STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215308	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Crest Village	8800 Walther Boulevard Parkville, MD 21234

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. 50385 Based on record review, resident interviews, and staff interviews, It was determined that the facility failed to treat the resident with dignity by improperly turning the resident. This was evident for 1 (resident #5) of 9 residents reviewed for dignity. The findings include: On 8/27/24 at 10:50 AM, an interview was conducted with Resident #5. The resident stated that s/he remembered an incident involving a staff member a while ago but could not remember the staff member's name. The resident stated, It seems like they took care of her though because I haven't seen her. On 8/28/24 at 1:40 PM, the Facility Reported Incident (FRI) MD00205236 was reviewed. The allegation reported was physical abuse from a staff member to the resident. The facility reported that a Geriatric Nursing Assistant (GNA) noticed Resident #5 to have multiple bruises on arms. On 8/28/24 at 1:50 PM, the facility's 5-day investigation report was reviewed. The facility reported to have interviewed all staff who worked with the resident in the past 72 hours from the date the bruises were reported, which was 7/7/2024 at 12:30 PM. Out of all staff interviewed, GNA #66 admitted having used the resident's arms to turn them. In the corrective action section, the facility re-educated the staff, GNA #66, on proper techniques to use when turning and repositioning residents with return demonstrations. On 8/28/24 at 1:55 PM, a statement from GNA #66 on 7/8/24 was reviewed. GNA #66 admitted to the interviewer that she turned the resident while s/he was in bed using his/her arms rather than using the draw sheet. 08/28/24 at 02:03 PM, Resident #22's medication orders were reviewed. Resident was on Aspirin as a blood thinner and to prevent blood clots during the time of the incident.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 50385 Based on observations and staff interview, the facility failed to accommodate the resident's (#22) dietary needs. This was evident for 1 of 2 residents reviewed for nutrition. The findings include On 9/5/24 at 12:10 PM, Resident #22's meal ticket was reviewed. The meal ticket states, Equipment: Need Assistance --- opening everything. Need Assistance ---cut the food. Supplements: 8pm - Snack, Super cereal at B [breakfast], L/D [lunch/dinner]: 2 desserts, 2pm: in-house milkshake, L [lunch]: ice cream. On 9/5/24 at 12:45 PM, an observation was made of Resident # 22 eating lunch at bed. On the tray there was a sandwich split in half, a drink, a mixed fruit bowl, and a closed container. Surveyor verified with Care Assistant (CA) passing out trays that item in container was the resident's ice cream. On 9/5/24 at 1:08 PM, Resident #22 was observed sleeping with meal tray on table in front of them. On meal tray there is an uncut sandwich with 3 bite sized cuts, the container on tray was still unopened, and the fruit cup was still full. On 9/6/24 at 2:15 PM, Resident #22's care plan was reviewed. Under the Dining and Eating section of the care plans and under the subsection I require the following nutritional approaches, it states, Assist with opening containers and cutting foods.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on medical record review, staff interviews, and review of facility investigation documents, it was determined that the facility failed to ensure that residents remained free of abuse and neglect. This failure led to physical abuse and harm of Resident #135. This finding was evident for 5 of 34 (Resident #135, #130, #117, #122, #125) residents reviewed for abuse during the survey. The findings include: The facility's investigation related to facility-reported incident MD00191125 was reviewed on 8/28/24 at 2:39 PM. In the investigation, the facility substantiated there was an altercation between Resident #132 and Resident #135 which led to Resident #135 sustaining multiple injuries. On 8/29/24 at 12:15 PM review of Resident #132's Hospital #3 (inpatient psychiatric hospital) discharge summary dated 3/21/23 revealed a diagnosis of dementia with behavioral disturbance, agitation and aggression and relapse of illness. It was documented, Patient presented to the ER (emergency room) due to agitation and paranoid behaviors towards residents and staff at his/her assisted living. Patient was recently admitted to the ER from 11/20-12/2/22 for similar behaviors. And His/her daily pattern is to wander around, restless and intrusive, and can be pleasant at times. However, patient with agitation, combativeness and would require 3-5 staff to provide personal care. Patient was also getting prn (as needed) meds almost daily due to his/her behaviors. On 3/21/23 a Nurse Practitioner's (NP's) note written by NP #65 documented in the History of Present Illness (HPI) section: He/she was a resident in IL (Independent Living); worsening cognition/dementia. He/She was sent to the ER then transferred to LTC (long term care); sent to ER again due to uncontrolled agitation and aggression. Complicated hospital admission since 11/2022 related to dementia/aggression; sent back to ED due to dementia/uncontrolled aggression. Increasing agitation and combativeness requiring 3-5 staff during personal care; A trial of Zoloft was not effective. Transitioned back to the facility on [DATE]. Further review of the NP's note revealed in the Past Medical History: Dementia with Aggression and agitation. Continued review of Resident #132's medical record on 9/3/24 at 8:00 AM revealed increasing episodes of agitation with verbal and physical attacks on staff during personal care, lying in other residents' beds, frequent re-direction needed requiring 2 staff to remove Resident #132 from other residents' rooms, wandering into other residents' rooms, and pushing other residents in their wheelchairs. These aggressive behaviors continued between 3/21/2023 and 3/28/2024 when Resident #132 was transferred to the hospital. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	From 3/28/23 to 4/4/23 Resident [#132] was admitted to Hospital #2 for a presumed syncopal episode. The hospital's discharge summary was reviewed on 8/30/24 at 4:00 PM and revealed: he/she [Resident #132] is intermittently violent, which is a chronic issue that is only partially controlled on multiple antipsychotics. Resident #132 was medically stable to discharge before today but due to behavioral problems there were delays with discharge but the facility is now ready to take him/her back. It was also documented, Appreciate Geriatrics and Psychiatry recommendations. Both are doubtful that he/she will improve adequately for acceptance to long-term facility. His/her original facility [Oak Crest Village] wants to try and take him/her back and in our discussion with them today indicated that they are specifically hiring staff members to help accommodate his/her [Resident #132's] return. He/she does, unfortunately, appear to be at his/her baseline, so significant improvement from this intermittent combativeness is not expected. In PMH (past medical history) it was documented, Potential for harm to others. A review of the medical record for Resident #132 on 8/29/24 at 10:27 AM revealed the resident was readmitted to the facility on [DATE] with a diagnosis of unspecified dementia with behavioral disturbance, severe, with agitation, assault by unspecified means, and vascular dementia, severe, with agitation. Further review of the medical record revealed the resident had a Brief Interview for Mental Status (BIMS) of 3 out of 15, which indicates the resident had severe cognitive impairment. Resident #132's decision making capacity was described as, Severely impaired-never/rarely made decisions, and s/he may exhibit the following expressions/actions: Physical expression(s) towards others (e.g. hitting, biting, kicking, pushing, scratching, grabbing, abusing others sexually, etc.), Verbal expression(s) towards others (e.g. threatening others, screaming at others, cursing at others, etc.), Refuses medications. Other descriptors of Resident #132's behavior were as follows: Put myself/others at significant risk for physical illness or injury, Significantly interfere with the resident's care, Significantly interfere with resident's participation in activities or social interaction, Put others at significant risk for physical injury, Significantly disrupt care or living environment. Review of the registered dietician's notes revealed, hospitalized due to intermittent violent behavior .multiple ER/hospitalization related to dementia, psychosis and agitation .Resident [#132] has sitter today with [him/her]. Continued review of the medical record for Resident #132 revealed a facility initiated care plan on 4/4/23 to address the following: agitation, syncope, and wandering. The approaches included, Staff will supervise me and help redirect me while I am wandering to help keep me safe, I will be monitored for safety concerns and will be redirected as appropriate and It is possible I will be eligible to move to Memory Care at some point, but not yet. On 4/4/23 a Medical Doctor's (MD's) progress note written by MD #64 revealed: On 11/14/22, prior to admission to Oakcrest Village, sent to Hospital #1's ER (emergency room) for behavior/aggression. On 11/15/22 transitioned to Long Term Care (LTC) at Oakcrest Village. On 11/19/22 - 12/2/22 sent to Hospital #2 for dementia with behavior/aggression. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/7/22 - 12/20/22 sent to Hospital #2 for agitated delirium, aggressive and violent behavior. On 12/20/22 - 3/21/23 sent to Hospital #3 (inpatient psychiatry) for worsening dementia with behavioral issues where he/she had multiple adjustment/trials of medication. Medications were maximized with reduction of behavioral issues and transferred to Oak Crest LTC on 3/21/23. On 3/28/23-4/4/23 sent to Hospital #2 for vascular dementia with hospital stay complicated by intermittent violent behavior. Another note documented, admitted s/p (status post or after) numerous psychiatric ED and prolonged Hospital #3 (inpatient psychiatry) stay, continued with intermittent violent behavior per discharge summary per inpatient psychiatry and geriatrics, [NAME] corporate care support visiting with resident and staff, SW (Social Worker) has reached out to [another facility] who feels may be appropriate for resident if needed. On 4/4/23 at 1:27 PM a nursing note written by LPN #27 documented Resident [#132] arrived by [NAME] (ambulance) on a stretcher with two paramedics at 11am. Resident is alert and responsive. Resident is a readmit. DX (diagnoses): Syncope, dementia with aggression. Resident has a private duty . Continued review of Resident #132's medical record on 9/3/24 at 5:00 PM revealed agitation, wandering into other residents' rooms, taking food from resident's plates, and verbal and physically aggressive behaviors continued when the resident returned to the facility on [DATE] through 4/7/23 when the incident with Resident #135 occurred. On 4/7/23 at 8:15 PM handwritten statement from RN #5, RN, was the nurse on [nursing unit]. She stated the aide called her and told her [Resident #135] has blood on [his/her] face and was hit by [Resident #132]. Nurse met Resident #135 on the hallway, pointed to at [Resident #132], and stated that [Resident #132] pushed him/her and lost control, fell and hit his/her face. RN#5 then reported the incident to the clinical manager [ADON #13]. On 4/7/23 at 8:30 PM handwritten statement from Care Associate (CA) #47, CA #47 was an aide on the floor. She saw Resident #132 sitting on Resident #135's bed. She heard Resident #135 telling Resident #132 to get out of his/her room. Resident #132 said, 'You don't tell me what to do, you don't know me'. Then she heard Resident #135 scream saying, '[s/he] pushed me'. On entry to the room, he saw Resident #132 walking out and Resident #135 bleeding on the face. CA #47 went ahead and alerted the RN#5. On 4/7/23 at 11:21 PM a nursing note written by RN #5 documented, Around 3:20pm, the CA assigned to Resident #132 came to report a resident had blood coming down from his/her face and saw another resident come out of his/her room. Upon assessment, a cut was noted on the right ear lobe measuring 3.5cm x 0. 