STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215299	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate Hills Rehab & Healthcare Ctr	10 North Rock Glen Road Baltimore, MD 21229

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31145 Based on documentation review and interview it was determined the facility staff failed to promptly notify the physician of a resident's change in condition. This was evident for 1 (#61) of 63 residents reviewed during a complaint survey. The findings include: On 1/9/25 at 11:39 AM a review of Resident #61's medical record revealed Resident #61 was admitted in August 2023 from an acute care hospital for rehabilitation due to debility. Review of complaint MD00196479 alleged that Resident #61 stated to family that he/she had been having chest pains since 10:00 AM on 9/2/23 and that staff had disregarded the resident's complaints. The family arrived at the facility at 4:40 PM and informed staff to call 911, and if they didn't the family would call them. Review of nursing notes dated 9/2/23 at 17:56 (5:56 PM) documented, chest pain. The note also documented, Nitrostat 0.4mg tablet offered, resident refused. Several attempts made and educated on the importance of the medication in the presence of responsible party, [he/she] still refused. Responsible party requested that [he/she] be transferred to the ER for evaluation. Review of a grievance report for an incident dated 9/2/23, that was given to the surveyor from the Nursing Home Administrator (NHA), documented that the previous Director of Nursing (DON) and the NHA spoke to the resident's daughter about the resident's chest pain not being addressed until 4:40 PM. The DON and NHA interviewed the primary nurse for the resident that day, Staff #45, who stated he was told at about 3:50 PM and he offered the resident Nitrostat, a drug used for chest pain. The grievance form documented that there was a statement attached, however it was not attached to the report given to the surveyor. There was no documentation in the medical record until 5:56 PM. On 1/16/25 at 2:49 PM a call was placed to Staff #45. The surveyor was unable to speak to Staff #45. On 1/16/25 at 2:51 PM the NHA stated there was no attachment to the grievance report, therefore could not be reviewed. The NHA was informed that documentation did not support that the physician was notified at 3:50 PM when the nurse became aware of the resident's complaint of chest pain. The NHA agreed with the surveyor's findings.

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on review of facility reported incidents with documentation and interview, it was determined the facility failed to report 1) allegation of misappropriation of property, 2) an injury of unknown source and 3) allegations of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 6 (#31, #42, #47, #34, #48, #50) of 50 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 1/7/25 at 11:30 AM facility reported incident MD00192632 was reviewed and revealed an allegation that on 5/22/23 at approximately 3:00 AM Resident #31 requested to speak with a nursing supervisor to report a geriatric nursing assistant (GNA) threatened the resident, yelled and pounded her first against in the palm of her hand. Review of the email confirmation sheet revealed documentation that the allegation was first reported to OHCQ on 5/22/23 at 9:27 AM. On 1/7/25 at 1:30 PM an interview was conducted with the Nursing Home Administrator (NHA). It was pointed out to the NHA that the nursing supervisor was informed at 3:00 AM, however the report was not submitted to OHCQ until 9:27 AM. The NHA confirmed the finding and said he sent it in as soon as he became aware. 2) On 1/12/25 at 11:35 AM facility reported incident MD00203678 was reviewed and revealed an allegation that on 3/14/24 at 2:00 AM someone came in Resident #42's room and hit the resident in the back. The NHA was made aware on 3/15/24 at 3:00 PM. Review of the facility's investigation revealed a written statement from Staff #47 that documented Resident #42 told Staff #47 at 1:00 AM that he/she wanted Tramadol (pain medication) so Staff #47 said she would tell the nurse. Staff #47 went back 15 minutes later, and the resident said someone hit [him/her] in the head. Staff #47 said she would let the nurse know. Staff #47 stated she reported it to the nurse and the supervisor who were both at the desk. A written statement from the nurse and the supervisor documented they were never made aware. Facility staff failed to report to the NHA immediately after being made aware of the allegation. On 1/15/25 at 7:30 AM an interview was conducted with the NHA regarding the timely reporting. The NHA confirmed that staff did not report the allegation immediately, therefore the allegation was not reported to OHCQ within 2 hours. 3) On 1/13/25 at 7:23 AM facility reported incident MD00207546 was reviewed and revealed an allegation that on 6/9/24 on the 3-11 shift and on 7/6/24 at 11:00 AM Resident #47 was abused by staff members. The allegation was reported on 7/10/24 at 3:20 PM by GNA #51. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 8:02 AM an interview was conducted with the NHA. He stated that he reported it when he found out. He also confirmed all the staff members involved were educated on timely reporting. The NHA stated he was unable to substantiate abuse as there were no reports of witnessing or experiencing abuse by any staff members or residents, including the resident's roommate. 