STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215307	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Egle Nursing Home	57 Jackson Street Lonaconing, MD 21539

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 37276 Based on observation and interview with residents, it was determined that the facility failed to treat residents with respect and dignity as evidenced by failing to knock and request permission before entering a resident's room. This was evident for 1 (#33) of 28 residents included in the resident sample. The findings include: On 5/1/24, at 9:55 AM, an interview was conducted with Resident #33. During the interview, the door to the resident's room was closed. At approximately 10:00 AM, Staff #10, Geriatric Nursing Assistant (GNA) entered Resident #33's room without knocking. On 5/2/24 at 4:11 PM, the Director of Nurses (DON) was made aware that the GNA had failed to knock on the resident's door and request permission from the resident prior to entering the resident's room. The DON responded that the Staff #10 had told her about it, and indicated the GNA was thrown off because the door to the resident's room was closed, and the door was usually kept open.

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

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 37276 Based on record review and staff interview it was determined that the facility failed to assess a resident's cognition and mood on a comprehensive MDS assessment. This was evident for 1 (#33) of 1 residents reviewed for care planning. 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 these individualized needs, and that the care is provided as planned to meet the needs of each resident. The Annual MDS assessment is a comprehensive assessment for a resident that must be completed annually (at least every 366 days) unless a significant change in assessment has been completed since the most recent comprehensive assessment was completed. Completion of the comprehensive annual MDS assessment, must be completed no later than 14 days after the Assessment Reference Date (ARD). 1) Review of Resident #33's medical record on 5/2/24 at 12:46 PM revealed the resident's annual assessment with an assessment reference (ARD) date of 3/13/24 was not fully completed. Section C, Cognitive Patterns was not assessed and Section D - Mood was not assessed. On 5/2/24 at 1:44 PM, during an interview, Staff #9, MDS Coordinator confirmed that, at the time of Resident #33's comprehensive assessment, the resident's cognitive and mood assessments had not been completed, and Staff #9 stated that the Social Worker was responsible for completing those assessments. On 5/2/24 at 4:00 PM, the above concerns were discussed with Staff #12, Social Worker (SW). Staff #12 acknowledged the concerns and indicated, that at the time of the assessment, she had not realized there had been a recent change in Resident #33's health insurance provider which now required completion of the assessments in the MDS.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 48259 Based on record review and staff interviews, it was determined that the facility failed to complete a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days following a significant decline in a resident's condition. This was evident for 1 (#8) of 28 residents reviewed during the recertification survey. The findings include: The Minimum Data Set (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. MDS assessments must be accurate to ensure that each Resident receives the care they need. The nursing home should complete a significant change in status MDS assessment within 14 days when there's a major decline or improvement in a resident's status. A medical record review, completed on 5/7/24 at 1:22 PM, for Resident #8 showed that they were admitted to the facility in June 2019. Further review found a nurse's note, dated 2/13/24, that recorded that Resident was complaining of Left knee hurting. not wanting it touched. Left knee is swollen. Resident states that it hurts. Dr. Made aware and order received for X-ray left knee, order placed with TRIDENT care. A continued record review contained a nurse's note, dated 2/15/24, that documented that Resident has a left tibial plateau fracture. A subsequent review, on 5/7/24 at 1:33 PM, showed a Significant Change in Status MDS assessment for Resident #8, dated 2/22/24, completed and signed in sections Z0500B & V0200B2 on 3/7/24. In an interview on 5/7/24 at 2:04 PM with staff #4, the MDS coordinator, she said that the start date for Resident #8's significant change in status was determined to be 2/13/24. However, the MDS was not completed until 3/7/24, 24 days after the determination that a significant change in the resident's status from baseline had occurred. In a continued interview, staff #4 reported that she was not aware that Significant change in status MDS assessments had to be completed by the 14th day after determining a significant change had occurred in a resident's condition.

