of the repairs that were needed for the walls, closets, sinks and counter tops, and the baseboards and floors. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Home Administrator (NHA) further stated that there was a plan in place for repairing these items and replacement of the sink counter tops and closets, but currently there was no flooring underneath the closets and that this would be a concern with replacement of the closets. 45733 2. Observation, on 12/2/24 at 01:04 PM, found that Resident #67 was upset about her cell phone charger which was broken 2 weeks ago and her notebook got taken by the resident who wandered into her room. Furthermore, this resident had other items missing and written information on a bulletin board got wiped out. The Resident was afraid and upset that her personal property was frequently taken or destroyed, especially when he/she was asleep. Resident #67 stated nursing staff were aware, but they could not stop the wandering residents. Resident #67 was admitted to the facility on [DATE] with encephalopathy with a substance abuse history, seizures disorder and contracture of the left hand. This resident was alert, oriented and can make he/she needs known. During the interview, on 12/10/24 at 10:20 AM, the Director of Nursing (DoN) and the [NAME] Clinical Director revealed that they were not aware that Resident #67's cell phone charger was recently destroyed. However, the DoN admitted that she was aware of the wandering residents roaming in the hallway who entered other residents' rooms to take and break personal properties. During Interview, on 12/10/24 at 10:36 AM, the DoN reported that the facility had replaced the Resident's cell phone charger. During the interview, on 12/11/24 at 9:15 AM, Resident #67 stated that he/she still did not feel safe and needed to secure personal belongings. During the further interview, the [NAME] Clinical Director was made aware that the above finding was a concern.

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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. 44440 Based on medical record review, and interviews it was determined the facility failed to provide the Resident and/or Representative with a written notice of the facility's bed hold policy upon transfer to an acute care facility. This was evident for 2 (Resident #54 [1.] and #34 [2.]) of 6 residents reviewed for hospitalization . The findings include: 1. On 12/3/24 at 1:53 PM, the surveyor reviewed Resident #54's medical record. The review revealed that resident #54 was sent to the hospital on 12/1/24. On 12/4/24 at 12:24 AM, the surveyor reviewed the transfer documents that were sent to the hospital. A bed hold was filled out on 12/1/24 by Unit Manager Staff #15 indicating that Resident #54 wanted a bed hold. There was no indication on the form that the resident and/or representative was informed or contacted to place the bed hold. On 12/4/24 at 12:57 PM, the surveyor conducted an interview with Staff #15 and the Director of Nursing (DON). During the interview Staff #15 reported that she initiated the bed hold because the Resident #54 was anticipated to return to the facility. The surveyor asked if she spoke to Resident #54's representative. The DON stated the Admissions Director reaches out to the family. On 12/4/24 at 1:47 PM, the surveyor interviewed Admission Director Staff #12. During the interview Staff #12 stated she reaches out to residents and/or their representatives once she is notified they have transferred to the hospital. She further stated that she goes over the bed hold policy and financial obligations via phone and mails them the policy and financial details. Staff #12 stated she reached out to Resident #54's Representative and was waiting to hear back. Staff #12 also stated that she mailed the policy to the Representative. The surveyor asked about the bed hold that was part of Resident #54's transfer packet and asked if the resident and/or representative was not contacted why would it be documented that Resident #54 had a bed hold. Staff #12 stated that Resident #54 was not currently on a bed hold and that nursing staff on the weekends may have sent the document incorrectly. On 12/4/24 at 2:48 PM, the surveyor conducted a follow-up interview with the DON. During the interview the DON stated an in-service was needed to educate nursing staff on the bed hold and procedures for when a resident is transferred on a weekend. 49815 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A Bed Hold is the act of holding or reserving a Resident's bed while the Resident is absent from the facility for therapeutic leave or hospitalization . It must be provided to all facility Residents regardless of payment source. The Bed Hold policy should be disclosed in the admission packet during initial admission to the facility and it should be disclosed to Resident and, if applicable, Resident Representatives at the time of transfer; if emergency transfer, within 24 hours. The surveyor conducted a record review on 12/4/2024 at 11:00 AM of Resident #34's medical record. The review of the medical record revealed that Resident #34 was transferred to the hospital on the following dates: 10/4/2022 and 7/21/2024. Further review of the medical record revealed that Resident #34 had a Resident Representative/Guardian and physician certification of incapacity. The Guardian of Resident #34 was notified by mail of the bed hold policy for the 10/4/2022 transfer to the hospital but was not notified of the bed hold policy for the 7/21/2024 transfer to the hospital. At 1:00 PM on 12/4/2024 the surveyor interviewed the Admissions Director employee #12 and asked what the expectation was for notification of bed hold policy when residents were transferred to the hospital. The Admissions Director stated that she was responsible for notification of the bed hold policy to Resident and Resident Responsible Party when residents were transferred to the hospital. The Admissions Director stated that she did not notify Resident #34's Responsible Party of the bed hold policy for the 7/21/2024 transfer to the hospital since the resident only went to the emergency room (ER) even though Resident #34 stayed out of the facility overnight. The Admissions Director further stated that for the last couple of months, she has notified the resident and/or Responsible Party of bed hold policy for all transfers to the hospital, no matter if the resident was admitted to the hospital or only seen in the ER. The Admissions Director provided a copy of the notification of bed hold policy to the surveyor.