4) On 1/25/25 at 2:15 PM facility reported incident MD00194296 was reviewed and revealed an allegation that Licensed Practical Nurse (LPN) #48 yelled at Resident #34 and refused to change the resident's wound dressing on 6/30/23 at 1:00 AM. Review of the facility's investigation revealed the incident was not reported to the NHA until 7/11/23. Further review of the investigation documented that Staff #48 alleged that Staff #49 and Staff #50 refused to assist in getting Resident #34 out of bed. The NHA and social services interviewed the resident who denied the verbal abuse and did not recall the incident. On 1/15/25 at 7:30 AM the NHA was interviewed and stated that it appeared to be that it was employees that did not like each other and were weaponizing each other. The NHA stated that he wrote both employees up for failing to report the incident in a timely manner. The NHA confirmed he reported it when he was made aware, however he agreed that the staff failed to timely report it to him. 37276 5) On 1/9/25 at 12:00 PM, a review of facility reported incident, MD00208950, revealed on 8/19/24, at approximately 8:50 AM, Resident #48 reported to Staff #44, Geriatric Nursing Assistant (GNA), that there was money missing from the resident's wallet, and Staff #44 then reported the resident's allegation to the Unit Manager. The facility's self-report documented Resident #48 reported that on 8/18/24, before going to bed, the resident had $647 in his/her wallet, and the wallet was left on the resident's bedside table. Resident #48 reported that when s/he woke up, the resident checked his/her wallet and there was only $347 in the wallet. Resident #48 alleged that during the night someone took $300 of his/her money from the resident's wallet. Review of facility documentation revealed an email confirmation that documented the facility's initial report was sent to the State Survey Agency, on 8/19/24 at 7:22 PM. The facility failed to report the allegation of misappropriation of resident property, immediately, but not later than 2 hours after the allegation was made. The concerns with the late reporting of an allegation of misappropriation of property was discussed with the Nursing Home Administer (NHA) on 1/10/25 at 12:42 PM. The NHA acknowledged the concerns at that time and indicated he would look into it. 6) On 1/13/24, a review of facility reported incident, MD00210186, documented Resident #50 was observed with a laceration and swelling above his/her right eye that was an injury of unknown source which was noted by the night shift supervisor on 9/25/24 at 7:00 AM and the Nursing Home Administrator was notified of the injury on 9/25/24 at 9:00 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's self-report documentation revealed an email confirmation which documented the facility's initial report was sent to the State Survey Agency on 9/25/24 at 1:45 PM. The facility failed to report the injury of unknown origin immediately, but not later than 2 hours after the becoming aware of Resident #50's injury of unknown source. On 1/15/25 at 4:53 PM, the facility reported incident, along with the results of the facility's investigation was discussed with the NHA. At that time, when made aware of the concern with late reporting the injury of unknown source to the State office, the NHA stated he could not recall the exact timeline of the events and indicated he was unsure why the incident was not reported timely.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34484 Based on review of facility reported incidents with documentation review and interview, it was determined the facility failed to thoroughly investigate allegation of abuse for residents (Resident #1 and #21). This was evident for 2 of 50 facility reported incidents reviewed during a complaint survey. The findings include: 1. On 1/14/25 review of facility reported incident MD00183017 revealed Resident #21's family member accused other residents of abusing the Resident. Review of Resident #21's medical record on 1/14/25 revealed the Resident was seen by Staff #56 (PsyD/Doctorate of Psychology) on 8/20/22. At that time Staff #56 documented: Resident (#21) stated other residents informed Resident (#21's) family member that a resident was being disrespectful and verbally abusive to patient. The Resident's family member reportedly confronted the Resident. Resident (#21) stated the Resident turned his/her *ss up to me. I'm not doing good. He/she bent down and pulled his/her pants down in the doorway. On 1/15/25 the Surveyor asked the Administrator for the investigation related to the incident that occurred between Resident #21's family member and Resident #58. Review of the investigation revealed although the facility staff investigated the incident between Resident #21's family member and Resident #58 on the smoking patio on 8/18/22, they failed to fully investigate what lead up to that incident including the allegations made by Resident #21 to Staff #58 on 8/20/22. Further review of the facility's investigation revealed that there is no statement from Resident #21 in the investigation related to him/her alleging Resident #58 pulling down his/her pants in Resident #21's doorway. No statement from Resident #58 if the event occurred and no statements from staff that working at that time to see if anyone witnessed the event in the doorway of Resident #21. Interview with the Administrator on 1/15/25 at 1:57 PM confirmed the facility staff failed to complete a thorough investigation of Resident #21's allegations of abuse by Resident #58.