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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** 48259 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for 2 (#64 and #35) of 5 residents reviewed for unnecessary medications. The findings include: The Minimum Data Set (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. MDS assessments must be accurate to ensure that each Resident receives the care they need. Active diagnoses documented on the MDS assessment are attending provider-documented diagnoses in the last 60 days that directly relate to the Resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. 1. Medical record review on 5/6/24 at 12:05 PM found that Resident #64 was admitted to the facility in April 2024 with diagnoses including Dementia. Continued review showed admission medications for Resident #64 that included an antipsychotic medication for delusions (false beliefs) and hallucinations (seeing, hearing, feeling, or smelling something that does not exist). Further record review on 5/6/24 at 3:03 PM contained an Admission MDS assessment, dated 4/12/24, for Resident #64. The MDS recorded in section N that Resident #64 had taken antipsychotic medication during the observation period. The MDS also had a check (meaning a YES) to the question indication noted (meaning there was an indication noted for the use of the medication). However, the MDS failed to capture Resident #64's actual diagnosis/indication for the medication. During an interview, on 5/7/24 at 11:12 AM, staff #4, an MDS coordinator, said that to document active diagnoses on the MDS assessment, she would use a physician's order report signed by an attending provider. However, a physician order report for Resident #64, which listed delusions and hallucinations as the indications/diagnosis for the use of the antipsychotic medication, had been signed by an attending provider on 4/8/24. It was not recorded in Resident #64's MDS assessment, dated 4/12/24. In a subsequent interview on 5/7/24 at 11:28 AM, staff #4 confirmed that she forgot to record the diagnosis for the use of the antipsychotic medication on Resident #64's MDS assessment dated [DATE]. 49409 2. Resident #35 is [AGE] years old and diagnosed with depression, schizophrenia, and hypertension. The resident has been at the facility for more than four years as a long-term resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS is a federally mandated assessment tool that helps nursing home staff 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. MDS assessment information is based on an Assessment Reference Date (ARD), which defines the last day of the lookback period. The MDS should be completed based on information in the lookback period, including the ARD. On 05/02/24 at 04:02 PM, a review of Resident #35's record revealed a social service progress note, dated 03/15/24, that stated a brief interview for mental status (BIMS) test was conducted on that date, generating a score of 15/15. A review of the resident's most recently completed MDS assessment with an assessment reference date (ARD) of 03/15/24 by the MDS coordinator (Staff #4) failed to reveal that the resident's BIMS score from the same date was included in the assessment. MDS assessments should include all relevant assessment information, including the BIMS score, that is available on the ARD and within the lookback period. On 05/02/24 at 01:36 PM, the surveyor reviewed with the DON and Social Services Director the MDS inaccuracy of not including the BIMS score, assessed on 03/15/2024, as part of MDS, which was submitted on 03/19/2024. The Social Service Director confirmed that the MDS coordinator did not capture the BIMS score.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on observation, medical record review and staff interview, it was determined the facility failed to review and revise resident care plans after each assessment. This was evident for 1 (#39) of 7 residents reviewed for accidents, and 1 (#45) of 5 residents reviewed for unnecessary medications. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1) Bed rails are adjustable bars attached to the bed. As enablers, bedrails assist to facilitate mobility, and/or repositioning in bed. On 4/30/24 at 12:24 PM, an observation of Resident #39 lying in bed revealed bilateral bed rails attached to the resident's bed. At that time, the fingers on both of Resident #39's hands were observed bent in a partial fist position and a palm protector was in each hand, indicating the resident had limited use of his/her hands. A review of Resident #39's medical record on 5/3/24 at 11:20 AM revealed an 8/24/23 physician's order, for 1/4 (quarter) rails on bed as enablers, every shift, a 5/27/22 order for right and left palm protectors at all times, as tolerated to decrease risk of further contractures. Continued review of the orders, failed to reveal evidence that Resident #39 utilized a bed alarm (device to monitor when a resident gets up). Review of Resident #39's annual MDS, with an assessment reference date (ARD) of 2/15/24, revealed documentation that the resident had severe cognitive impairment with diagnoses including dementia, hemiplegia (paralysis of one side of the body) or hemiparesis (one sided muscle weakness) and right and left-hand contractures (limited movement of a joint). The MDS documented that Resident #39 was dependent (helper does all the effort) for all activities of daily living (ADLs), dependent for performing all mobility activities such as turning and positioning and always incontinent of bladder and bowel. On 5/8/24 at 3:04 PM, during an interview, Staff #11, Physical Therapist (PT) stated that Resident #39 was dependent for bed mobility, and unlikely able to grasp and hold the bed rail as the resident was pretty much totally dependent with maximum assistance, indicating that Resident #39 was unable to utilize bed rails to aid in his/her mobility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #39's care plans revealed a care plan, Resident #39 uses 1/4 side rails up as enablers, with the goal, Resident #39, will remain free from injury secondary to side rail use during this evaluation period, with the approaches, (1) 1/4 side rails up as enablers, (2) assess reasons for rail usage, (3) equip with a device that monitors attempts to arise as needed, (4) keep call light within reach, (5) provide assistance with toileting as needed, (6) PT/OT evaluation as needed, (7) Re-evaluate