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on observation, facility staff interview and medical record review, it was determined that the facility failed to accurately document resident assessments on the MDS (Minimum Data Set) as evidenced by inaccurate coding for residents. This was found to be evident for 2 (Resident #42 [1.] and #79 [2.]) out of 2 residents reviewed for accuracy of MDS assessments. The findings include: 1. A colostomy is a surgical procedure that creates an opening in the colon (large intestine). The opening is called a stoma. A bag called a stoma appliance is placed around the opening to allow stool to drain. On 12/2/2024 at 10:45 AM the surveyor observed Resident #42 in bed in the resident's room. The resident was observed with a colostomy bag on the abdomen. The surveyor interviewed Registered Nurse (RN) Unit Manager #8 on 12/5/2024 at 10:15 AM. The surveyor asked the RN, Unit Manager #8, if Resident #42 had a colostomy and if Resident #42 was admitted to the facility with a colostomy. The RN Unit Manager #8 stated that Resident #42 had a colostomy and was admitted to the facility with a colostomy. Resident #42 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. The Minimum Data Set (MDS) is a health status screening and assessment tool used for all residents of Long-Term Care Nursing Facilities. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems. The surveyor conducted a record review of Resident #42's medical record on 12/5/2024 at 11:00 AM. The medical record review revealed that the Discharge MDS dated [DATE] Section H - Bladder and Bowel was coded Appliances - Ostomy/Colostomy and Bowel Continence - Always incontinent. In addition, the Medicare/5-day MDS dated [DATE] Section H - Bladder and Bowel was coded Appliances - None and Bowel Continence - Always incontinent. The surveyor interviewed the MDS Director #9 on 12/5/2024 at 11:10 AM and asked what the expectation was for coding a MDS for a resident with a colostomy and bowel continence. The MDS Director stated that if a resident had a colostomy that Bowel Continence was to be coded as Not rated and Appliances coded as Ostomy. The MDS Director acknowledged the inaccurate coding for Resident #42 on the Discharge MDS dated [DATE] and the Medicare/5-day MDS dated [DATE]. Further review of the Resident #42's medical record on 12/5/2024 revealed that the MDS Director completed a Modification to the 10/27/2024 Discharge MDS and the 11/8/2024 Medicare/5-day MDS with the accurate codes for Appliances/Ostomy and Bowel Continence/Not rated after surveyor intervention. 51589 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. On 12/4/2024 at 10:40 AM, Resident #79's medical record was reviewed by the surveyors. The care plan with completion date of 11/4/2024 revealed Resident #79 was on hospice services, initiated on 4/27/2023, and revised on 9/16/2024. Further record review on 12/4/2024 at 10:44 AM revealed a quarterly MDS assessment dated [DATE] which, under section O for hospice, no was documented. An interview was conducted by surveyors with the MDS Director on 12/5/2024 at 9:37 AM. The MDS Director was asked about the quarterly MDS assessment being documented no for hospice services. The MDS Director stated to surveyors that it was an error hospice services was incorrectly coded no, and submitted a modification of quarterly to MDS to correct the discrepancy. During an interview on 12/5/24 at 10:30 AM, the Executive Director acknowledged the concern that the MDS was coded inaccurately and stated she thought the MDS modification was already transmitted.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 51589 Based on medical record review and staff interview, it was determined that the facility failed to initiate a new pre-admission screening and resident review (PASARR) Level I screen after a resident was diagnosed with bipolar disorder while admitted to nursing facility. This was identified for 1 (Resident #49) of 1 resident reviewed for PASARR requirements during an recertification survey. The findings include: According to the State Operations Manual, The PASARR process requires that all applicants to Medicaid-certified nursing facilities be screened for possible serious mental disorders, intellectual disabilities and related conditions. This initial screening is referred to as Level I Identification of individuals with mental disorder (MI) or intellectual disorder (ID), and is completed prior to admission to a nursing facility. The purpose of the Level I pre-admission screening is to identify individuals who have or may have MD/ID or a related condition, who would then require PASARR Level II evaluation and determination prior to admission to the facility. Resident #49's medical record was reviewed by surveyors on 12/5/2024 at 1:30 PM. The record revealed that Resident #49 was admitted to the nursing facility from an acute care hospital on 11/15/2021. The resident ' s record show a PASARR level I screening was completed on 11/15/2021 by the discharging hospital, and that Resident #49 was not identified as requiring a PASARR Level II evaluation. Further review of the discharge summary from the acute care hospital did not reveal a diagnosis of bipolar disorder. Review of the nursing facility diagnosis report on 12/6/2024 at 10:00 AM revealed that Resident #49 was not diagnosed with bipolar disorder upon admission on 11/15/2021, but the diagnosis was later added during the resident's stay on 4/6/2022. Review of the quarterly Minimum Data Set (MDS) from 5/22/2022 shows that Resident #49 was coded yes under section I for bipolar disorder. On 12/9/2024, the nursing facility Admissions Director (AD) was interviewed at 7:44 AM. The AD stated during the interview that residents who have an updated diagnosis of MI or ID while admitted to the nursing facility should have a new Level I PASARR conducted to determine if a Level II evaluation is appropriate. The AD stated she was in the process of updating Resident #49's PASARR, and that a new PASARR Level I should have been conducted when Resident #49 was diagnosed with bipolar disorder while admitted to the nursing facility. The Executive Director (ED) was interviewed on 12/10/2024 at 8:50 AM. The ED acknowledged the concern about PASARR assessments, stating to surveyors that there is now a process in place to update PASARRs when new MD/ID diagnoses are captured while residents are in the nursing facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review and interviews, it was determined that the facility failed to include all initial healthcare information in the baseline care plan. This was found evident of 1 (resident #94) of 5 residents reviewed for care planning. The findings include: On 12/5/24 at 10:04 AM, the surveyor reviewed Resident #94's medical record. The review revealed that Resident #94 was admitted to the facility on [DATE]rd 2024. Further review revealed that Resident #94 had a past medical history that included, but not limited to, congestive heart failure, atrial fibrillation (abnormal heart rhythm), malaise (weakness) disease of the digestive system and dementia. Next the surveyor reviewed Resident #94's care plan. Care plan topics were first initiated on 10/3/24 and included activities of daily living, risk for pain and risk for falls. On 10/4/24 additional care plans were added to include the need for enhanced barrier precautions, risk for bleeding, congestive heart failure, hypertension (high blood pressure)/atrial fibrillation. On 10/7/24 a care plan was initiated for altered nutrition and a need for a therapeutic diet. Some of the interventions listed were to observe for signs and symptoms of aspiration (accidental inhalation of food or liquid into the lungs), and dysphagia (difficulty