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (#36, #37, #42, #34) of 63 residents reviewed during a complaint survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 1/8/25 at 8:46 AM a review of Resident #36's medical record revealed progress notes that documented on 2/22/24 at 3:00 AM, Resident #36 was found by the aide on the floor mat next to the resident's bed. Review of the MDS with an assessment reference date (ARD) of 3/6/24, Section J falls, documented there were no falls during the assessment reference period. The facility failed to capture the fall. Continued review of Resident #36's medical record revealed Resident #36 had additional falls on 3/29/24, 4/6/24, and 5/12/24. Review of the MDS with an ARD of 6/7/24 documented there were no falls. The facility failed to capture the falls. Further review of Resident #36's medical record revealed a 6/19/24 at 11:36 AM nursing note that documented the resident was found on the floor mat in the room by the bedside, stating that [he/she] wanted to go to the bathroom. Review of the MDS with an ARD of 9/7/24 documented no falls in Section J, falls. The facility failed to capture the fall. Review of Section N, injections, was coded as no injections given during the previous 7 days prior to the ARD of 9/7/24. Review of Resident #36's September 2024 Medication Administration Record (MAR) documented that Resident #36 received a Fluad Intramuscular Suspension Prefilled Syringe 0.5 ML (Influenza Virus Vaccine Types A & B Surface Antigen Adjuvant) intramuscularly one time only for Immunization on 9/6/24. The facility failed to capture the injection. On 1/8/25 at 11:42 AM Staff #10 and Staff #11, MDS coordinators, were interviewed. Both staff reviewed the 3/6/24, 6/7/24, and the 9/7/24 errors with capturing falls and the injection. Both reviewed and confirmed the findings. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 1/9/25 at 9:27 AM a review of Resident #37's medical record revealed a 12/28/23 physician assistant progress note that documented Resident #37 was hospitalized on [DATE] to 12/6/23 for treatment for hypoglycemia and dehydration after a fall at home. Review of Resident #37's admission MDS with an ARD of 12/26/23, Section J1700 Fall history of admission/entry: A. Did the resident have a fall any time in the last month prior to admission? Response was 9. Unable to determine. The facility failed to capture the fall at home. Review of Section J2000 Prior Surgery. Did the resident have major surgery during the 100 days prior to admission? The answer was, No. Review of the hospital discharge summary dated 12/6/23, that was uploaded to the system on 12/26/23, documented that the resident was at the hospital for weakness following a fall at home. The discharge summary documented during the hospital stay the resident had a right endarterectomy, (a surgical procedure to remove plaque from a blocked or narrowed carotid artery in the neck) and was transferred to ICU (intensive care unit) for 24 hours for every hour neuro checks. The facility failed to capture the surgery. On 1/9/25 at 12:16 PM Staff #10 confirmed that she made the error. Staff #10 said she meant to ask the resident but forgot about it. She stated that they are doing an audit on all falls. 3) On 1/12/25 at 11:35 AM a review of Resident #42's medical record revealed a quarterly MDS with an assessment reference date of 3/17/24. Review of section C0100, should a brief interview for mental status be conducted; the answer was yes. Review of Section C, Cognitive Patterns, C0200, C0300, C0400, C0600, C0700, C0800, C0900, and C1000 were documented as, not assessed. Review of Section D, Mood was not assessed even though the facility documented a resident mood interview should be conducted. Review of Section J0100 pain management; received scheduled pain medication regimen? The documentation was, yes. Received PRN (when needed) pain medications or was offered and declined? The documentation was, yes. Section J0200: should pain assessment interview be conducted? The documentation was, yes. Section J0300: pain assessment interview. This section was not done even though the resident received pain medication and the prior answer was that a pain assessment should have been conducted. Section J1800, any falls since admission/entry or reentry. This was answered, No. Review of the medical record revealed a 2/14/24 at 6:00 AM nursing note that documented the resident was observed sitting on the floor next to the bed. The facility failed to capture the fall. On 1/15/25 at 8:55 AM an interview was conducted with Staff #11. Staff #11 confirmed that Section C and D were not assessed. Staff #11 stated that they had an issue with social work doing the MDS late. Staff #11 confirmed that pain was not assessed, and she could not understand why. Staff #11 also confirmed the fall error. 4) On 1/25/25 at 2:15 PM Resident #34's medical record was reviewed and revealed an 11/22/23 change in condition note that documented Resident #34 reported that he/she had a fall during the night. Review of the MDS with an ARD of 11/24/23 documented in Section J, no falls. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/15/25 at 8:55 AM an interview with Staff #11 was conducted. Staff #11 confirmed that the 11/22/23 fall was not captured on the 11/24/23 MDS. On 1/15/25 at 1:45 PM the Assistant Director of Nursing was informed of the concern with MDS documentation.