the need for the bed rails per policy and PRN (as needed) On 2/28/24 in a care plan evaluation note, the nurse documented goal met and wrote Resident #39 was dependent for all ADLs (activities of daily living), uses 1/4 side rails as enablers, is turned and positioned q [every] 1 - 2 hours and wears right and left palm protectors. S/he is always incontinent of b/b [bowel and bladder], staff to provide incontinence care, and no injuries r/t (related to) side rail use noted, will cont. with POC [plan of care]. The care plan evaluation failed to reassess the effectiveness of the interventions to meet the resident's needs as evidenced by the approaches, equip with a device that monitors attempts to arise as needed and provide assistance with toileting. In addition, the facility failed to follow the care plan by failing to re-assess the need for the bed rails. Cross Reference F700 On 5/8/24 at 5:18 PM, the concerns with failing to review a resident's care plan after each assessment and failing to revise the care plan based on the resident's changing goals, preferences and needs of the resident and in response to current interventions were discussed with Staff #9, MDS Coordinator. Staff #9 verbalized understanding and acknowledged the concerns at that time. 2) On 5/7/24 at 9:59 AM, a review of Resident #45's medical record revealed that the resident was admitted to the facility at the end of 2020 and resided in the facility for long term care. Review of Resident #45's most recent MDS quarterly assessment, with an ARD of 4/4/24, revealed the resident's BIMS (brief interview for cognitive status) score was 3, indicating the resident had severe cognitive impairment. The MDS documented that, in the MDS 7 day look back period, Resident #45 exhibited physical behavioral symptoms toward others on 1 to 3 days, verbal behavioral symptoms directed towards others on 1 to 3 days, rejection of evaluation or care on 1 to 3 days and wandering behaviors occurred on 1 to 3 days in the look back period. The MDS documented that Resident #45 diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, anxiety disorder, depression, psychotic disorder, and delusional disorders and, that in the MDS 7 day look back period, the resident had received antipsychotic medication, antianxiety medication, and antidepressant medication. The MDS also documented the resident used a restraint in a chair to prevent the resident from rising, and documented Resident #45 had a Stage 3 pressure ulcer (full thickness tissue loss). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #45's Medication Administration Record (MAR) revealed an 8/10/22 order for Buspirone (anxiolytic) by mouth once a day for anxiety order, unspecified, an11/29/23 order for Lorazepam (Ativan) (anxiolytic) by mouth for anxiety disorder, unspecified, a 2/27/24 order for Remeron (mirtazapine) (antidepressant) by mouth once a day for depression, poor appetite, a 11/29/23 order for Seroquel (quetiapine) (antipsychotic)) by mouth, for dementia with psychosis, specific behaviors; paranoia, argumentative with staff, restless, repetitive calling out, once a day at 8:00 AM, and a 11/29/23 order for Seroquel by mouth, for dementia with psychosis, specific behaviors; paranoia, argumentative with staff, restless, repetitive calling out (Dx: Anxiety Disorder), once a day at 8:00 PM. Also, the resident had an 3/12/24 order Roxinol (morphine) twice a day for pain, and an order for Fentanyl (synthetic opioid) patch transdermal (on skin) change every 72 hours for pain, polyarthritis diagnosis. In the MAR, the orders were documented as being administered as ordered every day in April. Additionally, Resident #45 had a 1/11/24 treatment order to a Stage 3 left lateral ankle, once a day on Thursdays and an order for a pummel cushion (helps prevent sliding out of wheelchair), A review of Resident #45's care plans (CP) and care plan evaluations, failed to reveal evidence that the care plans were reviewed and revised following the residents most recent MDS assessment on 4/4/24: 2.1 Resident #45 had a Behavioral Symptoms care plan, Resident #45 has potential to display behaviors towards others such as cursing at staff, making accusatory statements towards staff and resisting care, pinching, scratching and attempting to hit staff and repetitive calling out a/e (as evidenced) by progress notes, with the goal, during this eval period, [Resident #45] will not experience a/e (adverse effects) r/t (related to) behaviors. Review of the CP evaluation notes revealed a CP evaluation completed on 1/23/24. The evaluation notes also indicated the CP was reviewed/revised on 3/12/24, however there was no documentation of the evaluation found in the medical record. 2.2 Resident #45's care plans revealed a Behavioral Symptoms care plan, Resident #45 displays wandering with repetitive calling out for [name] which may place her at risk for injury, initiated on 12/15/21, with the long-term goal during this eval period [Resident #45] will be free from harm secondary to wandering. Review of the CP evaluation notes revealed a CP evaluation completed on 1/23/24. The evaluation notes also indicated the CP was reviewed/revised on 5/3/24, however no documentation of the evaluation was found in the medical record. 2.3 Resident #45 had a Cognitive loss/Dementia care plan, Resident #45 has altered thought process r/t dementia with a start date of 12/22/20, that had the goal, during this eval period, [Resident #45] will continue to communicate basic needs and preferences to staff through verbal and non-verbal communication. Review of the CP evaluation notes revealed an evaluation completed on 1/23/24. The evaluation notes also indicated the CP was reviewed/revised on 3/11/24, however no documentation of the evaluation was found in the medical record. 2.4 Resident #45 had a communication care plan, Resident #45 has alteration in communication r/t dementia, initiated 8/4/23 with the goal [Resident] needs will be met with staff assist during this eval. pd (period). Review of the care plan evaluation notes revealed a CP evaluation completed on 1/24/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.5 Resident #45 had a Psychotropic Drug Use care plan, Resident #45 is at risk for complications related to psychotropic medication use, initiated on 12/22/20, with the goal, [Resident #45] will remain free from . psychotropic medication use during this eval pd. Review of the care plan evaluation notes revealed an evaluation of the CP was completed on 1/24/24. The CP also indicated the CP was last reviewed/revised on 3/12/24, however no documentation of the evaluation was found in the medical record. 