1cm. A hematoma noted to be forming as well. Resident #132 also sustained an open area on his right forearm measuring 0.8cm x 0.2cm. As per resident, the resident in rm x, Resident #132, came into the room and there was an altercation. Resident #135 said, He/she came in and will not leave, he/she pushed me and I fell and hit my head against the wall. POA [of Resident #135] was notified as well as Resident #132's daughter. The abuse was also reported to the State and Police officer called in as well. No acute distress noted. Will continue to monitor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/7/23 a Progress Note written by Medical Doctor (MD #46) revealed, [Resident #132] was visually responding to unseen objects/situations. Patient has a history of recurrent psychiatric hospitalization due to his/her behavior problems in last few months. He/she has been on 1:1 observation due to behavior. The episode occurred while changing nursing shifts. Another note revealed, his/her behavior due to his/her mental illness. Cannot be reasoning with him/her. In the facility's Investigative Tool document dated 4/10/23, ADON #13, Writer met with LPN #48 who is the 7-3p nurse for Resident #132. LPN #48 is aware that Resident #132 should have a 1:1 private aide but there is no consistency on one being available as scheduled. LPN #48 was not a witness to the incident but is aware that the incident took place. LPN #48 is aware of the inappropriate tendencies of Resident #132 that be expressed at any given time, especially in the evenings. LPN #48 signed the document. In the facility's Investigative Tool document dated 4/10/23, ADON #13, wrote in the section called Interviewee's Explanation of Event or Incident, Writer met with RN #49 who is the 3-11 nurse for [Resident #132]. RN #49 is aware that [Resident #132] should have a 1:1 private aide but there is no consistency on one being available as scheduled. She had contacted his/her family member before letting him/her know that a 1:1 was not available. RN #49 did not witness the incident but is aware of the inappropriate tendencies of [Resident #132]. RN #49 signed the document. On 4/10/23 a Progress Note written by Medical Doctor (MD #64) documented, resident (#132) seen for follow up of altercation of another resident and behavioral issues on the unit, resident walking around the unit without his/her private aide, resident is unable to provide any related history through verbal due to degree of dementia and loose association attempts at conversation, and resident unable to provide any recollection of the incident that occurred with police coming afterward. In the Treatment section it was documented, Assault: Clinical Notes: resident s/p numerous hospitalization s with agitation and negative behavior due to progression of dementia. Resident since 3 month Hospital #3 [inpatient psychiatry] stay has sat on a minimally verbal resident while he/she was lying in bed, and had gotten in bed with a frail elderly male/female as he/she was sleeping in bed. Recent altercation 4/7/23, resident [#132] entered another resident's [#135] room and pushing altercation insured as the resident [#135] whose room it was, attempted to get resident [#132] out. Resident #132, who is the taller and stronger resident pushed the resident [#135] who was attempting to maintain his/her personal space down resulting in that resident [#135] being injured with a large brow hematoma. Vascular dementia, severe, with agitation and in the Clinical Notes it was documented, This provider does not feel the patient is appropriate to remain on this unit for his/her health and the safety of other residents and staff; similar was communicated to care center administration. On 4/10/23 a Progress Note of [Resident #132], written by Nurse Practitioner (NP #65) documented: had recent altercation encounter with another resident [Resident #135]; (no caregiver at that time). On 8/28/24 at 2:22 PM review of a Medical Doctor's (MD's) progress note written by MD #46 for Resident #135 documented on 4/7/23, Resident #135 reported that another resident came into his/her room and pushed him/her during their altercation. Developed hematoma and laceration at right eyebrow and bleeding from laceration. In the Examination section: Right eyebrow hematoma and horizontal laceration cut about 1 inch and bleeding from it. Shear pressure open skin lesion at right forearm. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/28/24 at 3:42 PM, in an interview with the Administrator, he stated that Resident #132 went out to the hospital and was readmitted to Oak Crest Village on 4/4/23. During the interview he stated that the Resident #132 had a private duty aide when he/she came back that was hired by his/her family and he/she had had them for years prior to entering the facility. On 8/28/24 at 4:04 PM and then again on 8/29/24 at 8:27 AM the surveyor asked the Administrator to provide documentation of Resident #132's Private Duty Aide (PDA), also referred to in the documentation as his/her sitter and/or 1:1 as confirmed by the Administrator. On 8/29/24 at 9:10 AM, in an interview with the Administrator, when asked for a third time if there was documentation of when there was or was not a PDA for Resident #132, he stated, No, it is not consistent. On 8/30/24 at 9:38AM in an interview with the Administrator, he stated, 'there was nothing that we [facility] saw that Resident #132 was aggressive towards other residents. We cannot claim to have eyes on residents 24/7. The documentation showed Resident #132 was only aggressive during care.' On 8/30/24 at 10:01 AM in an interview with Staff #10 when asked about the incident between Resident #135 and Resident #132, they stated 'we (facility) knew Resident #132 was having issues such as agitation and refusing care. Staff #10 stated Resident #132 went out to [another facility] to a dementia unit at the end of April 2024 because we (the facility) could not handle him/her. Many other facilities would not accept him/her because of his/her combativeness. He/she did have a private duty aide which was a recommendation from Hospital #3 (an inpatient psychiatric hospital). The PDA was here before Resident #132 even arrived on his/her last admission.' On 8/30/24 at 10:21 AM NP #51 stated she knew Resident #132 had multiple episodes of aggression and agitation. When asked why Resident #132 was sent out after being aggressive with staff and not after the incident with Resident #135, she stated the difference would be how Resident #132 reacted afterwards. If he/she was continually aggressive and escalated, that is when we would send him/her out. On 8/30/24 at 10:45 AM an interview was conducted with the Administrator, Medical Director, and ADON #13 and the survey team. During the interview, ADON #13 stated she was working on 4/7/23 but was not present when the incident occurred. She stated she did go to the scene. Resident #135 called me and had blood and a cut on his/her ear and Resident #132 had already left his/her room. When asked about a hematoma on Resident #135, she stated the bruise probably started forming later, but she did not observe one at that moment. In addition, the Medical Director stated he did believe the hematoma was likely drainage from the initial cut. When asked if he assessed Resident #135, he stated, No, I did not do an assessment of the resident after the incident. On 8/30/24 at 10:55 AM when asked about the interventions that were put in place for Resident #132, the Medical Director stated we had Webex's with regional and home office management and went into specifics such as more oversight, activities he/she [Resident #132] liked to do, and what he/she [Resident #132] liked to read. A lot of his/her [Resident #132] aggression occurred during showers and showers with female staff. During the interview when asked for documentation of the interventions, the Medical Director stated, Why didn't I write a one-page document of everything that was discussed on the Webex? I do not know. This was a learning experience. I put together a lot of stuff and did not document it correctly. We keep looking back and saying why did we not look at the discharge note and question the documentation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/30/24 at 11:05 AM ADON #13 stated our fault is that we did not document the interventions well. It is unfortunate you cannot be everywhere at every time and the incident happened at change of shift. During the interview she also stated the only thing she could 100 percent agree with is the documentation for the facility's interventions was not there. When asked about the standard of practice ADON #13 stated, if it is not documented, it is not done. On 8/30/24 at 11:09 AM the Medical Director stated we had an incident [between Resident #132 and Resident #135], and the interventions put in place were not properly documented afterwards, referring to it as a mistake. On 8/30/24 at 11:12 AM ADON #13 stated the private duty was in the facility before Resident #132 came into the building after the 4/4/23 to 4/25/23 hospital admission. Resident #132 would not have been allowed back in the facility without the private duty aide. On 8/30/24 at 11:14 AM the Administrator then stated the private duty aide was supplemental to facility staff. On 8/30/24 at 2:17 PM in an interview with RN #5, the nurse for Resident #135, stated she was getting report in the nurse's station and was called by Care Associate (CA) #47. She stated the resident had blood on his/her face and upon assessment noted a cut on his/her right eyebrow and some swelling. Furthermore, she stated she asked him/her what happened. Resident #135 said that guy/girl came to my room and pushed me, so I hit the wall and fell into my wheelchair. Then, she reported that she cleaned up Resident #135 and then made his/her family member, ADON #13, and the supervisor aware. In addition, RN #5 stated, usually we have two nurses. Resident #135 was on my side and Resident #132 was on the other side and he/she must have come over. During the interview she stated Resident #132 had psychiatric issues. On 8/30/24 at 2:43PM in an interview with LPN #27 she stated she was the nurse for Resident #132 on the day of the incident on 4/7/23 and was in the nurse's station getting report and heard Resident #135 had been attacked. Resident #135 was right outside of the nurse's station in his/her wheelchair and had blood coming from his/her forehead and it was found out Resident #132 had gone into Resident #135's room. When asked about Resident #132's PDA she stated they were coming at random hours and sometimes staff would have to call the agency to find out if and when a PDA was coming. Furthermore, PDAs would say Resident #132 was aggressive and that they did not want to get hit and so they would not really watch him/her. The PDAs were coming for such a short time, and they were just saying they were scared Resident #132 was going to hit them and would back off. LPN #27 indicated it was in his/her care plan for having an aide because he/she had one when he/she was admitted and that Resident #132 never got physical with her, but was quite a fighter and she did not recall a PDA being there the day of the incident (4/7/23) for any of that shift. 8/30/24 at 3:17 PM in an interview with Care Associate (CA #50) when asked about the incident on 4/7/23 between Resident #132 and Resident #135, she stated she remembered both residents. During the interview, she stated that day, we had split hallways, Resident #132 was in room [room#] which is the middle hall, and he/she must have gone around to room [room#]. She reported that the only thing she did see was Resident #135 with blood. When asked about Resident #132's PDA she stated sometimes he/she did have a PDA but could not remember if he/she did that day. When asked if she was the CA assigned to Resident #132 and if she was afraid of him/her, she stated, yes, she was assigned to Resident #132 that day and yes, she was afraid of him/her. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/5/24 at 12:20 PM in an interview with the Administrator he stated the PDA was not part of the resident's plan of care but was additional support. During the interview he stated, based on everything we reviewed, there was nothing showing that having a private duty was part of his plan of care. On 9/5/24 at 12:38 PM in an interview with the DON when asked why a private duty was not consistently scheduled, she stated we did not have an order for a private duty, so it was just supplemental. When asked what exactly the facility's expectations are for a private duty, she stated that if they are only a companion then they are here to assist with activities and not to assist with ADL's or care. Neither the POA nor emergency contact for Resident #132 could be reached for an interview during the survey. 50385 2. On 9/4/24 at 9:46 AM, a review of Facility Reported Incident MD00192370 was conducted regarding an allegation of neglect of Resident #130 related to the resident placement on a bed pan and left for an extensive amount of time with no follow-up assistance on 5/13/23. On 9/4/24 at 9:55 AM, a review of the facilities investigation report for Resident #130 revealed that Care Associate (CA) #52 was identified as the staff member who placed the resident on the bed pan. The facilities report revealed the following: According to the final 5-day report submitted to the Office of Health Care Quality stated, Care associate found to be in neglect of assigned duties and suspended pending outcome determination and In Conclusion, investigation was completed. It has been noted that the resident was place on the bedpan during the 3-11 shift and spent about 1 hour on the bedpan. It has been noted that the resident did voice discomfort to the Care Associate and was removed off the bedpan immediately. It has been noted that during the time the resident called to be removed from bedpan, dinner was being served and other residents were being fed, All staff from the community have been educated on delivering good Customer Service and the responsible Care Associate received disciplinary action According to CA #52's interview from 5/19/23, she stated that she had placed the resident on the bedpan on 5/13/2023 and continued to attend to other residents including passing of trays in the assignment. After Passing of trays the GNA admitted to going into the resident's room and seeing that the resident was visibly uncomfortable and removed the bed pan from the resident and made the resident comfortable. On 9/4/24 at 10:15 AM, an interview was conducted with Administrator #1. When asked what the disciplinary action for CA #52 was, he stated that the CA was ultimately terminated. When asked whether the termination of CA #52 was due to the allegation of neglect relating to Resident #130, the Administrator confirmed that the CA was terminated due to this incident. On 9/4/24 at 10:37 AM, the CA's termination was verified with a termination letter. The official termination date was 5/22/23. 50904 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. The facility's investigation related to facility reported incident MD00195738 was reviewed by the surveyor on 08/30/24 at 12:59 PM. The review revealed that: On 08/18/2023 at 11:AM, it was reported by staffing that Staff #38 turned in her badge to the Assistant Director of Nursing (ADON) and walked off her shift. On the same day at 11:22AM Staff #38 returned to the facility and stated she would stay. The Nursing Home Administrator (NHA) and Director of Nursing (DON) went to meet with her and learned from the nurse, Staff # 39, that staff #38 refused to provide care to a resident that had COVID. The NHA and DON asked staff #38 why she did not provide care for Resident #117 and Staff #38 stated that she (staff #38) would not work with COVID residents because she (referring to herself) was old. Further review of the incident investigation report showed that on the same day, the facility interviewed Resident #117 and asked if he/she had bathed and had breakfast. Resident #117 stated that he/she had not had breakfast, that he/she was not sure why he/she did not get breakfast and was hungry at that time. Resident #117 further stated that therapy helped him/her with bathing and getting out of bed, he/she just did not eat. Staff #38 was immediately terminated by the facility, Resident #117 was provided with a meal immediately and all other residents on staff #38 assignments were checked on, interviewed, reassigned, all the residents were stable, and no ill effects were noted. On the same day at 03:04 PM, the alleged abuse incident's initial investigation was reported to the state agency, Adult Protective Services, the ombudsman, and the law enforcement agency. On 08/30/24 at 1:19 PM in an interview with the DON and the administrator, when the surveyor asked why Staff #38's employment was terminated, the administrator stated that the staff's employment was terminated because a resident had been abused and neglected. When asked if the facility reported Staff #38 to the board of nursing, they both stated that they were planning to do that. They were also asked how the other residents on Staff #38's assignments were taken care of after the incident, the DON stated that the assignment was redistributed to other staff members. On 09/04/24 at 10:24 AM The provided the surveyor with a copy of complaint form sent to the board of nursing for Staff #38. 42782 4. On 09/03/24 at 9:00 am during a review of FRI MD00200806 revealed on 12/19/23 during the 11:00 pm - 7:00 am shift GNA #67 provided incontinence care to Resident #122 and the resident complained of pain and asked GNA#67 to stop providing care, but GNA#67 continued to provide care. A written statement from GNA#67 confirmed the resident cried out that they were in pain when GNA#67 turned them to change their Depends. The written statement included GNA#67 continued to render care and did not report the incident to the assigned nurse, nor did GNA#67 request assistance with providing care to Resident#122. The facility substantiated the allegation of abuse. On 09/04/24 at 9:06 am during an interview with Administrator#1 and Director of Nursing #8 the surveyor verbalized reviewing the investigation and confirmed the facility substantiated the allegation of abuse. 50457 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	5. On 08/28/24 at 12:29 PM, during review of facility reported incident MD00196402 dated 09/01/23, Resident #125 stated that Geriatric Nursing Assistant (GNA) #68 entered the residents' room to provide incontinence care. Resident #125 reported that GNA#68 man handle them, pushing them to their side roughly. On 08/28/24 at 12:29 PM, the surveyor received a copy of the facility's self-report for Resident #125. A written statement for the assigned nurse confirmed abuse allegations made against GNA #68. The facility substantiated abuse allegations after completing interviews with neighboring residents and staff working during the time of the event. During an interview with Administrator #1 on 08/28/24 at 01:03 PM,the surveyor asked what was their process when an employee is involved in an allegation of abuse. Administrator #1 explained, when an employee is involved in an alleged allegation of abuse they are immediately suspended pending investigation. Administrator #1 verbalized the abuse allegations related to Resident #125 were substantiated based on the facility's investigation and GNA #68 was terminated on 9/1/2023.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50458 Based on surveyor review of a facility reported incidents, review of medical records, employee records and facility staff interviews, it was determined that the facility failed to report an allegations of abuse, neglect and injuries of unknown origin to the state agency, OHCQ (Office of Health Care Quality) as required. This finding was evident for 16 of 16 residents (Resident #120, #92, #119, #66, #122, #129, #34, #79, #7, #78, #125, #124, #127, #28, #116, #117) selected for abuse investigation. The findings include: The Office of Health Care Quality (OHCQ) is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse, neglect and injuries of unknown origin are to be reported to the OHCQ in a timely manner (within 2 hours for the initial report and within 5 working days for the final report). 1. Review of Facility Reported Incident MD00199656 on 8/28/2024 at 8:45 AM revealed on 11/12/23 Resident #120 was found unresponsive, was sent to hospital via 911. On 11/15/23 at 6:00 PM, Resident #120 returned to the facility. The discharged summary noted that Resident #120 sustained a right acetabular fracture with fracture line involving both the anterior and posterior columns and Acute nondisplaced fracture to Left vertebral body. Review of the facility investigation on 8/28/24 at 10am revealed that on 11/16/23 at 11am Staff #35 was made aware of the incident and notified the Administrator of the injury of unknown origin found on admission to the hospital. According to the facility self-report the allegation was not reported to the state agency until 11/16/23 at 6:40pm. On 08/28/2023 at 10:30 during an interview with the Administrator, he verified the incident was not reported as required. 2. Review of Facility Reported Incident MD00200749 on 8/28/2024 at 10:15 AM revealed that on 12/18/23 at 3:30 PM, Resident #92's family member reported to Staff #61 that Resident #92 had a bruise to the left eye and left upper arm bruise. According to the facility investigation the Administrator was notified 12/18/2023 at 5:00PM of the injury of unknown origin. According to the facility self-report the allegation was not reported to the state agency until 12/18/2023 at 8:30 PM. During an interview on 8/28/24 at 2:30pm the Director of Nursing verified the findings. Stating she thought the facility had 24 hours to report any allegations of possible abuse to the state. 3. Review of Facility Reported Incident MD00201462 on 8/28/2024 at 11:45 AM revealed that on 1/09/24 at 8:30 PM, Resident #119 reported to Clinical Manager #61 that Clinical Associate #59 threw the remote on his/her face. According to facility investigation the Administrator was notified on 1/10/24 at 3:00 PM; however, the allegations were not reported to the state agency until 1/10/24 at 5:35 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/6/2023 at 10:00 during an interview with the Administrator, he verified the incident was not reported as required. 4. Review of Facility Reported Incident MD00206189 on 8/29/24 at 10:00 AM, revealed that on 5/29/24 at 11:00 AM, Care Associate #75 reported to Nurse Care Manager #74 that she saw 2 circular in shape bruises on resident #66 right and left arm. Review of the facility reported investigation revealed the incident was reported to the Administrator on 5/30/24 at 6:39 AM; however, it was not reported to the state agency until 5/30/24 at 2:00 PM. The Administrator verified the findings on 9/6/24 at 12pm. 42782 5. On 09/03/24 at 3:00 pm review of the facility's investigation of Resident #122 alleged allegation of abuse revealed there was not a date on the reporting form to verify when the facility reported the incident to the state agency. There was no email to verify the date and time the incident was sent to OHCQ. Administrator #1 was made aware and asked to provide documentation of when the state agency was made aware of the allegation of abuse. On 09/04/24 at 08:16 am received a copy of the email when the incident concerning Resident #122 was reported to OHCQ. The incident was reported on 12/20/23 at 1:30 pm. Per documentation provided by the facility, Administrator #1 was made aware of the incident on 12/20/23 at 9:30 am. The alleged allegation of abuse was reported to the state agency outside the allotted 2-hour timeframe. 6. On 09/04/24 at 9:34 am a review of the facility's investigation of the incident involving Resident #129 revealed the self-report did not indicate when the report was submitted to the state agency; Administrator #1 & Director of Nursing # 8 were made aware. On 09/04/24 at 10:17 am the surveyor received a copy of the self-report email sent to OHCQ. Administrator#1 was made aware of the alleged incident on 11/14/23 at 3:40 pm. The incident was reported to the state agency on 11/14/23 at 6:17 pm which was outside the 2-hour allotted timeframe of reporting abuse. Administrator #1 was made aware of the deficient practice. 