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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. 37276 Based on observation, medical record review, and interviews, it was determined that the facility staff failed follow the care plan, and failed to evaluate and revise a resident's care plan to reflect accurate and current interventions. This was evident for 1 (50) of 50 resident reviewed for facility reported incidents during a complaint survey. The findings include: Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 1/13/25, a review of facility reported incident, MD00210186, documented that on 9/25/24, at approximately 7:00 AM, Resident #50 approached the nurse's station and was observed to have a laceration and swelling above his/her right eye, which was an injury of unknown source. The facility's investigation concluded that the resident, who was cognitively impaired, and independently ambulatory with poor safety awareness, had an unwitnessed fall, and that the resident would be provided a helmet as tolerated for safety. Following review of the facility's self-report, a review of Resident #50's medical record was conducted. In the medical record, the resident's most recent quarterly assessment with an assessment reference date of 12/4/24 documented Resident #50 had severe cognitive impairment, walked independently, and had wandered on 1 to 3 days in the assessment lookback period. 1) Review of Resident #50's care plans revealed a care plan, I require the use of a safety helmet r/t Safety Measure when all else has failed, initiated on 10/3/24 that included the intervention, ensure resident wears soft helmet when out of bed. On 1/15/25 at 2:56 PM, Resident #50 was observed sitting in a chair in front of the nurse's station, and the resident was observed not wearing a safety helmet at that time. The facility staff failed to follow the care plan by failing to ensure the resident wore a soft helmet when s/he was out of bed. Continued review of the medical record failed to reveal documentation to indicate the care plan had been reviewed and revised according to the residents' needs following Resident #50's most recent quarterly MDS quarterly assessment with an assessment reference date of 12/4/24 documented Resident #50, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of Resident #50's care plans revealed a care plan, I had actual falls r/t impaired cognition and poor safety awareness, initiated on 10/7/24, with interventions which included, Ensure I wear nonskid socks at all times, and hipsters (hip protectors) (briefs with hip pad protectors) on at all times and off during care. On 1/15/25 at 2:56 PM, Resident #50 was observed sitting in a chair in front of the nurse's station. At that time, Resident #50 was observed not wearing non-skid socks and s/he was not wearing hipsters. The facility staff failed to follow the care plan by failing to ensure the resident wore a non-skid socks, and hipsters when s/he was out of bed. Continued review of the medical record failed to reveal documentation to indicate the care plan had been reviewed and revised according to the residents' needs following Resident #50's most recent quarterly MDS quarterly assessment with an assessment reference date of 12/4/24 documented Resident #50, On 1/15/25 at 4:24 PM, the concerns with failing to follow the care plan and failing to evaluate and revise the care plan following each assessment were discussed with the Director of Nurses (DON). On 1/16/25 at 3:32 PM, the DON confirmed the above findings and reported that the care plan interventions had been revised.

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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. 34484 Based on complaint, medical record review and interview, it was determined that the facility staff failed to provide needed activities of daily living for a resident dependent on assistance with care (Resident #22). This was evident for 1 of 31 residents reviewed for complaints during a complaint survey. The findings include: On 1/9/25 review of complaint MD00184963 revealed an allegation that Resident #22 complained the Resident only received 2 showers in a 6 week period. Review of Resident #22 medical record on 1/9/25 revealed the Resident was admitted to the facility in August 2022 and discharged in October 2022 with a diagnosis to include need for assistance with personal care. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of the MDS assessment with an assessment reference date of 8/8/22 documented Resident #22 was totally dependent on staff for bathing. Review of Resident #22's Documentation Survey Report for August, September and October 2022 revealed the facility staff documented the Resident received a shower on 8/12, 8/17 and 9/6/22. There were no other shower documentation provided to the Surveyor. Review of nursing notes for Resident #22 failed to produce documentation the Resident received any additional showers. Interview with the Director of Nursing on 1/14/25 at 12:05 PM confirmed the facility staff documented only documented 3 showers during the Resident's 8 week stay at the facility.