2.6 Resident #45 had a Pain care plan, Resident #45, is at risk for pain r/t decreased mobility, left neck dystonia, RLS, s/p traumatic hemorrhage of cerebrum, scoliosis, chronic compression fractures (6/10/21), with the goals, Resident #45 will remain free from uncontrolled pain with the use of pain medication during this eval and will remain free from pain this eval pd. Review of the care plan evaluation notes revealed an evaluation of the CP was completed on 1/24/24, and indicated the CP was last reviewed/revised on 3/12/24, however no documentation of the evaluation was found in the medical record. 2.7 Resident #45's had a pressure ulcer care plan, Resident #45, has a ST (stage) III pressure ulcer to left lateral malleolus, r/t (related to poor intakes, decreased mobility, and Resident #45 has a ST III pressure ulcer to the left lateral malleolus, ST III right buttocks (9/11/23) r/t poor intakes and decreased mobility; initiated on 7/20/23 and revised on 9/28/23, that had the goal, Resident #45 will remain free from infection r/t ST III ulcer to left ankle during this eval period, and Resident #45's ulcer will heal without complications, with the short term goal target 4/24/24. Review of the CP evaluation notes revealed a CP evaluation completed on 1/24/24. The evaluation notes also indicated the CP was reviewed/revised on 3/15/24, however there was no documentation of the evaluation found in the medical record. 2.8 Resident #45 had a care plan, Resident #45 requires a pummel cushion (to w/c (wheelchair) r/t weakness, decreased mobility, poor safety awareness, initiated on 5/19/22, with the goal, [Resident #45] will not have negative outcomes r/t pummel cushion use during this eval pd. Review of the care plan evaluation notes revealed an evaluation of the CP was completed on 1/24/24. Continued review of Resident #45's care plan evaluations failed to reveal evidence that following Resident #45's quarterly MDS assessment on 4/4/24, the resident's progress or lack of progress towards meeting his care plan goals had been evaluated, or evidence the care plan had been updated based on the needs of the resident or in response to current interventions. Staff #9, MDS Coordinator was made aware of the above concerns regarding the failure to evaluate and revise care plans following the MDS assessments on 5/7/24 at 4:35 PM. At that time, Staff #9 verbalized understanding of the concerns and indicated that Resident #45's MDS had been completed on 4/18/24 and she had not yet evaluated the careplans following the completion of the resident's assessment. The Director of Nurses was made aware of the concerns regarding care plan evaluations on 5/7/24 at 4:35 PM, and acknowledged the concerns at that time.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on observation, record review, and interviews, it was determined that the facility failed to ensure that a resident with a limited range of motion received treatment and services as ordered by the attending provider to prevent further decline in the range of motion. This was evident for 1 (#43) of 3 residents reviewed for position and mobility. The findings include: The Minimum Data Set (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. Palm Protectors offer relief from hand contractures and cramping. They are put over the thumb and around the hand, providing a cushioning pad for the fingers to curl onto. This prevents the nails from digging into the palms and keeps the fingers warm and supported. An observation was made of Resident #43 on 4/30/24 at 10:55 AM, lying in bed, unable to move his/her left hand, and having no device in place. A medical record review on 4/30/24 at 11:30 AM found that Resident #43 was admitted to the facility in December 2020 with diagnoses that included left hemiparesis (paralysis of the left arm and leg) due to a stroke. Continued review revealed an MDS assessment dated [DATE] for Resident #43. The MDS had recorded in section G that Resident #43 required extensive to total assistance from staff for all his/her self-care needs. Further review of the MDS showed that Resident #43 had functional limitations of his/her upper and lower extremities. A subsequent record review on 5/1/24 at 9:34 AM contained an attending provider's order initiated on 4/17/23 for LUE palm protector to be worn at all times. May remove for bathing and hand hygiene [LUE- Left upper extremity]. Further review found an occupational therapy evaluation and plan of treatment dated 2/16/24 that recorded that Resident #43 had right CVA with dominant left side weakness and left neglect. Has a left palm protector [he/she] is to wear at all the times except during bathing and daily hand hygiene [CVA- cerebrovascular accident. It is also known as stroke]. In an interview on 5/2/24 at 3:29 PM with staff #16, a licensed practical nurse, she confirmed that Resident #43 did not have the palm protector on. She stated it was not in the Resident's room and did not know where it was placed. In a subsequent interview on 5/2/24 at 3:46 PM, staff #18, a geriatric nurse aide, stated that they were supposed to check if Resident #43 had the palm protector on every shift but did not because they got too busy. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/3/24 at 9:27 AM with staff #19, an occupational therapist, and staff #20, a certified occupational therapy assistant. During the interview, they stated that the palm protector was to keep Resident #43's hand contracture from worsening and recommended that it be used daily. However, earlier observations by the surveyor failed to show that it was being used daily.