42863 7. Resident #34, was a 98 y.o. with a BIMS score of 4/15, indicating severe cognitive impairement. Resident complained of pain in the left arm on 11/12/23 at around 11:00 AM while receiving activities of daily living (ADL) care per the facility incident report. On 08/27/24 at 1:18 PM the surveyor reviewed MD00199462 which documented the facility submitted both an initial facility incident report as well as a final incident report. The facility reported that the police, the resident representative, the medical director, the head to toe physical assessment was completed, and the nursing supervisor were all contacted on 11/12/23 by 1:13 PM by the assistant director of nursing (ADON), staff # 9. According to the facility's documentation Adult Protective Services (APS) and the Ombudsman were notified on 11/13/24 at 3PM. Resident #34 was sent to the hospital and confirmed the resident had a displaced fracture involving the surgical neck of the left humerus. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/27/24 at 3:50 PM During an interview with the Administrator, the surveyor asked what their policy for reporting abuse was. He verbalized when there is no bodily injury, they report the allegation within 24 hours and when there is a bodily injury, it should be reported within 2 hours. He also added that staff members were educated and that the reporting education is ongoing. 08/28/24 10:24 AM during an interview with the assistant director of nursing (ADON), staff # 9 the surveyor asked what the facility's policy was reporting potential /and /or alleged abuse. Staff #9 stated that staff are to immediately report all incidents of potential and/or actual abuse, neglect, or injuries of unknown origin to a supervisor or administrative staff member. The clinical leaders are to report all alleged incidents of actual or potential abuse, neglect, and or injury of unknown origin immediately to the administrative staff such as the administrator and/or the Director of Nursing (DON). Clinical staff are required to attend a mandatory in-service training on abuse immediately after the investigation of the potential abuse, neglect, and or injury of unknown origin is discovered. The administrative staff are to notify OHCQ via email of all actual, potential, and/or reports of injury of unknown origin within two hours. Staff # 9 added that the facility has a Workday App that shows the training for staff members, and they go into the app to do most of their training. 08/28/24 at 13:55 PM the surveyor reviewed the facility's abuse policy and reporting of abuse policy. It showed that Alleged allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident's property are reported immediately but not later than 2 hours after the allegation is made based on state and federal regulations On 08/28/24 at 10:30 AM the surveyors interviewed the director of nursing (DON). The DON stated that the nursing staff are to report incidents such as suspected abuse, neglect, or injury of unknown origin immediately to the administrative staff within a two-hour timeframe. Also, the DON stated that the staff have been provided in-services regarding the importance of reporting and submitting the facility incident reports to OHCQ regarding the discovery of events within the required two-hour time period. The administrator and the DON stated that the facility recognized that there has been a history of non-compliance with notifying OHCQ within the two-hour timeframe however the facility is addressing the issue currently. The DON stated that there was period of time that the administration was treating the first day as if it were not a part of the 24-hour reporting process. The alleged injury of unknown origin was discovered on 11/12/23, at 11:00 AM and the initial facility report was submitted to OHCQ on 11/13/2023 at 2:52 PM and the final facility report was submitted to OHCQ on 11.20.2023 at 4:57 PM. The timely submission of initial and final self-report facility reports was reviewed prior to and during the exit conference. 48167 8. Review of Initial Facility Reported Incident MD00208165 on 08/24/2024 at 12:09 PM revealed that the facility was made aware of an allegation of physical abuse involving Resident #79 on 07/25/2024 at 4:25 PM. The facility's initial report was submitted and reported on 07/25/2024 at 9:49 PM to the Office of Health Care Quality. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and review of Facility Reported Incident MD00208165 on 08/24/24 at 12:15 PM with the Administrator, he stated and agreed that the incident was reported late to the Office of Health Care Quality and that he has spoken to his staff about submitting reports within 2 hours. 49304 9. On 9/3/24 at 8:24 AM, the facility's investigation for the incident that occurred on 8/24/23 was reviewed. It revealed Resident #7 alleged that 2 staff Geriatric Nursing Assistants (GNAs) were rough and screamed at him/her while providing care. Further review of the facility's investigation documents revealed that the facility submitted the final investigation report to the OHCQ on 8/24/23. The final investigation report was not submitted to the OHCQ until 9/1/23, seven working days later. The facility failed to submit the final investigation report within 5 working days. Review of the facility's Abuse Reporting & Investigation policy's Reporting section on 9/4/24 at 3:05 PM revealed: The community's designated Abuse Investigation Coordinator is the Executive Director/Associate Executive Director or Administrator/Assistant Administrator. Each staff member (IL or CC) must report any actual/known, suspected or alleged incident of physical abuse, neglect, financial abuse, abandonment or isolation to his or her supervisor and/or other community leadership immediately. This includes incidents/actions that the staff member observes, suspects or is informed of by a resident. Under the Elder Justice Act, staff in the nursing home have an additional responsibility to report incidents to the state survey agency [OHCQ] and law enforcement. An employee must also comply with any State designated reporting responsibilities specific to his or her professional licensure. Executive Director/Associate Executive Director or Administrator/Assistant Administrator or designee will submit a written report within five (5) working days or sooner as required by State regulation with the results of the investigation to the appropriate agencies. On 9/3/24 at 10:15AM in an interview with the Administrator he confirmed the final investigation report was not submitted in the required time frame. 10. On 9/3/24 at 9:50 AM, the facility's investigation for the incident that occurred on 11/14/23 was reviewed. Review of the facility's investigation documents revealed Licensed Practical Nurse (LPN #74) became aware of the incident, a bruise of unknown origin, on 11/14/23 at 6:15am and the Assistant Director of Nursing (ADON #9) on 11/14/23 at 10:30 AM. Further review of the facility's investigation documents revealed the initial report was submitted by the facility on 11/14/23 at 5:39 PM and the final report submission on 11/21/23 at 6:45 PM. On 9/3/24 at 11:44 AM in an interview with the Director of Nursing (DON), she was shown the facility's investigation documents where the initial report was submitted by the facility on 11/14/23 and the final report submission on 11/21/23, 6 working days later. During the interview, she stated any allegations of abuse must be submitted to the OHCQ within 2 hours for the initial and 5 working days for the final report and confirmed the initial and final reports were not submitted within the required time frame. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	50457 11. On 08/27/24 at 11:52 AM, during a review of investigation MD00205139 and review of the facilities self-report form, revealed that the alleged incident with Resident #78 injury of unknown origin occurred 04/28/24 at 10:00 AM. The incident was reported to the state agency 04/28/24 at 4:49 PM. On 08/30/24 at 9:08 AM, during an interview with Administrator #1, they verbalized submission of facility reported incident number MD00196402 to the state agency outside of the allotted 2-hour time frame. 12. On 08/28/24 at 12:29 PM, during a review investigation MD00196402, and review of the facilities self-report form revealed that the alleged incident with Resident #125 took place during the evening shift on 08/30/23 at 8:05PM. The incident was reported to the state agency on 09/01/23 at 10:56 AM. 13. On 08/30/24 at 9:47 AM, during a review of investigation MD00200743 and review of the facilities self-report form revealed that the facility received an email from Resident #124s family member on Friday 12/15/23 at 5:05 PM. The email was reviewed by Administrator Assistant #69 on Monday 12/18/23 at 10:00 AM. The incident was reported to the state agency by Assistant Director of Nursing # 9 on 12/18/23 at 3:30 PM. 14. On 09/05/24 at 08:53 AM, during a review of investigation MD00201638 and review of the facilities self-report form revealed that the alleged incident of neglect for Resident #127 occurred 01/16/24 at 8:10 AM. The Administrator #1 was made aware of the incident on 01/16/24 at 8:12 AM. The Incident was reported to the state agency on 01/16/24 at 1:20 PM, which was outside the required two-hour timeframe for reporting alleged abuse. 50904 15. A review of intake MD00206735 was started on 08/27/2024 at 02:24 PM. The facility report indicated that on 06/08/2024 at 4PM, Resident #28 stated to License Practical Nurse (LPN) #22 during the evening shift that he/she was mishandled during care by the day shift Care Associate (CA) #42 at approximately 10 AM of the same day. Review of CA #42's statement revealed that Resident #28 started screaming that he/she had pain in their foot as soon as CA #42 entered the resident's room for his/her morning care. CA #42 added that she had not touched the resident but had moved the resident's puzzle from the table. A review of the clinical nurse report note revealed that LPN #22 called the nurse supervisor, Registered Nurse (RN) #45 and informed her of the alleged incident on 06/08/24 around 11:30 AM. RN #45 interviewed the resident at 12:00PM of the same day. RN #45 informed the administrator on 06/09/2024 at 5:32 AM. Further review revealed that the incident was not reported to the state agency until 06/09/2024 at 2:30 PM. On 08/27/2024 at 3:50 PM During an interview with the Administrator, concerns with reporting an abuse were discussed with him in summary that an alleged resident abuse allegation occurred on 06/08/2024 at 10 AM and the allegation was reported to the state agency on 06/09/2024 at 2:30 PM. He acknowledged that the reporting time was late and stated that the abuse allegation was not substantiated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	16. A review of intake MD00187803 was started on 09/03/2024 at 07:43 AM. On 01/06/2023 per facility's concern report investigation, family member of Resident #116 had expressed resident's concern about being handled rough by CA #32 during his/her admission weight on 01/05/2023 at approximately 6 PM. On 01/13/2023 at 5:02 PM The initial report was sent to the state agency and the law enforcement agency at 6:04 PM on the same day. On 01/16/2023 the facility obtained a statement from the Care Associate CA #32 who was assigned to the resident on 01/05/2023 and she stated that she discovered that the scale was not working, and she asked for help from another colleague CA #54. She added that the resident refused to be weighed while the two staff members attempted to fix the Hoyer lift so that the scale could work. She further stated that they both left Resident #116. On 01/17/2023, the facility obtained a statement from CA #54, and he stated that the resident refused to be weighed when he was called in to help by CA #32. The facility could not substantiate the allegation of abuse. On 09/03/2024 at 1:39 PM The administrator and Director of Nursing's attention was brought to the late reporting time and they both agreed that the self- report should have been completed and sent to the state agency on 01/06/2023 within the required reporting time of 2 hours and not on 01/13/2023. 17. A review of intake MD00195738 was started 08/30/24 at 12:59 PM and revealed that on 08/18/2023 at 11:00AM it was reported by staffing that Staff #38 turned in her badge to the Assistant Director of Nursing (ADON) Staff #9 and walked off her shift. On the same day at 11:22AM Staff #38 returned to the facility and stated she would stay. Nursing Home Administrator (NHA) and Director of Nursing (DON) went to meet with her and learned from the nurse, Staff #39 that staff #38 refused to provide care to a resident that had COVID. The NHA and DON asked staff 38 why she did not provide care for Resident #117 and Staff #38 stated that she would not work with COVID residents because she (referred to herself) was old. Staff #38 was terminated immediately because the allegation of abuse(neglect) was substantiated. On 09/03/2024 at 2:58 PM A copy of the initial self-report email was provided to the surveyor. Upon review of the document, it indicated that the initial report was sent on 08/18/2023 at 3:04 PM. The administrator confirmed that it was out of the 2-hour window because it was reported at about 4 hours after the alleged neglect incident.