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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. 34484 Based on review of complaint, medical record review, and staff interview, it was determined the facility failed to provide care to meet the needs of a resident's physical, mental, and psychosocial health (Resident #27 and #1). This was evident for 2 of 31 residents reviewed for complaints during a complaint survey. The findings include: 1. The facility staff failed to properly perform neuro checks after a fall for Resident #27. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. Review of Resident #27's medical record on 1/10/25 revealed a nurse's note on 1/20/23 that stated, the Resident was observed lying on the floor on his/her right side beside a wheelchair in which he/she was seated, was attempting to transfer himself/herself to bed. Slight hematoma to forehead. Completed a comprehensive multisystem assessment. No other injuries. Neuro checks initiated and normal so far. No further injury. MD notified. New testing orders: Continue Neuro checks, report any abnormalities. Further review of the Resident's medical record revealed after the initial neuro check was documented, no further neuro checks were documented in the medical record. Interview with the Assistant Director of Nursing (ADON) on 1/10/25 at 12:33 PM, stated the facility staff are to complete neuro checks for a resident after a unwitnessed fall or if the resident hits their head. The ADON stated the facility staff should get an initial neuro check after the fall and then every 15 minutes times 4, every 30 minutes times 2, every hour times 4 then every shift for 24 hours. Interview with the ADON on 1/10/25 at 1:33 PM confirmed the facility staff failed to completed neuro checks as ordered for Resident #27 after a fall on 1/20/23.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 31145 Based on medical record review and staff interview it was determined the facility failed to provide timely treatment/services to prevent/heal pressures ulcers. This was evident for 1 (#31) of 31 residents reviewed for complaints during a complaint survey. The findings include: A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). On 1/16/25 at 7:27 AM a review was conducted of Resident #31's medical record which revealed Resident #31 was admitted to the facility in May 2023 from an acute care hospital with diagnoses that included sepsis, end stage renal disease that required dialysis, systemic lupus erythematosus, diabetes, acute respiratory failure, and heart disease. Review of a health status note dated 5/10/23 documented Resident #31 had multiple wounds upon arrival. A 5/10/23 at 19:38 wound note documented there was a healing wound above the sacrum and a pressure ulcer noted near the left inner thigh closest to the groin. A 5/16/23 wound note documented there was a pressure ulcer on the buttock that was a stage II. Review of Resident #31's May 2023 Treatment Administration Record (TAR) revealed the wound dressing for the stage II pressure ulcer was not started until 5/17/23. There were no treatments documented from 5/10/23 until 5/17/23. Continued review of Resident #31's medical record documented that the resident was discharged to the hospital on 5/29/23 and returned on 6/2/23. A 6/3/23 at 6:42 AM nursing note documented that the resident refused to be assessed on admission, two attempts were made with the assigned nursing assistant and the resident still refused. On 6/6/23 a wound note documented there was a pressure ulcer on the left buttock that was a stage III. Review of Resident #31's June 2023 TAR failed to document treatment to the stage III pressure ulcer from 6/3/23 to 6/7/23. Review of a 6/8/23 health status note documented that Resident #31 was transferred to the hospital due to an abscess/cyst to the left abdomen. Review of a 6/16/23 health status note documented Resident #31 returned to the facility from the hospital. A 6/19/23 skin/wound note documented there was a right and left buttock wound and a right heel suspected DTI (deep tissue injury) present on admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the June 2023 failed to show evidence of treatment being done for the right and left buttock until 6/21/23. On 1/16/25 at 11:43 AM an interview was conducted with the Director of Nursing (DON). The DON stated she could not find any documentation to dispute the surveyor's findings. She stated that her expectation was that the charge nurse would assess the resident upon admission and notify the physician of the skin condition and get orders for immediate treatment and then have the wound care nurse assess the resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to assess and evaluate the nutrition needs of residents in a timely manner. (Resident #20). This was evident for 1 of 3 residents reviewed for weight loss during a complaint survey. The findings include. Review of Resident #20's medical record on 1/9/25 revealed the Resident was admitted to the facility on [DATE] and facility staff documented the Resident weight as 285.1 pounds. Review of the nutritional assessment revealed it was completed on 11/1/21, 3 days after admission. The nutritional assessment stated goals were to maintain nutritional status with no signs or symptoms of dehydration and malnutrition. Consume at least 50% of meals and supplements daily. Wound healing. Review of the Resident's documented weights revealed the Resident was not reweighed until 11/16/21 and documented weight of 278.7 pounds, for a weight loss of 6.4 pounds. The next weight documented was 252. 4 pounds on 12/2/21, for a weight loss of 32.7 pounds since admission. Review of a Dietitian note on 12/7/21, the Dietitian documented Weight warning Value 252.4. Resident will be re-weighed. The Resident was assessed by the Dietitian on 12/15/21 and used the weight of 252 from 12/2/21 for the Resident assessment. Further review of Resident #20's documented weights, the Resident was not reweighed until 12/16/21, 14 days after the Dietitian's note. At that time the facility staff documented the Resident's weight is 270 pounds. Further review of Resident #20's medical record revealed the facility staff failed to recognize a documented weight loss on 11/16/21 and on 12/2/21 until 12/7/21, failed to reweigh the Resident timely after the weight loss was identified until 12/16/21. The Resident was discharged from the facility on 12/24/21. Interview with the Director of Nursing on 1/14/25 at 12:50 PM confirmed the facility staff failed to recognize Resident #20's weight loss and intervene timely.