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48259 Based on record review, observation, and interviews, it was determined that the facility staff failed to ensure that the head of bed (HOB) was properly elevated for a resident during medication administration and infusion of a percutaneous endoscopic gastrostomy (peg) feeding. This was evident for 1 (#43) of 3 residents reviewed for tube feeding. The findings include: A percutaneous endoscopic gastrostomy (PEG) feeding tube is placed into the stomach through an opening in the stomach wall. If one cannot eat or drink all the nutrients they need, liquids such as formula, fluids, and medicines are put through the PEG tube. The Minimum Data Set (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 review of Resident #43's admission MDS assessment, dated 12/21/20, found that Resident #43 had a PEG feeding tube. A subsequent record review on 4/30/24 at 10:50 AM showed that a care plan, initiated on 12/31/20,had documentation that Resident #43 required PEG tube feedings for nutritional support due to difficulty swallowing. A continued review of the care plan noted an intervention to Elevate HOB 45 degrees at all times. Further review done later that day revealed an attending provider's order initiated on 4/17/2023 to Keep HOB elevated 45 degrees every Shift. Observation on 5/2/24 at 12:16 PM found Resident #43 lying on his/her back in bed with HOB elevated to only about a 10-degree angle. Staff #16 gave medications to him/her through the peg tube and then resumed the peg feeding. During an interview on 5/2/24 at 12:24 PM, staff #16 confirmed that Resident #43's HOB was not elevated to 45 degrees when she administered his/her medications and resumed the peg tube feeding. In a continued interview on 5/2/24 at 12:38 PM with staff #16, she said that she would usually elevate Resident #43's HOB before giving medications or peg tube feedings to avoid the risk of aspiration but only elevated it to about 15 degrees this time because she was nervous. In a subsequent interview on 5/3/24 at 11:02 AM, the director of nursing (DON) stated that her expectation of the nurses was to ensure that the HOB for residents with peg tubes would be elevated per the attending provider's order to reduce the risk of aspiration. The DON also reported that staff #16 made her aware that she failed to elevate Resident #43's HOB correctly before giving medications and peg tube feeding.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 37276 Based on observation, medical record review, and staff interview, it was determined that prior to the installation of bed rails, the facility 1) failed to identify and use appropriate alternatives prior to installing or using bed rails, and 2) failed to assess a resident's risk of injury or entrapment prior to installing or using bed rails. This was found to be evident for 1 (#39) of 1 residents reviewed for side rails. The findings include: Bed rails are adjustable bars that attach to the bed and are available in a variety of types, shapes, and sizes. As enablers, bedrails facilitate movement and may promote independence. Entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. On 4/30/24 at 12:24 PM, an observation was made of Resident #39 lying in bed and bilateral bed rails were observed attached to the resident's bed. At that time, Resident #39 was observed to have palm protectors on both hands, with his/her fingers bent in a partial fist position. Review of Resident #39's annual MDS with an assessment reference date (ARD) of 2/15/24 revealed documentation that Resident #39 had severe cognitive impairment with diagnoses which included dementia, hemiplegia (paralysis of one side of the body) or hemiparesis (one sided muscle weakness) and had right and left-hand contractures (limited movement of a joint). The assessment documented that Resident #39 was dependent (helper does all the effort) for all activities of daily living (ADLs) and dependent for performing all mobility activities such as turning and positioning. On 5/3/24 at 11:20 AM, a review of Resident #39's medical record conducted on 5/3/24 at 11:20 AM revealed a 8/24/23 physician's order, for 1/4 (quarter) rails on bed as enablers, every shift. Review of Resident #39's medical record revealed a Side Rails Informed Consent and Release form, that stated the risks of side rails included entrapment, followed by a list of ways a resident could become entrapped, that side rails may also be associated with accidental skin injury, and that there was a risk of significant injury if the resident should fall. The form also listed the benefits of using side rails were improved bed mobility, improved mobility getting in and out of bed, and the side rails were to be used as a mobility aid and not as a physical restraint. The form revealed documentation that the resident/representative was informed of the risks and benefits for the use of the side rails and was signed by Resident #39's representative on 12/27/19. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39's medical record revealed side rail assessment forms, dated 11/16/23, 2/13/24 and 5/7/24, that assessed the medical symptoms which required the use of side rails, the reason for the side rail usage, the types of rails to be used, and the frequency for use of the rails. Each side rail assessment documented Resident #39's medical symptoms that required the use of side rails. Those diagnoses were muscle weakness, impaired mobility, and osteoarthritis, with the reasons for the side rails listed as bed mobility and boundary limitations. The type of rails were top half, two sides and documented the risks and benefits of the bed rails were explained to the RP (Resident Representative) on 12/27/19. Continued review of Resident #39's medical record failed to reveal evidence that prior to installing or using bed rails, appropriate alternatives were explored. No documentation was found in the medical record to indicate that Resident #39 had been assessed for risks of entrapment prior to the installation or use of the bed rails, and there was no evidence of an ongoing evaluation of the resident's risk for entrapment. In addition, no documentation was found in the medical record to indicate that Resident #39 was re-evaluated for the need for bed rails once s/he was unable to utilize the rails as enablers for mobility. The medical record review failed to reveal evidence of an ongoing evaluation to ensure that the use of the bed rails met the resident's needs. Also, no documentation was found to indicate that specific monitoring and supervision of the resident was provided during the resident's use of the bed rails. On 5/8/24 at 3:04 PM, during an interview, Staff #11, Physical Therapist (PT) stated that Resident #39 was dependent for bed mobility. Staff #11 stated that it was unlikely that Resident #39 would be able to grasp and hold the bed rail as the resident was pretty much totally dependent with maximum assistance, indicating Resident #39 would be unable to utilize bed rails to aid in his/her mobility. The concerns related to failing to