swallowing). On 12/5/24 at 1:06 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated that a lot of the care plans are initiated based on the assessments of the Minimum Data Set (MDS) resident assessments. The surveyor requested Resident #94's baseline care plan. On 12/05/2024 at 1:21 PM, the surveyor interviewed the MDS Staff #10. During the interview Staff #10 stated the nurse manager initiates the base line care plan and that the MDS staff adds to the care plan based on further assessments. On 12/5/24 at 1:41 PM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the surveyor asked to see the baseline care plan for Resident #94. The NHA stated that the base line care plan is documented in the same place as the comprehensive care plan and that the base line care plan is distinguished by the date it was initiated. She further explained that the baseline care plan is the care plan initiated within 48 hours of admission. The NHA stated that baseline care plans are gone over with the resident and that a copy of the care plan and order are given during the comprehensive care plan meeting. The surveyor relayed the concern that Resident #94's baseline care plan (or care plan that is to be developed in 48 hours after admission) was missing a care plan for diet/nutrition especially because in Resident #94's comprehensive care plan Resident #94 required a special diet with supervisory intervention. The surveyor reviewed the facility's policy on baseline care plans. The policy described that a baseline care plan was also referred to as the 48-hour care plan. It further explained the minimum requirement of the base line care plan which includes addressing the physician and dietary orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review and interviews it was determined that the facility failed to develop a comprehensive person-centered care plan. This was found to be evident of 3 (Resident #94 [1.], #77 [2.] & #42 [3.]) of 13 Residents reviewed for care planning. The findings include: 1. On 12/5/24 at 10:04 AM, the surveyor reviewed Resident #94's medical record. The review revealed that Resident #94 was admitted to the facility in October of 2024. Further review revealed that Resident #94 had a past medical history of urinary retention and malaise (weakness). On 12/5/24 at 11:16 AM, the surveyor observed Resident #94 resting in bed with a urinary bag hanging on the side of the bed. Next the surveyor reviewed Resident #94's care plan. No care plan was noted for an indwelling urinary device. On further review a care plan for Activities of Daily Living (ADLs) that was initiated on 10/3/24 indicated that Resident #94 was dependent, needing substantial/maximal assistance, and totally dependent for hygiene, shower/bath, lower body dressing, putting on and taking off footwear. Additional ADL care areas had multiple dependency levels as well. On 12/5/24 at 1:06 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated that care plans are initiated based on the assessments of the Minimum Data Set (MDS) resident assessments. The DON confirmed that there was no care plan for Resident #94's indwelling urinary device and that Resident #94's ADL care plan was not appropriately developed and based on Resident #94's individual assessment of support needs. She further clarified Resident #94 should have only had one level of support indicated. On 12/05/2024 at 1:21 PM, the surveyor interviewed the MDS Staff #10. During the interview Staff #10 stated the nurse manager initiates the initial care plans and that the MDS staff adds to the care plan based on further assessments. Staff #10 confirmed the support/functional needs assessment was documented in error and that every box was not supposed to be checked for Resident #94's support assessment. She further stated she would revise the assessment and care plan. On 12/5/24 at 1:38 PM, the surveyor conducted an interview with Unit Manager Staff #8. During the interview Staff #8 stated that nursing would be responsible for initiating a foley or indwelling urinary device care plan for a Resident. She confirmed Resident 94 should have an indwelling device care plan but it was missed. She further stated she would initiate the care plan. 50385 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 12/02/24 at 11:20 AM, an observation and interview of Resident #77 was conducted. It was noted that the resident had one lens on the left side of their glasses and no lens on the other side. When asked how long ago the resident had lost their lens, the resident stated it was months ago at the facility. The resident stated they let the staff know their lens fell out. When asked if they knew when their last ophthalmologist appointment was, the resident stated they had not seen an ophthalmologist since admission to the facility. On 12/05/24 at 10:20 AM, an interview was conducted with the Director of Nursing (DON). When asked whether Resident #77 has seen an ophthalmologist since being admitted to the facility, the DON stated he has not seen one. This surveyor made the DON aware of resident's missing lens from glasses, and the DON stated that they will request for the ophthalmologist to see him. On 12/05/24 at 10:35 AM, a review of Resident #77's care plan was conducted. The resident has no care plan in place for vision or accessibility to glasses. 49815 3. A colostomy is a surgical procedure that creates an opening in the colon (large intestine). The opening is called a stoma. A bag called a stoma appliance is placed around the opening to allow stool to drain. On 12/2/2024 at 10:45 AM the surveyor observed Resident #42 in bed in the resident's room. The resident was observed with a colostomy bag on the abdomen. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. The surveyor conducted a record review of Resident #42's medical record on 12/5/2024 at 8:30 AM. The medical record review revealed that Resident #42 did not have a care plan developed and implemented for the colostomy. The surveyor interviewed Registered Nurse (RN) Unit Manager #8 on 12/5/2024 at 10:15 AM. The surveyor asked the RN Unit Manager #8 if Resident #42 had a colostomy and if Resident #42 was admitted to the facility with a colostomy. The RN Unit Manager #8 stated that Resident #42 had a colostomy and was admitted to the facility with a colostomy. Resident #42 was originally admitted to the facility on [DATE] and readmitted to facility on 11/3/2024. At 11:00 AM on 12/5/2024 the surveyor interviewed the Director of Nursing (DON) with the Nursing Home Administrator (NHA) in attendance regarding the care and services of a resident with a colostomy. The surveyor conveyed to the DON and the NHA that Resident #42 had a colostomy but did not have a care plan for colostomy care and services. The DON stated that she would look into this. On a follow up interview with the Director of Nursing on 12/5/2024, the DON acknowledged that Resident #42 did have a colostomy but did not have a care plan for colostomy care. The DON provided the surveyor with a copy of the comprehensive care plan for Resident #42 and this care plan did not have a focus, goal or intervention for colostomy care and services.