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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. 50904 Based on review of records and interview with facility staff, it was determined that the facility failed to ensure that staff reported suspected abuse to the administration in a timely manner resulting in the alleged perpetrator being allowed to continue to provide services to the victim prior to the initiation of the investigation. This was evident for 1(Resident #28) out of 8 residents reviewed for abuse during the recertification survey. The findings include: On 08/27/2024 at 02:24 PM, review of intake MD00206735 was started and revealed clinical notes written by LPN #22 on 6/14/2024 with an effective date of 6/8/2024 at 11:30 AM. The note stated that Resident #28 informed License Practical Nurse (LPN) #22 that he/she was going to report to someone that he/she was mishandled during care by the day shift Care Associate (CA) #42. LPN #22 told Resident #28 to stay on the unit for physical assessment for injuries and called the supervisor, RN #45 afterward. At 12:00 PM of same day, RN #45 interviewed the resident about the suspected abuse incident. On 06/08/2204 at 4:00PM, RN #45 stated that she became aware of the suspected abuse incident in the initial report sent to the state agency and submitted the report on 06/09/2024 at 2:30 PM. On 08/28/2024 at 10:24 AM, during an interview with the Assistant Director of Nursing (ADON) Staff #9, she was asked what the facility's policy was after an alleged abuse. She stated that the staff automatically gets a mandatory in-service training on abuse after being suspended per facility's protocol, and an impromptu mandatory service may be done depending on events that happened in the facility. On 08/28/2024 at 01:05 PM, during an interview with the administrator, he was asked what the procedure was after the report of alleged resident abuse by a staff member, he stated that the alleged perpetrator is suspended immediately until the investigation is completed. RN #45 and RN #22 were not available for an interview while the surveyor was at the facility. On 08/29/24 at 09:28 AM, during another interview with the administrator, he was asked what was done to protect Resident #28 from further abuse. He stated that CA #42 continued to work with the resident with another staff member to assist throughout the morning shift. At 12:23 PM of the same day, review of CA #42's Timecard Report revealed she had finished a double shift on 06/08/2024 with an in time of 6:53 AM and out time of 11:24 PM. The Assignment sheet also showed that she worked with Resident #28 throughout the morning shift and her assignment was only changed during the evening shift. The staffing sheet and timecard was reviewed with the administrator, and he acknowledged that CA #42 continued to work with the resident with another staff member throughout the morning shift when she should have been suspended or had a change of assignment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 42782 Based on medical record review and interviews it was determined that the facility staff failed to follow professional nursing standards as evidenced by nursing staff failure to sign the medication record after an antibiotic was administered. This deficient practice was evident in 1 (#123) of 2 medical records reviewed for medication administration during the survey. The findings include: On 09/05/24 at 3:13 pm the surveyor reviewed notes in the electronic medical record (EMR) which revealed Resident #123 was ordered antibiotic therapy, but the medication was not available. An alternative antibiotic was ordered and given by Nurse #70 per nursing note. Further review of the medication record revealed the antibiotic was not signed off as given by Nurse #70 on the medication record. On 09/06/24 at 11:30 am during an interview with Assistant Director of Nursing RN #9 who verbalized the nurses are supposed to sign the medication record after medications are given. On 09/06/24 at 12:37 pm During an interview with RN #5 the surveyor asked what the expectation of the nursing staff after giving a resident medications. RN #5 verbalized when giving a resident medication they make sure the resident swallows the medication and afterwards the medication is signed off on the medication record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42782 Based on medical record review and interview it was determined that the facility staff failed to administer antibiotic therapy as ordered for a resident. This deficient practice was evident in 1 (#123) of 2 resident records reviewed for medication administration during the survey. The findings include: On 09/05/24 at 2:35 pm the surveyor reviewed Resident #123 which revealed the resident was admitted to the facility on [DATE] with a known infection of the right prosthetic hip and ordered to receive antibiotic therapy Cefazolin 2 grams intravenously (IV) every 8 hours for 6 weeks. Review of the medication administration record revealed Resident #123's first dose of antibiotic therapy was due on 08/03/22 at 10:00 pm and the antibiotic was not given. Nurse #78 wrote a note on 08/04/22 at 2:48 am indicating the prescribed IV antibiotic was not available, but an alternative antibiotic was ordered and available in the Omnicell medication dispensing machine. Nurse #70 wrote a note on 08/04/22 at 7:16 am indicating the resident received Ceftriaxone 1 gram IV at 2 am, but did not sign off the antibiotic was given on the medication administration record. Resident #123 also missed a dose of antibiotic therapy on 08/04/22 at 2pm. On 09/06/24 at 11:30 am the surveyor and Assistant Director of Nursing (ADON) #9 reviewed Resident #123's medication administration record and notes to verify the resident missed two doses of antibiotic therapy. On 09/06/24 at 2:19 pm during an interview with ADON #9 the surveyor asked how the nursing management team verify medications are given as ordered. ADON #9 verbalized they monitor the medication exception report and review if there was a note in the system. The report is reviewed weekly by the nursing management team. Now they call the physician to make aware an antibiotic is not available and they will start another antibiotic the next day. The treatment will be extended to make sure the resident gets the full dose of antibiotic therapy.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on medical record review, staff interviews, and review of facility investigation documents, it was determined that the facility failed to provide adequate supervision to Resident #132 who had a documented history of wandering, agitation, and physically aggressive behaviors as evidenced by the physical abuse and harm of Resident #135. This was evident for 1 (Resident #132) of 4 residents reviewed for accidents and adequate supervision during the survey. The findings include: The facility's investigation related to facility reported incident MD00191125 was reviewed on 8/28/24 at 2:39 PM. In the investigation, the facility substantiated there was an altercation between Resident #132 and Resident #135 which led to Resident #135 sustaining multiple injuries. On 8/29/24 at 12:15 PM review of Resident #132's Hospital #3 (inpatient psychiatric hospital) discharge summary dated 3/21/23 revealed a diagnosis of dementia with behavioral disturbance, agitation and aggression and relapse of illness. It was documented, Patient presented to the ER (emergency room) due to agitation and paranoid behaviors towards residents and staff at his/her assisted living. Patient was recently admitted to the ER from 11/20-12/2/22 for similar behaviors. And His/her daily pattern is to wander around, restless and intrusive, and can be pleasant at times. However, patient with agitation, combativeness and would require 3-5 staff to provide personal care. Patient was also getting prn (as needed) meds almost daily due to his/her behaviors. Continued review of Resident #132's medical record on 9/3/24 at 8:00 AM revealed increasing episodes of agitation with verbal and physical attacks on staff during personal care, lying in other residents' beds, frequent re-direction needed requiring 2 staff to remove Resident #132 from other residents' rooms , wandering into other residents' rooms, and pushing other residents in their wheelchairs. These aggressive behaviors continued between 3/21/2023 and 3/28/2024 when Resident #132 was transferred to the hospital. Additionally, staff documented that the Private Duty Aides (PDAs) were not coming as scheduled and were not coming consistently in the afternoons and evenings, when according to the documentation, one was most needed. For example, on 3/24/24 a Nurse Practitioner's (NP's) note written by NP #65 documented in the History of Present Illness section: Review mood with staff, Increase agitation in the afternoon, Need redirecting at all times, Sitter with resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	From 3/28/23 to 4/4/23 Resident [#132] was admitted to Hospital #2 for a presumed syncopal episode. The hospital's discharge summary was reviewed on 8/30/24 at 4:00 PM and revealed: he/she [Resident #132] is intermittently violent, which is a chronic issue that is only partially controlled on multiple antipsychotics. Resident #132 was medically stable to discharge before today but due to behavioral problems there were delays with discharge but the facility is now ready to take him/her back. It was also documented, Appreciate Geriatrics and Psychiatry recommendations. Both are doubtful that he/she will improve adequately for acceptance to long-term facility. His/her original facility [Oak Crest Village] wants to try and take him/her back and in our discussion with them today indicated that they are specifically hiring staff members to help accommodate his/her [Resident #132's] return. He/she does, unfortunately, appear to be at his/her baseline, so significant improvement from this intermittent combativeness is not expected. In PMH (past medical history) it was documented, Potential for harm to others. A review of the medical record for Resident #132 on 8/29/24 at 10:27 AM revealed the resident was readmitted to the facility on [DATE] with a diagnosis of unspecified dementia with behavioral disturbance, severe, with agitation, assault by unspecified means, and vascular dementia, severe, with agitation. Further review of the medical record revealed the resident had a Brief Interview for Mental Status (BIMS) of 3 out of 15, which indicates the resident had severe cognitive impairment. Resident #132's decision making capacity was described as, Severely impaired-never/rarely made decisions, and s/he may exhibit the following expressions/actions: Physical expression(s) towards others (e.g. hitting, biting, kicking, pushing, scratching, grabbing, abusing others sexually, etc.), Verbal expression(s) towards others (e.g. threatening others, screaming at others, cursing at others, etc.), Refuses medications. Other descriptors of Resident #132's behavior were as follows: Put myself/others at significant risk for physical illness or injury, Significantly interfere with the resident's care, Significantly interfere with resident's participation in activities or social interaction, Put others at significant risk for physical injury, Significantly disrupt care or living environment. Continued review of the medical record for Resident #132 revealed a facility initiated care plan on 4/4/23 to address the following: agitation, syncope, and wandering. The approaches included, Staff will supervise me and help redirect me while I am wandering to help keep me safe, I will be monitored for safety concerns and will be redirected as appropriate and It is possible I will be eligible to move to Memory Care at some point, but not yet. Review of the registered dietician's notes revealed, hospitalized due to intermittent violent behavior .multiple ER/hospitalization related to dementia, psychosis and agitation .Resident [#132] has sitter today with [him/her]. Upon further review of Resident #132's medical record on 9/3/24 at 5:00 PM revealed agitation, wandering into other residents' rooms, taking food from resident's plates, and verbal and physically aggressive behaviors continued when the resident returned to the facility on [DATE] through 4/7/23 when the incident with Resident #135 occurred. On 4/4/23 at 1:27 PM a nursing note written by LPN #27 documented Resident [#132] arrived by [NAME] (ambulance) on a stretcher with two paramedics at 11am. Resident is alert and responsive. Resident is a readmit. DX (diagnoses): Syncope, dementia with aggression. Resident has a private duty . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/4/23 (11PM-7AM shift): Resident [#132] with a fast paced ambulation, dressed in a gown. Corporate present for assistance with making Resident [#132] comfortable with neighborhood as well as engaging him with activity. Agency aide with him for cues for direction. On 4/5/24 (3PM-11PM shift): Resident [#132] had sitter in room from about 8:30 AM - 1:00 PM. On 4/6/24 (7AM-3PM shift): Resident [#132] trying to go into other residents' rooms and difficult to redirect. Walking quickly from room to room. Directed to his/her room several times but would not stay in the room. On 4/6/24 (3PM-11PM shift): Resident [#132] had a private duty sitter this morning from 8:30am-1pm. Ambulating in and around the hallway. He/she does go into other rooms, was redirected today out of another resident's room. On 4/7/23 at 8:15 PM handwritten statement from RN #5, RN, was the nurse on [nursing unit]. She stated the aide called her and told her [Resident #135] has blood on [his/her] face and was hit by [Resident #132]. Nurse met Resident #135 on the hallway, pointed to at [Resident #132], and stated that [Resident #132] pushed him/her and lost control, fell and hit his/her face. RN#5 then reported the incident to the clinical manager [ADON #13]. On 4/7/23 at 8:30 PM handwritten statement from Care Associate (CA) #47, CA #47 was an aide on the floor. She saw Resident #132 sitting on Resident #135's bed. She heard Resident #135 telling Resident #132 to get out of his/her room. Resident #132 said, 'You don't tell me what to do, you don't know me'. Then she heard Resident #135 scream saying, '[s/he] pushed me'. On entry to the room, he saw Resident #132 walking out and Resident #135 bleeding on the face. CA #47 went ahead and alerted the RN#5. On 4/7/23 at 11:21 PM a nursing note written by RN #5 documented, Around 3:20pm, the CA assigned to Resident #132 came to report a resident had blood coming down from his/her face and saw another resident come out of his/her room. Upon assessment, a cut was noted on the right ear lobe measuring 3.5cm x 0. 1cm. A hematoma noted to be forming as well. Resident #132 also sustained an open area on his right forearm measuring 0.8cm x 0.2cm. As per resident, the resident in rm x, Resident #132, came into the room and there was an altercation. Resident #135 said, He/she came in and will not leave, he/she pushed me and I fell and hit my head against the wall. POA [of Resident #135] was notified as well as Resident #132's daughter. The abuse was also reported to the State and Police officer called in as well. No acute distress noted. Will continue to monitor. On 4/7/23 a Progress Note written by Medical Doctor (MD #46) revealed, [Resident #132] was visually responding to unseen objects/situations. Patient has a history of recurrent psychiatric hospitalization due to his/her behavior problems in last few months. [He/she] has been on 1:1 observation due to behavior. The episode occurred while changing nursing shift. Another note revealed, his/her behavior due to his/her mental illness. Cannot be reasoning with [him/her]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In the facility's Investigative Tool document dated 4/10/23, ADON #13 wrote, Writer met with LPN #48 who is the 7-3p nurse for Resident #132. LPN #48 is aware that Resident #132 should have a 1:1 private aide but there is no consistency on one being available as scheduled. LPN #48 was not a witness to the incident but is aware that the incident took place. LPN #48 is aware of the inappropriate tendencies of Resident #132 that can be expressed at any given time, especially in the evenings. LPN #48 signed the document. In the facility's Investigative Tool document dated 4/10/23, ADON #13, wrote in the section called Interviewee's Explanation of Event or Incident, Writer met with RN #49 who is the 3-11 nurse for [Resident #132]. RN #49 is aware that [Resident #132] should have a 1:1 private aide but there is no consistency on one being available as scheduled. She had contacted his/her family member before letting him/her know that a 1:1 was not available. RN #49 did not witness the incident but is aware of the inappropriate tendencies of [Resident #132]. RN #49 signed the document. On 4/10/23 a Progress Note of [Resident #132], written by Medical Doctor (MD #64) documented, resident (#132) seen for follow up of altercation of another resident and behavioral issues on the unit, resident walking around the unit without his/her private aide, resident is unable to provide any related history through verbal due to degree of dementia and loose association attempts at conversation, and resident unable to provide any recollection of the incident that occurred with police coming afterward. In the Treatment section it was documented, Assault: Clinical Notes: resident s/p numerous hospitalization s with agitation and negative behavior due to progression of dementia. Resident since 3 month Hospital (#3) [inpatient psychiatric hospital] stay has sat on a minimally verbal resident while he/she was lying in her bed, and had gotten in bed with a frail elderly male/female as he/she was sleeping in bed. Recent altercation 4/7/23, resident [#132] entered another resident's [#135] room and pushing altercation ensued as the resident [#135] whose room it was, attempted to get resident [#132] out. Resident #132, who is the taller and stronger resident pushed the resident [#135] who was attempting to maintain his/her personal space down resulting in that resident [#135] being injured with a large brow hematoma. Vascular dementia, severe, with agitation. Continued review of the progress note documented, This provider does not feel the patient is appropriate to remain on this unit for his/her health and the safety of other residents and staff; similar was communicated to care center administration. On 4/10/23 a Progress Note of [Resident #132], written by Nurse Practitioner (NP #65) documented: had recent altercation encounter with another Resident [#135]; (no caregiver at that time). On 8/28/24 at 2:22 PM review of a Medical Doctor's (MD's) progress note written by MD #46 for Resident #135 documented on 4/7/23, Resident #135 reported that another resident came into his/her room and pushed him/her during their altercation. Developed hematoma and laceration at right eyebrow and bleeding from laceration. In the Examination section: Right eyebrow hematoma and horizontal laceration cut about 1 inch and bleeding from it. Shear pressure open skin lesion at right forearm. On 8/28/24 at 3:42 PM, in an interview with the Administrator, he stated that Resident #132 went out to the hospital and was readmitted to Oak Crest on 4/4/23. During the interview he stated that Resident #132 had a PDA when he/she came back that was hired by his/her family he/she had had them for years prior to entering the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/28/24 at 4:04 PM and then again on 8/29/24 at 8:27 AM the surveyor asked the Administrator to provide documentation of Resident #132's Private Duty Aide (PDA), also referred to in the medical record as his/her sitter and/or 1:1 as confirmed by the Administrator. On 8/29/24 at 9:10 AM in an interview with the Administrator when asked for a third time if there was documentation of when there was or was not a PDA for Resident #132, he stated,No, it is not consistent. During the interview, when asked if the expectation is to have visitors who come into the building to sign in and out he stated sometimes. When asked if he knew if someone was in the building working with one of the residents, he stated yes. The survey team requested documentation of the PDA signing in and out. On 8/30/24 at 9:00 AM, review of the sign in sheets (2) the facility provided for all visitors during Resident #132's last two admissions revealed: On Resident #132's 3/21/23 to 3/28/23 admission: 2 of the 8 days from this admission, there were visitors who in the Visitor Type column signed in as Certified Nurse Aide. The sign in sheet documented 2 different names. On Resident #132's 4/4/23 to 4/25/23 admission: 12 of the 27 days from this admission, there were visitors who in the Visitor Type column signed in as Certified Nurse Aide, Nurse RN (Registered Nurse), Home Health, or Home Care. The sign in sheet documented 9 different names. On 8/29/24 at 12:58 PM in an interview with the Administrator he stated we have identified the PDA's agency and requested the records. On 8/30/24 at 8:37 AM in an interview with the Administrator, he stated the PDA's agency would not release information until they got documentation from Resident #132's POA (Power of Attorney) authorizing release. The surveyor requested the punch sheet for the PDA during Resident #132's last admission (4/4/23-4/25/23). At the time of survey exit, the facility did not provide documentation from the PDA's agency. On 8/30/24 at 9:38AM in an interview with the Administrator, he stated there was nothing that we [facility] saw that Resident #132 was aggressive towards other residents. We cannot claim to have eyes on residents 24/7 and the documentation showed Resident #132 was only aggressive during care. On 8/30/24 at 10:01 AM in an interview with Staff #10 when asked about the incident between Resident #135 and Resident #132, they stated 'we (facility) knew Resident #132 was having issues such as agitation and refusing care. Staff #10 stated Resident #132 went out to [another facility] to a dementia unit at the end of April 2024 because we (the facility) could not handle him/her. Many other facilities would not accept him/her because of his/her combativeness. He/she did have a private duty aide which was a recommendation from Hospital #3 (an inpatient psychiatric hospital). The PDA was here before Resident #132 even arrived on his/her last admission.' On 8/30/24 at 10:21 AM NP #51 stated she knew he/she [Resident #132] had multiple episodes of aggression and agitation. When asked why Resident #132 was sent out after being aggressive with staff and not after the incident with Resident #135, she stated the difference would be how Resident #132 reacted afterwards. If he/she was continually aggressive and escalated, that is when we would send him/her out. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/30/24 at 10:45 AM an interview was conducted with the Administrator, Medical Director, ADON #13 and the survey team. During the interview, ADON #13 stated she was working on 4/7/23 but was not present when the incident occurred. She stated she did go to the scene. Resident #135 called me and had blood and a cut on his/her ear and Resident #132 had already left his/her room. When asked about a hematoma on Resident #135, she stated the bruise probably started forming later, but she did not observe one at that moment. In addition, the Medical Director stated he did believe the hematoma was likely drainage from the initial cut. When asked if he assessed Resident #135 he stated, No, I did not do an assessment of the resident after the incident. On 8/30/24 at 10:55 AM when asked about the interventions that were put in place for Resident #132, the Medical Director stated we had Webex's with regional and home office management and went into specifics such as more oversight, activities [Resident #132 likes to do, and what Resident #132 likes to read. A lot of Resident #132's aggression occurred during showers and showers with female staff. During the interview when asked for documentation of the interventions, the Medical Director stated, Why didn't I write a one page document of everything that was discussed on the Webex? I don't know. This was a learning experience. I put together a lot of stuff for and did not document it correctly. We keep looking back and saying why did we not look at the discharge note and question the documentation. On 8/30/24 at 11:05 AM ADON #13 stated our fault is that we did not document the interventions well. It is unfortunate you cannot be everywhere at every time and the incident happened at change of shift. During the interview she also stated the only thing she could 100 percent agree with is the documentation for the facility's interventions was not there. When asked about the standard of practice ADON #13 stated, if it is not documented, it is not done. On 8/30/24 at 11:09 AM the Medical Director stated we had an incident [between Resident #132 and Resident #135], and the interventions put in place were not properly documented afterwards, referring to it as a mistake. On 8/30/24 at 11:12 AM ADON #13 stated the PDA was in the facility before Resident #132 came into the building. The resident [#132] would not have been allowed back in the facility without the private duty aide. On 8/30/24 at 11:14AM the Administrator then stated the PDA was supplemental to facility staff. On 8/30/24 at 2:17 PM in an interview with RN #5, the nurse for Resident #135 stated she was getting report in the nurse's station and was called by CA #47. She stated the resident #135 had blood on his/her face and upon assessment noted a cut on his/her right eyebrow and some swelling. Furthermore, she stated she asked him/her what happened. Resident #135 said that guy/girl came to my room and pushed me, so I hit the wall and fell into my wheelchair. Then, she reported that she cleaned up Resident #135 and then made his/her family member, ADON #13, and the supervisor aware. When asked about the alleged perpetrator, Resident #132, RN #5 stated, usually they have two nurses. Resident #135 was on my side and Resident #132 was on the other side and must have come over. During the interview she stated Resident #132 had psychiatric issues. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/30/24 at 2:43PM in an interview with LPN #27 she stated she was the nurse for Resident #132 on the day of the incident on 4/7/23. We were in the nurse's station getting report and heard Resident #135 had been attacked. Resident #135 was right outside of the nurse's station in his/her wheelchair and had blood coming from his/her forehead. We found out Resident #132 had gone into Resident #135's room. When asked about his/her PDA she stated she did not recall Resident #132's PDA being there the day of the incident (4/7/23) for any of that shift. During the interview she stated they were coming at random hours and sometimes the facility staff would have to call the agency to find out if and when a PDA was coming. Furthermore, PDA's would say Resident #132 was aggressive and that they did not want to get hit and so they would not really watch him/her. The PDAs were coming for such a short time, and they were just saying they were scared he/she was going to hit them and would back off. During the interview, LPN #27 stated it was in Resident #132's care plan for having an aide because he/she had one when he/she was admitted . He/she never got physical with me, but he/she was quite a fighter. 8/30/24 at 3:17 PM in an interview with Care Associate (CA #50) when asked about the incident between Resident #132 and Resident #135, she stated she remembered both residents. During the interview, she stated that day, we had split hallways, Resident #132 was in room [room #] which is the middle hall, and he/she must have gone around to room [room #]. She reported that the only thing she did see was Resident #135 with blood. When asked about Resident #132's PDA she stated sometimes he/she did have a PDA, but could not remember if he/she did that day. When asked if she was the CA assigned to Resident #132 and if she was afraid of him/her, she stated, yes, she was assigned to Resident #132 that day and yes, she was afraid of him/her. On 9/5/24 at 12:20 PM in an interview with the Administrator he stated the PDA was not part of the resident's plan of care but was additional support. During the interview he stated, based on everything we reviewed, there is nothing showing that having a PDA was part of his plan of care. On 9/5/24 at 12:38 PM in an interview with the DON when asked why a PDA was not consistently scheduled, she stated we did not have an order for one, so it was just supplemental. When asked what exactly the facility's expectations are for a PDA, she stated that if they are only a companion then they are here to assist with activities and not to assist with ADL's or care. Neither the POA or emergency contact for Resident #132 could not be reached for an interview during the survey.

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F 0692 Level of Harm - 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** 50457 Based on medical record review, administrative reviews, and staff interview, it was determined that facility staff failed to monitor and implement interventions to address the nutritional needs of residents who had a known significant weight loss. This deficient practice was evident for 5 (#127 and #22, #17, #40, #33) out of 15 residents reviewed for nutrition. The failure resulted in harm to Resident #127. The findings include: 1. On 8/30/24 at 10:47 AM, a review of the facility reported incident MD00201638 dated 01/18/24 alleged Resident #127 was being neglected by staff due to the resident's significant weight loss. Review of medical records on 8/30/24 at 11:10 AM revealed a clinical note dated 1/12/24 at 2:25 PM from Registered Dietitian (RD) #36 revealed that Resident #127 was noted to have lost 15.23% of their weight over 30 days, 28.49% over 90 days and 26.01% over 180 days. A dietary intervention was added to Resident #127's plan of care on 01/12/24 which included an in-house milkshake at 2pm. Review of Resident #127's medication and treatment record for January 2024 revealed there was no documentation indicating Resident #127 received a nutritional supplement until 1/19/24 at 9:00 PM. Review of Resident #127's medical records revealed the resident was admitted to the facility on [DATE] from the assisted living on campus. Further review of the medical records revealed weights from May 2023 to November 2023: 05/11/23-171.0lbs 06/06/23-172.0lbs 07/05/23-173.0lbs 08/02/23-171.9lbs 09/06/23-172.0lbs 10/05/23-183.9lbs 10/11/23-179.4lbs Review of Resident #127's weights on 8/30/24 at 11:16 AM revealed that the resident began experiencing weight loss in November 2023. The following weights were found from November 2023 to the end of January 2024: 11/6/23-178.0lbs 11/22/23-144.8lbs (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	11/29/23-144.4lbs 12/4/23-180.6lbs 12/21/23-150.8lbs 1/4/24-129.4lbs 1/9/24-128.8lbs 1/11/24-128.4lbs 1/15/24-119.60lbs 1/16/24-121.6lbs 1/18/24-124.7lbs After review of Resident #127's treatment orders and medication orders from November 2023 to January 2024, the records failed to reveal interventions to address the resident's weight loss. Ongoing chart review failed to reveal any nutrition note written prior to 1/12/24 that addressed Resident #127's weight loss. The review also failed to reveal any intervention to prevent further weight loss that had been initiated prior to the in-house milkshake that had been requested by the RD #36 on 1/12/24. During an interview with RD #36, Administrator #1, and Director of Nursing (DON) #8 on 8/30/24 at 3:27 PM, RD #36 expressed waiting on a reweigh of Resident #127 before recommending dietary interventions. When asked why Resident #127's weight was not verified RD #36 stated, nursing staff did not follow up with a weight or reweight. When asked if the policy for weight loss was followed for Resident #127, RD #36 stated, no. When asked if there a clinical note from RD #36 concerning Resident #127 in the month of December 2023, RD #36 replied no. When asked who RD #36 notified about Resident #127's significant weight loss. RD #36 stated that they sent a weekly email to the leadership team about the resident's weight loss. On 08/30/24 at 4:33 PM, review of an email sent on 11/24/23 at 9:19 AM, by RD #36 revealed that the clinical staff, including Administrator #1, DON #8, Assistant Director of Nursing (ADON) #9, Medical Director #25, and Nurse Managers were made aware that Resident #127 had a weight loss of 33.2lbs. Further review of the documentation revealed on 11/27/23 at 8:50AM and 11/29/23 at 9:12AM that RD #36 continued to submit Resident #127's weights via email. Additional emails were sent on 12/18/23 at 9:15 AM, 12/19/23 at 9:12 AM, and 12/20/23 at 9:58 AM. It was also noted that weekly weights were not completed (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 09/03/24 at 07:54 AM, review of Nurse Practitioner #53's assessment of Resident #127 on 11/13/23 revealed notes requesting weekly weights for 4 weeks to better trend true weight loss. Review of treatment orders from November 2023 to January 2024 revealed weight orders dated 11/13/23, 11/15/23, 1/4/24, 1/12/24, and 1/17/24. Additional recommendations included, speech language pathology (SLP) referral for swallowing evaluation, and a dietician consult for oral supplement to increase caloric intake. Further review of medical records revealed SLP, and occupational therapy consults were not ordered until 1/12/24. No oral supplement was ordered prior to 1/12/24. On 9/05/24 at 9:21 AM, during an interview with Administrator #1 and DON #8, they were asked how the nursing staff was expected to document the quantity of meals consumed by residents. DON #8 stated, there is no documentation to track how much each resident consumes. On 09/05/24 at 10:53 AM, during an interview with Registered Nurse (RN) #5, they were asked how the effectiveness of resident supplements, such as protein drinks and milkshakes, are monitored. RN #5 explained, if a resident is ordered supplements, I click a button in the system to indicate that the supplement was given. The system does not have a section to document the amount consumed. RN #5 stated that they verbally report the amount consumed to the oncoming nurse during shift change. When asked how resident weights are obtained, RN #5 explained that a care associate (generic nursing assistant) weighs the resident and verbally reports the weight to the nurse, and the nurse documents in the electronic medical record. When asked about monitoring weight changes, RN #5 stated they cannot view previous weights while documenting, but that the manager has access to previous weights. On 09/05/24 at 3:05 PM, during an interview with ADON #9, when asked about the lack of intervention for the significant weight loss of Resident #127 between November 2023 and January 2024, ADON #9 stated that the entire interdisciplinary team failed to follow the process. When asked why, they stated, A lot was going on at the time, and I can't remember the specific reason. On 09/06/24 at 1:56 PM, during an interview with the Medical Director #25 concerning Resident #127's significant weight loss, Medical Director #25 was presented with the residents' weights from November 2023 through January 2024. Medical Director #25 reported they were informed of the weight loss and stated that actions should have been taken sooner. Medical Director #25 reported that they should have been more proactive with hospice interventions or the initiation of palliative care. Resident #127 experienced a significant weight loss, losing over 50lbs between November 2023 and January 2024. Facility staff failed to implement timely dietary interventions or conduct consistent weight checks leading to ongoing weight loss. Additionally, the emails and documentation revealed that facility staff was aware of Resident #127's weight loss but failed to take corrective actions in a timely manner. 