reassess Resident #39's need for bed rails, assessing the resident for risk of entrapment, assessing, and implementing appropriate alternatives prior to installing or using bed rails, and failing to monitor and supervise residents during the use of bed rails, and were discussed with the Director of Nurses (DON) on 5/8/24 at approximately 4:40 PM, and the DON verbalized understanding of the concerns. On 5/9/24 at 11:14 AM, during an interview, Staff #6, Maintenance Director, stated that there were bed rails on all of the resident beds in the facility and when the facility bought new beds, the rails were already attached to the beds. When asked if the facility had a regular maintenance program to ensure the inspection of all bed frames, mattresses and bed rails, Staff #6 stated that no routine maintenance checks on the beds or the bed rails were conducted, but if someone reported a concern with a bed or bed rails, maintenance would check on the problem. Cross Reference F909. The above concerns were discussed with the Nursing Home Administrator (NHA) on 5/9/24 at 11:40 AM, and the NHA acknowledged the concerns at that time.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 37276 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that physician progress notes were written, signed, and dated at each visit. This was evident for 2 (#45, #29) of 5 residents reviewed for unnecessary medications. The findings include: 1) On 5/7/24 at 9:59 AM, a review of Resident #45's medical record was conducted. Review of Resident #45's electronic medical record (EMR) and paper medical record revealed that physician's visit notes were not written, signed, and dated at the time of each visit. In Resident #45's EMR, there was a physician's visit progress note, dated 2/3/24 at 7:22 PM, that indicated the day of the physician visit date was 1/22/24, a physician's visit progress note dated 4/7/24 at 2:27 PM, that indicated the date of the physician's visit was 3/25/24, and a physician's visit progress note dated 5/2/24 at 8:58 AM, that indicated the date of the physician's visit was 4/22/24. On 5/7/24 at 4:35 PM, the Director of Nurses (DON) was made aware of the concerns. At that time, the DON acknowledged the concerns and stated that s/he thought the physician dictated visit notes on the day of the visit. 2) On 5/8/24 at 10:17 AM, a review of Resident #29's medical record revealed that physician's visit notes were not written, signed, and dated at the time of each visit. In the resident's EMR, there was a physician's visit progress noted dated 4/7/24 at 3:08 PM that indicated the date of the physician's visit was 3/25/24, a physician's visit progress note dated 4/13/24 at 10:37 AM, that indicated the date of the physician's visit was 4/1/24, and a physician's visit progress note dated 4/21/24 that indicated the date of the physician's visit was 4/15/24. On 5/8/24 at 2:10 PM, the DON was made aware of the concerns with Resident #29's physician visit notes were not written, signed, and dated on the day of the physician visit. The DON acknowledged the concerns at that time and offered no further comments.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on surveyor observation and staff interview, it was determined that the facility staff 1) failed to properly store food items in the kitchen's walk-in refrigerator, and 2) failed to have a process in place to determine the expiration date of food procured from vendors. This was evident during the initial tour of the kitchen and had the potential to affect all residents. The findings include: On [DATE] at 10:35 AM, accompanied by Staff #7, Certified Dietary Manager (CDM), an initial tour of the kitchen by two surveyors identified the following concerns: 1) An observation of the kitchen's walk-in refrigerator revealed there was an uncovered, large rectangle, shallow pan that appeared to be filled with cooked food product. The uncovered pan was dated [DATE] and labeled 'potatoes', and there was an uncovered, large rectangle, shallow pan which appeared to be was filled with food product. The uncovered pan was dated [DATE] and labeled 'rice pudding'. At that time of observation, Staff #7 stated that the uncovered pans contained potatoes and rice pudding that had just been prepared and the pans were uncovered because the food was cooling. On [DATE] at 1:16 PM, Staff #7 indicated the facility's policy for cooling food products in the refrigerator had been reviewed and confirmed that pans with food needed to be loosely covered when the pans are cooling in the refrigerator. 2) An observation of the kitchen's dry storage room revealed: - 6 Harvest Value 6-pound (lb) 8-ounce (oz) cans of mandarin oranges were labeled with a production date of [DATE], however, none of the cans were labeled with a manufacturer's expiration date. - 1 Monarch 6lb 8oz can of apricots that did not have a manufacture's expiration date or a production date on the can. - 1 Monarch 6lb 8oz can of unsweetened apple sauce that did not have a manufacture's expiration date or a production date on the can. - 2 Monarch 6lb 8oz cans of peaches that did not have a manufacture's expiration date or a production date on the cans. - 2 Monarch 6lb 8oz cans of fruit cocktail that did not have a manufacture's expiration date or a production date on the cans. - 1 Monarch 6lb 8oz cans of golden corn that did not have a manufacture's expiration date or a production date on the can. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff #7, CDM, was present during the observation of the dry storage room. When made aware the above canned food products were not labeled with the manufacturer's expiration date, Staff #7 stated the food distributer would be contacted to determine the expiration dates of the canned products. On [DATE] at 11:35 AM, during a follow-up interview, Staff #7, stated she received information from the canned food distributer that indicated that the expiration date could be determined on cans labeled with a production date by looking at a [NAME] calendar. Staff #7 indicated she did not fully understand the process of determining the expiration date of the canned food product from the production date and the [NAME] calendar and she was waiting for more information. On [DATE] at 1:16 PM, Staff #7 provided the surveyor with information that indicated that some of the cans expired 999 days after their production dates, however, Staff #7 was unable to provide information to indicate