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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** 49815 Based on interview and medical record review it was determined that the facility failed to update and revise resident's care plans. This was found to be evident in 1 (Resident #42) out of 3 residents reviewed for care plan timing and revision. The findings include: The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems of residents. Apixaban (brand name Eliquis) is a prescription anticoagulant medication that helps prevent and treat blood clots. It works by inhibiting factor Xa, a clotting factor, which slows blood clotting. Clonazepam (brand name Klonopin) is a prescription benzodiazepine medication used to prevent and treat anxiety disorders and seizures and promote relaxation. Clonazepam produces a calming effect on the brain and nerves. On 12/5/2024 at 8:30 AM the surveyor conducted a record review of Resident #42's medical record. The record review revealed that Resident #42 had current physician orders for Apixaban 2.5 mg twice a day for DVT (deep vein thrombosis) and Clonazepam 0.5 mg three times a day for anxiety. The Admission MDS dated [DATE] and the Medicare-5-day MDS dated [DATE] for Resident #42 was coded for the usage of anticoagulant medication and antianxiety medication. 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. Further review of Resident #42's medical record on 12/5/2024 revealed the resident was originally admitted to the facility 10/8/2024 and discharged to the hospital on 10/27/2024, and then was readmitted to the facility 11/3/2024. There was a care plan for the usage and monitoring of anticoagulant medication and the antianxiety medication for the 10/8/2024 original admission to the facility, but there was no revision or update to the care plan that indicated the usage and the monitoring of anticoagulant medication and antianxiety medication for the 11/3/2024 readmission to the facility. On 12/5/2024 at 2:50 PM the surveyor interviewed the Director of Nursing (DON) and the DON confirmed that Resident #42 had two care plans, one care plan that was cancelled/closed when Resident #42 was discharged [DATE] to the hospital and another care plan that was initiated/created when Resident #42 was readmitted [DATE] to the facility.

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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 and interview, 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 (Resident #449[1.] & #68[2.]) out of 11 Residents reviewed for Activity of Daily Living (ADL) cares. The findings include: 1. On 12/2/24 at 2:13 PM, the surveyor interviewed Resident #449. During the interview Resident #449 stated that he/she had concerns about ostomy (a surgical procedure that creates an opening in the abdominal wall to allow waste to exit the body) cares. On 12/5/24 at 11:08 AM, the surveyor reviewed Resident #449's medical record. The review revealed that Resident #449 had a care plan initiated on 11/18/24 that stated, Resident #449 has an alteration in bowel elimination related to need for ileostomy (an ostomy in which the opening is the end of the ileum, the lowest part of the small intestine). An intervention listed was, provide assistance with ostomy care as needed. On further review a Minimum Data Set (MDS) assessment, that was completed on 10/20/24, documented that Resident #449 was dependent (a helper needed to complete the activity for the resident) with toileting hygiene or managing the ostomy, to include wiping the opening. On 12/6/24 at 8:11 AM, the surveyor reviewed Resident #449's orders. The review revealed that on 12/5/24 orders were put in for ostomy cares. The surveyor next reviewed the Treatment Administration Record (TAR) for Resident #449. No cares were documented on the December TAR for ostomy care and only starting on 12/5/24 was there an area for cares to be documented. On 12/6/24 at 11:07 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON confirmed that the ostomy care orders were only entered yesterday and not at the time of admission. She further stated that when orders are written they are entered into the TAR. The DON was unable to provide documentation that Resident #449 was assisted and provided ostomy cares according to his/her care plan. 50385 2. On 12/03/24 at 9:30 AM, an interview was conducted with Resident #68's representative. The representative stated that on 10/28/24 they visited the resident and upon observation the residents toenails were unkempt. They stated the nails were as long as my pinky finger. The representative stated that when they notified nursing and administration, the toenails were addressed. On 12/4/24 at 9:00 AM, a review of complaint #MD00211334 and the facilities investigation relating to FRI #MD00211725 was conducted. The facilities investigation documented that Resident #68's toenails were trimmed at time of complaint and podiatry was consulted. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 11:38 AM, a review of Resident #68's podiatry notes was conducted. The resident had last been seen by a podiatrist on 4/24/24. In the podiatry note on 4/24/24, the podiatrist noted, Debrided nail(s) to patient tolerance. Non-professional treatment is hazardous to the patient. On 12/4/24 at 1:21 PM, a review of Resident #68's Minimum Data Set (MDS). An MDS is a federally mandated assessment tool used in nursing homes to evaluate the health needs and functional capabilities of residents. Under the self-care portion (GG0130) of the MDS conducted on 10/31/24, it states that the resident is dependent, requiring the helper to do all the effort or the activity requiring 2 or more helpers to complete, for Putting on and taking off footwear and Personal hygiene.