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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. 37276 Based on medical record review and staff interviews, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary medication. This was evident for 1 (#54) of 31 residents reviewed for complaints. The findings include: Seborrheic dermatitis is a common skin condition that can cause dandruff On 1/8/25 a review of complaint MD00212696 alleged that Resident #54's had an infection on his/her head from a condition on the resident's scalp and the facility needed to be investigated for neglect. Review of Resident #54's medical record revealed on 12/13/24 at 5:16 PM, in a progress note, the nurse wrote that on 12/6/24, Resident #54 had his/her hair washed and a haircut, that no injury was sustained from the haircut, and the resident continued on Ketoconazole (antifungal) Shampoo 2 times a week for Seborrheic dermatitis, and the resident had a Dermatology Appointment scheduled on 12/23/24. On 12/23/24, in a Dermatology Report of Consultation, the physician documented the resident had Seborrheic Dermatitis (dandruff), and prescribed Ciclopirox shampoo weekly, let sit 5 minutes, then rinse, and Derma smooth scalp oil, apply to itchy areas on scalp QHS, prn itching and to follow-up in 2 months. Review of Resident #54's January 2025 Treatment Administration Record (TAR) and his/her January 2025 Medication Administration Record (MAR) revealed documentation of 3 active orders for medicated shampoo that were being implemented to treat Resident #54's seborrheic dermatitis. Review of Resident #56's January 2025 TAR revealed a) an 8/20/24 order for Selsun Blue shampoo (treats dandruff) twice a week on shower days for seborrheic dermatitis every day shift every Mon, Thu. that was documented as completed on dayshift on 1/2/25, 1/6/25, 1/9/25, and 1/13/25, and b) a 10/26/24 order for Ketoconazole (antifungal) Shampoo 2 %; Apply to scalp topically one time a day every other day for Seborrheic dermatitis on shower days that was documented as done every other day on 1/2/25, 1/4/25, 1/6/25, 1/8/25, 1/10/25 and 1/12/25. Review of Resident #54's January 2025 MAR revealed a 12/26/24 order for Ciclopirox (antifungal) External Shampoo 1 % (Ciclopirox) Apply to Scalp topically every day shift every Thu for Seborrheic Dermatitis; Leave in for 5 mins then rinse, that was documented as done on Thursday 1/2/24, and Thursday 1/9/24. On 1/15/25 at 4:41 PM, during an interview, the Director of Nurses (DON) was made aware that Resident #54 had 3 orders to treat his/her Seborrheic dermatitis, and the dermatology consult only indicated one medicated shampoo, Ciclopirox, was ordered. The resident's current shampoo treatment orders were reviewed with the DON who stated she would look into the concerns. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 4:26 PM, the DON confirmed that there should only be one medicated shampoo treatment order Resident #54. The DON stated that the resident's Dermatologist was contacted and the order for Ciclopirox Shampoo every Thursday was to be used to treat Resident #54's seborrheic dermatitis and the orders for Ketoconazole and Selsun Blue should be discontinued.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 34484 Based on medical record review and interview, the facility staff failed to follow up with a consultant physician (Resident #22). This was evident for 1 of 63 residents reviewed during a complaint survey. The findings include: Review of Resident #22's medical record on 1/9/25 revealed the Resident was admitted to the facility in August 2022 with diagnosis to include retention of urine. Further review of the Resident's medical record revealed on 8/16/24 the Resident went to a Urology consultation. Review of the Report of Consultation revealed the physician documented, Patient's ambulatory status very poor and wheelchair does not clear the doorway due to his/her bariatric size. Will reschedule at ambulatory surgery center for local cystoscopy and foley change. Further review of the Resident's medical record revealed the Resident was discharged home from the facility on 10/3/22 without a follow up appointment scheduled with Urology. Interview with the Director of Nursing on 1/14/25 at 12:05 PM confirmed the facility staff failed to ensure the Resident had a follow up appointment scheduled with Urology.