how the expiration dates were determined from their production dates, or how the expiration dates were determined on the cans without production dates. Staff #7 indicated that Staff #13 was assisting in getting the information and would come and speak to the surveyor. On [DATE] at 3:55 PM, during an interview, Staff #13 indicated that the facility was able to determine the production dates of most of the above canned food products and then determine the product's expiration date, which was 999 days after the date of production. Staff #13 stated that they were still pursuing the expiration dates of the canned apricots and applesauce and hoped to have the answers by tomorrow. On [DATE] at 11:40 AM, the above concerns were discussed with the Nursing Home Administrator, who acknowledged the concerns at that time. On [DATE] at at approximately 2:00 PM, Staff #13 stated that the distributer provided the facility of the expiration dates for the cans of Apricots and Apple sauce via email, and Staff #13 provided the surveyor with copies of the emails at that time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on medical record review and staff interview, it was determined that the facility failed to keep complete and accurate medical records as evidenced by 1) failing to transcribe an accurate indication for use of antipsychotic medication, 2) failing to document a resident's wound evaluation in the medical record, and 3) failing to ensure that the a care plan meeting was documented. This was evident for 2 (#45, #35) of 5 residents reviewed for unnecessary medications, 1 (#45) of 2 residents reviewed for pressure ulcers. The findings include: 1) On 5/7/24 at 9:59 AM, a review of Resident #45's medical record was conducted. Review of Resident #45's May 2024 Medication Administration Record (MAR) revealed a 11/29/23 order for Seroquel (quetiapine) (antipsychotic) 25 mg (milligrams) by mouth, special instructions: dementia with psychosis, specific behaviors; paranoia, argumentative with staff, restless, repetitive calling out, once a day at 8:00 AM, and a 11/29/23 order for Seroquel 50 mg (milligrams) by mouth, special instructions: dementia with psychosis, specific behaviors; paranoia, argumentative with staff, restless, repetitive calling out (Dx: Anxiety Disorder), once a day at 8:00 PM. In the orders, dementia with psychosis, specific behaviors; paranoia, argumentative with staff, restless, repetitive calling out was the indication for Resident #45's use of Seroquel Review of Resident #45's medical record revealed on 11/29/23 at 11:30 AM, in a psychiatric progress note, the Nurse Practitioner (NP) documented Resident #45's primary diagnoses were adjustment disorder with anxiety and depressed mood, generalized anxiety disorder and delusional disorder and the NP wrote continue on Seroquel for delusional disorder. The facility staff failed to transcribe an accurate indication for Resident #45's use of antipsychotic medication, Seroquel. The above concerns were discussed with the Director of Nurses (DON) on 5/7/24 at 4:35 PM and the DON confirmed the findings at that time. 2) A pressure ulcer is a lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged, from Stage I to Stage IV, according to their severity level. A Stage III pressure ulcer has full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater. On 5/8/24 at 9:49 AM, a review of Resident #45's electronic health record (EHR) revealed the resident had a Stage III pressure ulcer on his/her left ankle. Review of Resident #45's May 2024 MAR revealed a treatment order to Stage 3 LL ankle once a day on Thursdays, 7:00 AM - 3:00 PM which was documented as completed on Thursday, 5/2/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the wound management section of Resident #45's EHR revealed a wound progress notes with a PU (pressure ulcer) observation date of 4/25/24 at 1:34 PM that documented an assessment of the PU and the measurements of the wound. Continued review of the medical record failed to reveal documentation to indicate Resident #45's PU had been evaluated during his/her 5/2/24 dressing change. On 5/9/24 at 12:43 PM, during an interview, Staff #5, Wound Care Nurse, Registered Nurse (RN), stated that Resident #45 developed a left ankle wound about a year ago and went to the wound clinic, who staged the wound. Staff #5 stated Resident #45's PU had stayed about the same, that the wound bed would fill in, then regress and sometimes the wound had drainage. Staff #5 stated that Resident #45's wound measurements were obtained and the PU evaluated every week during the residents weekly PU treatment, and the evaluation and wound measurements would be documented in the wound management section of the resident's EHR. At that time, when asked if Resident #45's PU had been evaluated and wound measurements obtained when the PU dressing was changed on 5/2/24, Staff #5 stated the wound had been assessed, however, she had not yet written a note, and confirmed there was no documentation of the PU evaluation in the EHR. On 5/9/24 at 1:00 PM, Staff #5 provided the surveyor with a paper measuring tape labeled wound measuring guide, with the date 5/2/24, with wound measurements handwritten on the paper tape, indicating Resident #45's PU had been evaluated; however, the evaluation was not documented in the resident's medical record. 49409 3. Resident #35 is [AGE] years old and diagnosed with depression, schizophrenia, and hypertension. The resident has been at the facility for more than four years as a long-term resident. Medical record review on 05/06/24 at 1:44 PM revealed that the Minimum Data Set (MDS) assessment was completed on 03/15/24. Further review of the medical record failed to reveal documentation to indicate that the required care plan meeting occurred after the completion of the MDS assessment in March 2024. An interview was conducted with the Social Service Director (SSD) and the Director of Nursing (DON) on 05/03/24 at 02:11 PM regarding the care plan meeting. When asked what evidence was there that a care plan meeting occurred, the DON stated that it was documented under progress notes who attended the care plan. The SSD stated that a recent care plan meeting occurred on 03/20/24, but was unable to provide the medical record documentation that the facility conducted a care plan meeting with the Interdisciplinary team (IDT). The SSD did provide email documentation that a care plan meeting was held on 3/20/24.