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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. 44440 Based on observations, interviews, and record review, it was determined that the facility failed to provide treatments according to a resident's plan of care. This was found evident of 2 (Resident #71 & #94) out of 32 residents reviewed during the survey. The findings include: 1a) On 12/2/24 at 10:12 AM, the surveyor interviewed Resident #71. During the interview Resident #71 stated that he/she had problems with constipation. Resident #71 further stated that he/she was given Miralax (a medication used to prevent and treat constipation) but still could go 2-3 days without having a bowel movement. On 12/5/24 at 8:43 AM, the surveyor reviewed Resident #71's medical record. The review revealed Resident #71 had a care plan initiated on 3/28/23 that stated Resident #71 is at risk for constipation related to decreased mobility. An intervention listed was to administer medications per medical provider's order. On further review the surveyor noted a progress note written by Nurse Practitioner (NP) Staff #22 written on 9/19/24. The note stated that Resident #71 complained of occasional hard stools. Staff #22 wrote that she would increase Senna (a medication that helps prevent and treat constipation) to be given two times per day and to continue Miralax daily. Additionally, Dulcolax suppository and fleet enema would be available to be given as needed. On 12/6/24 at 6:12 AM, the surveyor reviewed documentation for Resident #71's bowel movements (BM). No bowel movement was recorded on 12/2/24, 12/3/24, 12/4/24 and 12/5/24. Next the surveyor reviewed the December 2024 Medication Administration Record (MAR) for Resident #71. The review revealed that Resident #71 did not receive any of the as needed medications to help with constipation. Dulcolax rectal suppository was written to be given as needed if no BM for two days and Bisacodyl fleet (rectal) enema was to be given in no results from suppository or if no BM for 3 days. On 12/6/24 at 8:28 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON stated she had talked to the Unit Manager Staff #8 and she had asked Resident #71 when his/her last BM was and he/she reported it was Wednesday 12/4/24. DON confirmed there was no documentation in Resident #71's chart to reflect that and that a late entry would be made. The surveyor reviewed the concern that if the nurse was reviewing the documentation of bowel movements that the as needed suppository would have been given per physician's order and if Resident #71 did report he/she had a bowel movement then there would be notation as to why the suppository was not given per order. 1b) On 12/5/24 at 10:04 AM, the surveyor reviewed Resident #94's medical record. The review revealed that Resident #94 was admitted to the facility in October of 2024. Further review revealed that Resident #94 had a past medical history of urinary retention. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 11:16 AM, the surveyor observed Resident #94 resting in bed with a urinary bag hanging on the side of the bed. The surveyor next reviewed Resident # 94's orders and noted an order written on 10/4/24 that stated foley catheter care every shift and as needed. It also stated to document output on every shift. The surveyor reviewed the December Treatment Administration Record (TAR) and point of care documentation. The review revealed that no documentation of urinary output was recorded. On 12/5/24 at 1:06 PM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that facility staff failed to document the urinary output according to the physician's order.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50385 Based on resident interview, record review, and staff interview, it was determined that the facility failed to ensure to coordinate vision services for a resident. This was evident for 1 (Resident #77) of 8 residents reviewed for vision. The findings include: On 12/02/24 at 11:20 AM, an observation and interview of Resident #77 was conducted. It was noted that the resident had one lens on the left side of their glasses and no lens on the other side. When asked how long ago the resident had lost their lens, the resident stated it was months ago at the facility. The resident stated they let the staff know their lens fell out, but there was never any follow up. When asked if they knew when their last ophthalmologist appointment was, the resident stated they had not seen an ophthalmologist since admission to the facility. On 12/05/24 at 10:04 AM, Resident #77's records were reviewed. A consult for Audiology, Dental, Optometry, Ophthalmology and/or Podiatry as needed was ordered on 6/20/2024 at 17:04 (5:04 PM) . The resident's record shows that the resident was admitted on [DATE]. On 12/05/24 at 10:20 AM, an interview was conducted with the Director of Nursing (DON). When asked whether Resident #77 has seen an ophthalmologist since being admitted to the facility, the DON stated he has not seen one. This surveyor made the DON aware of resident's missing lens from glasses, and the DON stated that they will request for the ophthalmologist to see him.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49815 Based on resident observation, staff interview and record review it was determined that the facility failed to provide adequate care and services for a resident that required colostomy care. This was found to be evident in 1 Resident #42 out of 1 Resident reviewed for colostomy care and services. The findings include: A colostomy is a surgical procedure that creates an opening in the colon (large intestine). The opening is called a stoma. A bag called a stoma appliance is placed around the opening to allow stool to drain. On 12/2/2024 at 10:45 AM the surveyor observed Resident #42 in bed in Resident room. The resident was observed with a colostomy bag on the abdomen. The surveyor conducted a record review of Resident #42's medical record on 12/5/2024 at 8:30 AM. The medical record review, specifically the physician orders, revealed that Resident #42 did not have a physician order for the care of the colostomy. The surveyor interviewed Registered Nurse (RN) Unit Manager #8 on 12/5/2024 at 10:15 AM. The surveyor asked the RN Unit Manager #8 if Resident #42 had a colostomy and if Resident #42 was admitted to the facility with a colostomy. The