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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. 37276 Based on medical record review and staff interview, it was determined that the facility staff failed to keep complete and accurate medical records. This was evident for 2 (#1 and #50) of 50 residents reviewed for facility reported incidents during a complaint survey. The findings include: 1. A wanderguard is a system that uses bracelets and sensors to monitor and prevent residents from wandering off or exiting a safe area. On 1/13/25, a review of facility reported incident, MD00210186, documented that on 9/25/24, at approximately 7:00 AM, Resident #50 approached the nurse's station and was observed to have a laceration and swelling above his/her right eye, which was an injury of unknown source. The facility's investigation concluded that the resident, who was cognitively impaired, and independently ambulatory with poor safety awareness, had an unwitnessed fall. Following review of the facility's self-report, a review of Resident #50's medical record was conducted. In the medical record, the resident's most recent quarterly assessment with an assessment reference date of 12/4/24 documented Resident #50 had severe cognitive impairment, walked independently, and had wandered on 1 to 3 days in the assessment lookback period. Review of Resident #50's Elopement/Wandering Risk Evaluations revealed an evaluation with an effective date of 12/3/24 at 10:57 AM that documented Resident #50 was at risk for wandering and/or elopement and generated care plan interventions which included Wander bracelet placed. Review of Resident #50's December 2024 Geriatric Nurse Aide (GNA) documentation revealed the Intervention/Task, Wanderguard Bracelet that documented Resident #50 wore a wanderguard bracelet on 26 of 31 dayshifts, on 24 of 31 evening shifts, and on 21 of 31 nightshifts in December 2024. Review of Resident #50's January 2025 GNA documentation revealed the Intervention/Task, Wanderguard Bracelet that was signed off to indicate Resident #50 wore a wanderguard bracelet on 11 of 15 dayshifts, 13 of 15 evening shifts and 14 of 15 nightshifts in January 2025. Review of Resident #50's current, active care plans revealed a care plan, I am a wanderer as evidenced by impaired safety awareness; resident wanders aimlessly due to dementia. In the care plan, there were no interventions for the resident to wear a wandering device. Continued review of Resident #50's medical record failed to reveal an order for a wanderguard bracelet On 1/15/25 at 2:56 PM, Resident #50 was observed sitting in a chair in front of the nurse's station, and the resident was observed not wearing a wanderguard device at that time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 4:24 PM, during an interview, when asked whether Resident #50 wore a wanderguard, the Director of Nurses (DON) stated that the resident did not wear a wanderguard and hadn't worn a wanderguard since at least September 2024. At that time, the discrepancy with the documentation in Resident #50's medical record indicating the resident wore wanderguard, which conflicted with the documentation that indicated the resident did not wear a wanderguard, was discussed with the DON. The DON acknowledged the concerns and stated she would look into the concerns and get back with the surveyor. On 1/16/24 at 3:32 PM, the DON confirmed the above irregularities with the documentation in the resident's medical record. The DON reported that Resident #50 did wander, however s/he was no longer at risk for elopement, and did not require a wanderguard. 43648 2. A facility policy titled, Administering Medication, revised 04/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. The policy revealed, 22. The individual administering the medication initials the resident's MAR [medication administration record] on the appropriate line after giving each medication and before administering the next ones. Resident #1's Admission Record indicated the facility admitted the resident on 07/19/2019. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction and bipolar type schizoaffective disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/15/2020, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #1 received scheduled medication to treat pain and received or was offered as needed (PRN; pro re nata) medication to treat pain during the assessment period. Per the MDS, the resident had occasional pain during the assessment period. The MDS indicated the resident received opioid medication three days during the seven-day look-back period. Resident #1's care plan included a focus area initiated 07/26/2024, that indicated the resident had episodes of accusatory and general suspicion of others as evidence by reporting that roommates were watching them, their phone was being tapped by the police, and unfounded claims that roommates needed medical attention related to paranoid personality disorder, and difficulty adjusting to a new roommate. Interventions directed staff to administer medication as ordered (initiated 07/26/2024); anticipate and meet the resident's needs (initiated 07/26/2024); encourage the resident to express their feelings appropriately (initiated 07/26/2024); if reasonable, discuss the resident's behavior (initiated 07/26/2024); and monitor the resident's behavior episodes and attempt to determine the underlying cause (initiated 07/26/2024). The care plan included a focus area initiated 07/22/2019, that indicated the resident had a stroke. Interventions directed staff to administer the resident's medications as ordered by the physician (initiated 07/22/2019). The care plan included a focus area initiated 02/25/2021, that indicated the resident was on antipsychotic medication related to schizoaffective disorder, bipolar disorder, and depression. Interventions directed staff to administer the resident's medications as ordered (initiated 07/22/2019). The care plan included a focus area initiated 07/22/2019, that indicated the resident had altered cardiovascular status. Interventions directed staff to administer the resident's medications as ordered (initiated 03/07/2024). Resident #1's Order Recap [Recapitulation] Report, for the timeframe from 07/19/2019 through 01/31/2025, included the following orders: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Aspirin (a platelet aggregation inhibitor) chewable tablet 81 milligrams (mg), one tablet one time per day for stroke prevention, with a start date of 06/14/2023. - Dicyclomine hydrochloride (HCl) (an anticholinergic gastrointestinal antispasmodic) 20 mg, one table by mouth one time a day for gastrointestinal supplement, with a start date of 09/16/2020. - Lidocaine (a topical anesthetic) patch 5%, to be applied to the lower back one time per day for pain, with a start date of 07/22/2022. - Ezetimibe (a cholesterol absorption inhibitor) tablet 10 mg, one time a day for Hypercholesterol, with a start date of 08/07/2023. - Lisinopril (an angiotensin converting enzyme inhibitor) tablet 40 mg, one tablet by mouth one time a day for hypertension, with a start date of 06/05/2021. -Polyethylene glycol (an osmotically acting laxative), 17 grams by mouth one time a day for a laxative, with instructions to not give the medication when the resident had any loose stools. The order had a start date of 06/05/2020. - Nitroglycerin (an antianginal agent) transdermal patch 24 hour 0.2 milligrams per hour (mg/hr), one patch one time a day for hypertension. - Prasugrel HCl (platelet aggregation inhibitor) tablet, 10 mg one time a day for coronary artery disease, with a start date of 08/07/2023. - Cinacalcet HCl (a calcimimetic) tablet, 30 mg one time per day for hypercalcemia, with a start date of 09/01/2024. - Quetiapine fumarate (an atypical antipsychotic) 25 mg, one tablet three times a day for schizophrenia, with a start date of 09/09/2024 and end date of 10/17/2024. Resident #1's MAR, for the timeframe from 10/01/2024 through 10/31/2024, revealed the MAR was left blank for the following medications on the following dates: - Aspirin chewable tablet 81 mg- 10/02/2024 and 10/09/2024. - Dicyclomine HCl 20 mg- 10/02/2024 and 10/09/2024. - Lidocaine patch 5%- 10/02/2024, 10/09/2024, and 10/22/2024. - Ezetimibe tablet 10 mg- 10/02/2024 and 10/09/2024. - Lisinopril tablet 40 mg- 10/02/2024 and 10/09/2024. - Polyethylene glycol 17 grams- 10/02/2024 and 10/09/2024. - Nitroglycerin transdermal patch 24-hour 0.2 mg/hr- 10/02/2024, 10/09/2024, and 10/22/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Prasugrel HCl tablet 20 mg- 10/02/2024 and 10/09/2024. - Cinacalcet HCl tablet 30 mg- 10/02/2024 and 10/09/2024. - Quetiapine fumarate 25 mg- 10/02/2024 at 9:00 AM and 2:00 PM and 10/09/2024 at 9:00 AM and 2:00 PM. During an interview on 01/10/2025 at 11:51 AM, the Assistant Director of Nursing (ADON) stated her expectation was for staff to administer medications as ordered and to document it. During an interview on 01/09/2025 at 1:15 PM, the Director of Nursing (DON) stated it was her expectation that all medications be given as ordered and documented as given on the MAR.