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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. 48259 Based on record review, observations, and interviews, it was determined that the facility staff failed to wear proper personal protective equipment (PPE) before giving direct care to a resident with a percutaneous endoscopic gastrostomy (peg) feeding tube. This was evident for 1 (#43) of 3 residents reviewed for tube feeding. The findings include: A percutaneous endoscopic gastrostomy (PEG) feeding tube is placed into the stomach through an opening in the stomach wall. It is used to give drugs and liquids, including liquid food. The Minimum Data Set (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. Enhanced Barrier Precautions are infection control interventions designed to reduce transmission of infection in nursing homes. It involves gown and glove use during high-contact Resident care activities like dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting for residents with central line, urinary catheter, feeding tube, tracheostomy, or any skin opening requiring dressing. A review of Resident #43's MDS assessment, dated 6/14/23 found that he/she had a PEG feeding tube. A continued review showed that Resident #43 required extensive assistance or depended on staff for all his/her self-care needs. An observation on 4/30/24 at 10:55 AM showed a signage on Resident #43's door that indicated Resident #43 was on enhanced barrier precautions, which required wearing gowns and gloves during high-contact resident care activities. A subsequent observation on 5/2/24 at 9:09 AM found staff #17, a geriatric nurse aid, giving Resident #43 a bed bath. Staff #17 had put on gloves before direct contact; however, the observation failed to show that staff #17 wore a gown. In an interview on 5/2/24 at 9:31 AM, Staff #17 stated that she only put on gloves to provide high-contact care activities to Resident #43, not gowns. During a subsequent interview on 5/2/24 at 12:24 PM, staff #16, a licensed practical nurse, reported that there was always a supply of gowns in Resident #43's room, and all staff knew where they were. In an interview on 5/3/24 at 7:53 AM, the director of nursing stated that all staff had been trained in enhanced barrier precautions and expected all staff to wear gloves and gowns when in direct contact with Resident #43.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 37276 Based on observation, medical record review and staff interview, it was determined the facility failed to conduct a regular inspection of all bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment and failed to ensure the equipment was inspected and maintained according to manufacturer's recommendations and requirements and timeframes. This was evident for 1 (#39) of 7 residents reviewed for accidents and had the potential to affect all residents. The findings include: On 4/30/24 at 12:24 PM, an observation was made of Resident #39 lying in bed. At that time bilateral bed rails were observed attached to the resident's bed. On 5/9/24 at 11:14 AM, during an interview, Staff #6, Maintenance Director, stated that all of the resident beds in the facility had bed rails attached to the bed, and when the facility bought new beds, the bed rails were already attached to the beds. When asked if the facility's regular maintenance program ensured the inspection of all bed frames, mattresses, and bed rails, Staff #6 indicated that no routine maintenance checks were performed on the resident beds or bed rails. Staff #6 indicated that aides assessed the beds, and if there was a problem with the bed or the bed rails, they would notify maintenance, and maintenance would go and check the bed and/or bed rails. Staff #6 stated that if there was a concern with a bed or bed rails, staff would call or page maintenance, and, in the mornings when he arrived at the facility, he also received a report from the nurse. On 5/9/24 at 11:40 AM, the concerns with failing to conduct regular inspection of all bed frames, mattresses, and bed rails, to prevent risk of entrapment, and ensure the equipment was inspected and maintained according to manufacturer's recommendations, requirements, and timeframes were discussed with the Nursing Home Administrator (NHA) and, at that time, the NHA indicated he understood the concerns.

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	215307	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Egle Nursing Home	57 Jackson Street Lonaconing, MD 21539

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 48470 Based on observations and interviews, it was determined that the facility failed to provide full visual privacy for a resident residing in a non-private room. This was evident for 1 (Resident #268) of 25 residents reviewed during the recertification survey. The findings include: Resident #268 was a newly admitted resident of the facility residing in a non-private room with 2 beds. Resident #268 occupied bed B and his/her roommate occupied bed A. On 5/1/24 at 11:58 AM, an inspection of the privacy curtain located between the 2 beds in the room was conducted and revealed that it only extended up to the length of the beds. On 5/3/24 at 8:58 AM, a review of Resident #268's medical records indicated that s/he used a bedside commode in the room for bowel and bladder elimination. A tour of the room was conducted with the Director of Nursing (DON) on 5/3/24 at 9:45 AM. The observation was confirmed and discussed the concern that privacy curtains must extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. The DON reported that the room had a different ceiling configuration that prevented them from installing the track for suspended curtains as observed with the other rooms in the facility. The DON also indicated that she would have a discussion with the maintenance staff to come up with a plan to be in compliance with the regulation.