RN Unit Manager #8 stated that Resident #42 had a colostomy and was admitted to the facility with a colostomy. Resident #42 was originally admitted to the facility on [DATE] and readmitted to facility on 11/3/2024. At 11:00 AM on 12/5/2024 the surveyor interviewed the Director of Nursing (DON) with the Nursing Home Administrator (NHA) in attendance regarding the care and services of a resident with a colostomy. The surveyor conveyed to the DON and the NHA that Resident #42 had a colostomy but did not have a physician order for colostomy care and services. The DON stated that she would look into this. On follow up interview with the Director of Nursing on 12/5/2024, the DON acknowledged that Resident #42 did have a colostomy but did not have a physician order for colostomy care. The DON provided the surveyor with a copy of a physician order for colostomy care and services for Resident #42 with a date stamp of 12/5/2024 at 11:21 AM after surveyor intervention.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49815 Based on observation, interview and medical record review it was determined that the facility failed to provide respiratory care and services appropriately. This was found to be evident for 1 (Resident #21) out of 1 resident that was reviewed for respiratory care and services. The findings include: On 12/2/2024 at 10:35 AM the surveyor conducted a tour of Unit 200 and observed Resident #21 in the resident's room with oxygen in use. The surveyor observed that Resident #21 did not have an oxygen in use - no smoking signage on Resident #21's door to the resident's room. The Medication/Treatment Administration Record (MAR/TAR) is a standardized record that organizes essential information about a resident and the prescribed medication and treatment. This vital document supports healthcare providers by tracking doses, preventing errors, and providing a clear record of care. The surveyor conducted a record review on 12/4/2024 at 7:30 AM of Resident #21's medical record. This record review revealed that Resident #21 had a physician order for continuous oxygen and had a care plan intervention for oxygen therapy as ordered. Further review of the medical record, specifically the medication/treatment administration record revealed that the nursing staff documented that Resident #21 used oxygen every shift daily since 11/1/2024. The surveyor observed Resident #21 in bed on 12/4/2024 at 9:00 AM with oxygen in use and there was no oxygen in use - no smoking signage posted on Resident #21's door. On 12/6/2024 at 8:58 AM the surveyor observed Resident #21 in the room with oxygen in use and there was no signage posted for oxygen in use - no smoking. The surveyor interviewed Registered Nurse (RN) Unit Manager #8 on 12/6/2024 at 9:05 AM and asked the RN Unit Manager what the expectation was for oxygen signage posted when oxygen was used for a resident. The RN Unit Manager stated that the oxygen signage should be posted on the resident's room door or the doorframe of the room. The RN Unit Manager further stated that the oxygen signage may have fallen off Resident #21's door or doorframe. The RN Unit Manager stated that she would take care of this.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on interview, record review and observation, it was determined that the facility staff failed to ensure that pain management of an intrathecal baclofen pump was provided to residents who require such services, consistent with professional standards of practice and monitoring appropriately for effectiveness and/or adverse consequences. This was found to be evident for 1 resident (#22) out of 1 for pain management review. The findings included: A baclofen pump is a surgically implanted device that delivers baclofen, a muscle relaxant medication, directly into the spinal canal to treat spasticity and other conditions. The pump's battery typically lasts around six to seven years. When the battery dies, the pump needs to be replaced with a surgical procedure. The pump needs to be refilled regularly, usually every four to six months. A needle is inserted through the skin into the refill port to add baclofen. Complications can occur, including catheter disconnections, migration, kinks, obstruction, and pump dysfunction. running out of baclofen causing symptomatic withdrawal symptoms, pump mechanical failure, pump battery end of life and the need for pump replacement. Observation, on 12/04/24 at 09:22 AM, found that Resident # 22 was asleep and all extremities were flat and rigid. The upper extremities were mildly contracted, and the head was tilted to the left side. Record review, on 12/04/24 at 10:12 AM, revealed that Resident #22 was admitted to the facility on [DATE] with the diagnoses of a motor vehicle accident in 2013 leading to traumatic brain injury status post hemicraniectomy and flap replacement, quadriplegia with severe spasticity, an intrathecal baclofen pump insertion March 2015 and seizures disorder. The current pain management order prescribed Baclofen 10mg give 1 tablet via G-tube three times a day for spasms. A follow-up scheduled at the community Hospital on 9/20/24 for intrathecal baclofen pump refill but no information sent back included for the pump's dosage regimen nor the battery status. During observation, on 12/04/24 at 11:09 AM, Nurse Manager staff #14 at bedside to locate the baclofen pump site and it was located at the resident's right lower quadrant of the abdomen under the skin, however, no nursing documentation for assessing nor monitoring the pump's function, effectiveness and complications. During the interview, on 12/6/24 at 09:20AM, Nurse Manager staff #14 confirmed that the resident's baclofen pump's regiment was not combined with the oral pain management order. In addition, the nursing staff had never had training on the intrathecal baclofen pump care to be able to provide the standard of care and monitoring for effectiveness or adverse consequences. Interview, on 12/06/24 at 09:45 AM, the Administrator and the [NAME] Clinical Director stated that they only had the next baclofen pump refill dates and understood this was a concern because of lacking a standard of care for the intrathecal baclofen pump: baclofen combined dosage orders, current pump dosage sitting, battery status and assessing effectiveness /monitoring for complications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary drugs. This was evident for 2 (Resident #94 and #106) or 7 residents reviewed for unnecessary medications. The findings include: 1a) On 12/5/24 at 10:04 AM, the surveyor reviewed Resident #94's medical record. The review revealed that Resident #94 was admitted to the facility in October of 2024. Further review revealed a progress note written by Nurse Practitioner (NP) Staff #23 on 12/4/24 related to Resident #94's abnormal lab values. Staff #23 documented Resident #94 had a low sodium and magnesium lab. The note further stated that she collaborated with the attending and a new order for sodium chloride 2 grams would be written and magnesium oxide 400 milligrams would be increased to two tables twice a day. On 12/6/24 at 7:25 AM, the surveyor reviewed Resident #94's December Medication Administration Record (MAR). The review revealed that Resident #94 had an order that started on 11/26/24 for sodium chloride 1 gram to be given three times a day. The dates of 12/1/24 through 12/5/24 all three doses were documented as given. On 12/5/24 another order for sodium chloride 2 grams daily was written and this dose was given on 12/5/24. Two different orders for the same medication were given on 12/5/24. On further review it was discovered that the order for sodium chloride 1 gram to be given three times a day was discontinued after all three doses were given on 12/5/24. The surveyor noted that the magnesium oxide order that started on 10/10/24 was discontinued and the increased order for magnesium oxide 400 milligrams to be given twice a day was placed on 12/4/24. There was no duplicate of administration for magnesium oxide. On 12/9/24 at 3:44 PM, the surveyor conducted a phone interview with Resident #94 ' s Primary Care Physician Staff #24. During the interview Staff #24 stated that providers usually do not write multiple medication orders for the same medication. He further stated if the medication needs to be changed the order should be reviewed, the old order discontinued, and the new order should be written. He further stated he was not sure if Staff #23 intended to have both doses given on 12/5/24 but that the 5 grams of sodium chloride would be an acceptable dose for a resident to receive. Staff #24 clarified if the medication was supposed to be given as a one-time dose it should have been written that way. He stated he would educate the NP on duplicate order. 1b) On 12/11/24 at 6:31 AM, the surveyor reviewed Resident #106's medical record. The review revealed that Resident #106 was admitted to the facility in late March of 2024 and was sent to the hospital in early April 2024 related to mental status changes, hypotension (low blood pressure), tachycardia (high heart rate) and increased creatinine and white blood cell count. Resident #106 returned to the facility with a Percutaneous Endoscopic Gastrostomy (PEG) tube or feeding tube related to his/her dysphagia (difficulty swallowing). After two days back at the facility Resident #106 then returned to the hospital due to a dislodged PEG tube and came back to the facility on [DATE] with a new tube placed. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On review of Resident #106's May 2024 Medication Administration Record (MAR) the surveyor noted that when Resident #106 returned to the facility after having his/her PEG tube replaced on 5/1/24, levofloxacin (a medication given to treat a bacterial infection) was ordered and documented as given via oral route on 5/2/24. This order was changed to PEG tube route on 5/2/24 at 11:50 AM but then discontinued altogether on 5/2/24 at 11:53 AM. On review of Resident #106's discharge summary from the hospital dated 5/1/24 Levofloxacin is listed under the medications with the instructions, stop taking these medications. On 12/11/24 at 1:39 PM, the surveyor conducted an interview with the DON. During the interview the surveyor reviewed the concern that the providers notes and orders were not updated according to Resident #106's current plan of care.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50385 Based on interviews and resident records, it was determined that the facility failed to coordinate routine dental services for a resident. It was evident for 1 (Resident #68) of 8 residents reviewed for dental services. The findings include: On 12/03/24 at 9:30 AM, an interview was conducted with Resident #68's representative. The representative stated that on 10/28/24 they visited the resident, and upon their observation the resident's teeth were black. On 12/03/24 at 9:45 AM, Complaint #MD00211334 was reviewed. This complaint expressed concerns with Resident #68's dental care and appointments. On 12/04/24 at 10:40 AM, a review of Resident #68's orders was conducted. An order for a dental consult was made on 8/28/23. On 12/04/24 at 1:52 PM, a review of resident records was conducted. The resident was last seen by the Dental Group on 10/30/23. On the dental note of 10/30/23, the recommendation for the resident was to be seen every 6 months for cleaning with a next annual appointment date of 10/30/24. On 12/04/24 at 1:55 PM, an interview was conducted with the Director of Nursing (DON). When asked who is responsible for scheduling appointments after a consultation or recommendation has been made, the DON stated the specialty care groups take care of following up with recommendations and scheduling appointments and nursing is not responsible for coordinating dental and specialty appointments for the residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44440 Based on interviews and record review, it was determined that the facility failed to keep accurate resident records in accordance with professional standards. This was evident of 1 (Resident #54) out of 32 residents reviewed for accuracy of documentation during the survey. The findings include: On 12/3/24 at 1:53 PM, the surveyor reviewed Resident #54 ' s medical record. The review revealed that Resident #54 was sent to the hospital on 12/1/24. Next the surveyor reviewed the transfer form for Resident #54 dated 12/1/24. The review revealed in the dedicated section titled; Resident Representative Notification, the date and time of 12/1/24 at 12 PM were there, however, the name of the representative was left blank. On 12/4/24 at 12:54 PM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #27. The surveyor asked Staff #27 if she notified Resident #54's representative of the transfer to the hospital. Staff #27 stated she notified Resident #54's representative however, she didn't lock the note until 12/3/24. She further stated the name of whom she notified was now present. On 12/6/24 at 6:23 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor reviewed the concern that when notes are not locked then, information is missing from the medical record and the records are incomplete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50385 Based on observations and staff interviews, it was determined that the facility failed to follow proper infection control practices when handling a resident's waste. This was evident for 1 (Resident #349) of 8 residents reviewed for infection control. The findings include: On 12/2/24 at 8:25 AM, an observation was made of Resident #349's room. A clear plastic bag was lining the commode. Inside the bag was a yellow-colored liquid with a piece of toilet paper inside. This Surveyor took a picture of the commode. On 12/2/24 at 8:27 AM, an interview was conducted with Registered Nurse (RN) #3. When asked why the resident had a plastic bag over the commode, RN #3 stated they were not sure but stated that the resident does things their way. On 12/3/24 at 10:30 AM, an interview was conducted with RN #7. When asked why there was a bag over the commode, the nurse stated they used bags to dispose of the waste when Resident #349 had a stomach infection recently and kept using the plastic bag even after the resident was cleared from the infection. When asked how the waste was disposed of, he could not provide an answer but went to DON for clarification. On 12/3/24 at 10:35 AM, an interview was now conducted with the Director of Nursing (DON). The DON stated that the waste would be disposed of in biohazard bags and that all staff should be aware of this.

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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** 51589 Based on clinical record review and staff interview, it was determined that the facility failed to notify and obtain consent from a resident representative for immunizations. This was evident for 1 (Resident #92) of 5 residents reviewed for immunizations during recertification survey. The findings include: Brief Interview for Mental Status (BIMS) is an assessment tool used to identify cognitive impairment in long-term care facilities and nursing homes. It's a mandatory tool for new residents and is also used regularly to track a resident's cognitive functioning over time. The BIMS score ranges from 0-15, with higher scores indicating better cognitive functioning. The Minimum Data Set (MDS) is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. Resident #92's medical records were reviewed on 12/9/2024 at 8:53 AM by the surveyors. Records revealed that Resident #92 had a BIMS score of 00 on the admission MDS dated [DATE] and Resident #92 had a representative designated on the medical chart. Further record review revealed Resident #92 had verbal declinations for influenza and pneumococcal vaccinations signed by the facility ' s Infection Preventionist (IP) on 10/18/2024. The facility's IP was interviewed on 12/9/2024 at 11:20 AM and asked by the surveyors about the facility's process for obtaining immunization consents. The IP stated they ask residents directly or contact residents ' representatives for consent or declinations. The surveyors addressed consent declination forms for Resident #92. The IP stated that for residents who do not have capacity to make their own medical decisions, there should be documentation that the resident ' s representative was consulted. The IP confirmed to surveyors that there was no documentation that Resident #92 ' s representative was contacted about the resident ' s verbal declination of immunizations. The facility ' s Executive Director acknowledged surveyors ' concerns that Resident #92's representative had not been contacted about immunizations during an interview on 12/10/2024 at 8:50 AM. Record review on 12/10/2024 at 9:02 AM showed that Resident 92's representative had been contacted by the facility's IP and had given consent to administer vaccinations.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42828 Based on observations, review of facility pest control records and interviews of facility staff, it was determined the facility failed to ensure an effective pest control program as flying gnats were observed throughout the building. This was found to be evident during the survey. The findings include: On 12/02/24 at 9 AM, during a tour of the 200 unit, surveyors observed gnats in room [ROOM NUMBER]'s toilet room. On 12/02/24 at 12 noon, surveyors were standing near the entrance of room [ROOM NUMBER] and observed gnats flying near their faces. On 12/03/24 at 9 AM surveyors interviewed, the Food Service Director, Staff #6, who confirmed that the kitchen had gnats by the floor drains and the juice machine. In addition, Staff #6 stated that the maintenance department was contacted at that time to address the issue. On 12/03/24 at 11:30 AM surveyors conducted a review of all maintenance records for room [ROOM NUMBER] which did not reveal any pest control visits or maintenance interventions for gnats. Further review of the facility's Pest Control Binder revealed numerous reports of gnats in resident care areas, however, it did not have any resolutions documented to address the multiple reports from 2017 through 2022 about gnats in the building. On 12/03/24 at 10 AM surveyors were standing at the nurses' station and observed multiple gnats flying around the area. On 12/03/24 at 12:40 PM Surveyors interviewed the Maintenance Director, Staff # 4, who confirmed there were reports of gnats in the building (including the kitchen and in resident areas) and he treated the areas with a device and called in their pest control company to address the issue as well. However, Staff #4 did not provide surveyors with the necessary documentation to show where and how this issue of gnats in the facility was treated or prevented. On 12/03/24 1:30 PM surveyors conducted an interview with the Director of Nursing (DON) and the Maintenance Director present. The surveyor expressed concerns about multiple observations of gnats in the facility by the survey team and a lack of documentation to support the facility's attempt to prevent or treat resident care areas from gnats.