50385 2. On 9/5/24 at 12:00 PM, a review of Resident # 22's documented weights are as follows: 107.6 lbs on 6/1/24 106.40 lbs on 6/20/24 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	106.2 lbs on 7/2/24 105.6 lbs on 7/15/24 103.6 lbs on 8/1/24 98.8 lbs on 9/1/24 Based on these weights there was a significant weight loss of 8.17% from 6/1/24 to 9/1/24. On 9/5/24 at 12:10 PM, Resident #22's meal ticket was reviewed. The meal ticket stated, Equipment: Need Assistance --- opening everything. Need Assistance ---cut the food. Supplements: 8pm - Snack, Super cereal at B [breakfast], L/D [lunch/dinner]: 2 desserts, 2pm: in-house milkshake, L [lunch]: ice cream. On 9/5/24 at 12:45 PM, An observation was made of Resident # 22 eating lunch at bed. On the tray there was a sandwich split in half, a drink, a mixed fruit bowl, and a closed container. Verified with CA passing out trays that item in container is the resident's ice cream. On 9/5/24 at 1:08 PM, Resident #22 was observed sleeping with meal tray on table in front of them. On meal tray, sandwich has 3 bites, container on tray was still unopened, fruit cup was still full. On 9/5/24 at 1:30 PM, Resident #22's provider notes were reviewed and revealed no provider notes in the month of August or September of 2024. Last completed note by provider (Medical Doctor #46) on 7/22/2024 stated Weights - stable. On 9/5/24 at 1:45 PM, Resident #22's clinical notes reviewed and revealed a change of condition/concurrent review note was made on 8/7/24 by Registered Dietician (RD) #36 at 12:25 PM. This notes stated, Resident noted with 8.77% significant weight loss x 90 days. Current weight noted 8/1 - 103.6# stable weight x 30 days. MD/NP and POA made aware of weight change. RD #36 also stated, [Resident] is offered super cereal with breakfast; ice cream with lunch; in-house milkshake at 2 pm and 2 dessert with lunch and dinner all for additional calories to help with weight maintenance. Time stamped notification to Medical Doctor #46 and Nurse Practitioner #51 on 8/6/24 at 10:17 AM. Time stamped notification to POA/resident representative on 8/7/24 at 11:09 AM. On 09/06/24 at 10:00 AM, two provider notes were provided by facility. One note with a date of service of 8/30/24 that was signed on 09/06/24 at 9:34 AM. Nurse Practitioner (NP) #51 noted Reason for appointment: 1 month follow-up and Pt has lost 2 lbs this month. Weight down from 105.6 in July to 103.6 lbs in August. S/he also noted, Change in weight, Pt with poor oral intake - will discuss potential of starting mirtazapine with primary MD and family Another note with a date of service of 9/6/24 that was signed 9/6/24 at 9:58 AM. The reason for appointment in this note is noted as Weight loss. NP #51 noted Pt seen today for continued weight loss. Weight in July was 105.6 lbs; weight for September reported at 98.8 lbs. D/W [discussed with] nursing - they report pt with poor appetite. In treatment section of note, NP #51 included Mirtazapine 7.5 mg nightly, labs to be drawn Monday, and start weekly weights x 4 weeks (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 9/6/24 at 1:10 PM, An interview was conducted with Nurse Practitioner (NP) #51. When asked why there was no note addressing the change of condition on 8/7/24 until 8/30/24, NP #51 stated monthly follow up was done on 8/30/24 and that it wasn't necessary since the resident was just seen on 7/22/24 for follow up. When asked when s/he was notified by RD #36, she was notified on 8/6 via email and did not see that weight until 8/30. When asked if there were additional interventions put in place after the dietary interventions NP #51 stated that as of today, 9/6/24 Mirtazapine has been ordered, Labs have been ordered for Monday. 42863 3. On 09.05.24 at 1:30 PM the surveyor reviewed the electronic medical record and found that the resident has a history of significant weight loss. Per the medical record, Resident #17 was originally admitted in October 2020. The resident had a history of significant weight loss. Resident's baseline weight as of 07.21.21 was 131 lbs. Weight on 06.04.24: 126 lbs Weight on 07.02.24: 120.4 lbs, reweighed on 07.02.24: 121 lbs Weight on 07.17:24: 131.70lbs , reweighed on 07.17.24: 132lbs , Resident readmitted to facility from the hospital. Weight on 08.01.24: 120.4, reweighed: 120.4 Weight on 08.06.24: 121.2 Weight on 08.20.24:122.2 Weight on 08.29.24: 124 Weight on 09.02.24:113, reweight on 09.02.24: 113.4 lbs. On 09.05.24 at 1:45 PM the surveyor reviewed the electronic medical record of Resident #17 determined that the resident was not reweighed until 17 days later (08.01.24) after being readmitted to the facility on 07. 17.24. No During a medical record review on 09.06.24 at 11:08AM the surveyor found that the resident #17's most current MOLST form was dated 09.03.2024 within section 7d: do not provide artificially administered fluids or nutrition. On 09.06.24 at 10:17 AM the surveyor reviewed the documentation dated 08.05.24 at 3:04 PM that included a clinical note entry written by the registered dietician (RD) #36. RD #36 documented that Resident #17 was identified with -9.09% weight loss x 30 days. RD #36 stated in the clinical note: However, I question the accuracy of return weight from the hospital. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Current weight noted on 08.01.24 was 120.4 lbs., the confirmation weight noted 08.01.24 for the resident was 120.4.4 lbs. [Resident #17] weight noted prior to hospitalization 07.12.24: 121 lbs per the medical record review performed on 09.06.24 at 10.15 AM. On 09.06.24 at 11:26 AM the surveyor reviewed the clinical note written by RD #36 on 09.04.24 at 8:55 PM. The resident noted 8.87% significant weight loss x 30 days and: -10.31 % weight loss x 90 days. The current weight noted on 09.02.24 was 112.8 lbs. and the confirmation weight was noted to be on 09.02.24 was 113 lbs per the dietician documentation. On 09.06.24 at 12:45 PM the dietician # 36 stated that her practice is to send an email to the medical director, the clinical nursing staff, the nurse practitioner, and the administrative team providing updates regarding weight loss and these residents are discussed during interdisciplinary team meetings. The facility failed to follow through with the monitoring and assessment of the resident's significant weight loss. This concern was reviewed with the administrative staff prior to and during the exit conference. 49304 4. On 9/4/24 at 11:27 AM review of the medical record for Resident #40 revealed on 1/12/24 the resident weighed 146 lbs.(pounds) and on 2/5/24 weighed 131 lbs. This was a 15 lb. (10% weight loss) in 3 weeks & 3 days which was considered a significant weight loss. Further review of the medical record revealed a Minimum Data Set assessment (MDS) dated [DATE]. Section K stated, Loss of 5% or more in the last month or loss of 10% or more in the last 6 months with a code of 2, Yes, not on physician-prescribed weight loss regimen. There were no dietary physician related orders nor dietary treatment orders noted in Resident #40's medical record. Continued review of the medical record revealed the resident had a Brief Interview for Mental Status (BIMS) of 10 out of 15, which indicates the resident had moderate cognitive impairment and was diagnosed with unspecified dementia, moderate, with mood disturbance, muscle wasting and atrophy, and adjustment disorder mixed with anxiety and depressive mood. In addition, a Progress Note written by Nurse Practitioner (NP #53) dated 1/30/24 documented, [Resident #40] full ROS (review of systems) is unreliable given her impaired cognition. No documentation regarding percentages and/or amounts of meals supplements could be found in the medical record. On 9/4/24 at 11:44 AM in an interview with Registered Dietician (RD) #36, stated any weight loss interventions go in her notes, the dining detail notes (which goes on the resident diet list, which is kept in the dining room where trays are assembled), and the resident's care plan. The surveyor requested this documentation for Resident #40. Review of the documentation provided revealed a Dietary note dated 2/8/24 written by RD #36 that documented: Weight discrepancy identified by clinical team as of 2/5/24- 131 lbs. and confirmed as of 2/5/24- 128.2 lbs., this is resident's new baseline. She is noted with -12.92% significant weight loss x 30 days; -11.11% loss x 90 days. Spoke with Resident #40 today, 2/8/24. Resident had finished breakfast and noted he/she ate 100% of raisin bran cereal with milk and noted Resident #40 eats that same breakfast every day. When writer told resident his/her lost weight, resident was very happy. When asked if he/she wanted any additional food items for additional calories, he/she declined any food or drinks for additional calories. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 9/4/24 at 12:44 PM in an interview with the Registered Dietician (RD # 36) and Administrator, the surveyor was provided a one page document. When asked where the weight loss interventions were, RD #36 pointed out the Supplements section. When asked where the order for the supplement/shake can be found in the medical record, RD #36 stated we do not write orders for supplements because it is not a part of our process, which the Administrator confirmed. Furthermore, RD #36 stated we do not use Ensure, we use an in-house supplement, referred to as milkshakes, that are delivered to the dining room and labeled with the resident's name. When asked to describe the process for a meal, she stated the residents come to the dining room, sit down at the table, are greeted and asked their drink preference, and then the meal flows (e.g. soup/salad, meal, dessert, etc). When asked who ensures the dietary interventions such as a shake being provided to the resident, the dietician stated the dining associate, assigned Care Associate (CA) for the resident, and dining manager ensure the dietary interventions are put in place. When asked the process for documenting the supplements, the Administrator and RD #36 confirmed that supplements are not documented in the medical record and that the information is communicated verbally. On 9/5/24 at 1:18 PM in an interview with Care Associate (CA #37) she reported Resident #40 had eggs and pancakes and ate a little more than 50% of the portion which is huge for [Resident #40] and a couple of bites of sausage. For lunch [Resident #40] had about 50% of the tuna sandwich, a few pieces of cantaloupe, and entire ice cream (1 scoop), and some diet coke and cranberry juice. She stated that there were staff who come to feed the residents 1-2 days a week and the other days it is the responsibility of the CA for that resident. On 9/6/24 at 7:57 AM review of the medical record revealed the following: 1/12/24 at 10:44 AM 146 lbs 2/5/24 at 9:00 AM 131 lbs (146-131=15 lb wt loss=10% wt loss in 3 weeks & 3 days) 2/5/24 at 2:15PM 128.2 lbs 2/8/24 Change in Condition/Concurrent Reviews- Assessment/Eval Reason: Significant weight change-Reason for Change in Condition: Weight Loss, Provide a factual description of even and the environment/surroundings: -12.92% significant weight loss x 30 days. The weight loss for Resident #40 was documented on 2/5/24 however the facility waited 3 days to complete a change in condition or put interventions in place for a resident with significant weight loss. On 9/6/24 at 9:05 AM the surveyor requested a copy of where the care plan was updated and documentation of interventions from Resident #40's significant weight loss between January and February 2024. Review of the care plan on 9/6/24 at 10:27 AM revealed: 3e. Dining and Eating/Swallowing, Nutritional Status, Oral and Dental: Goal(s): I will receive encouragement to improve my dining self-performance. I require the following level of assistance:'Total dependence' Nutritional Status Goal(s): I will enjoy my favorite beverages or foods as desired. I will continue to follow my prescribed diet. Other Goal(s) if Applicable: [there was nothing documented in this section] (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	There were no interventions listed on the care plan to address the significant weight loss of the resident. 30440 5. Resident # 33 was admitted with the following but not limited diagnosis: Chronic Ulcer Right Foot (Non-Pressure), GERD, Chronic Kidney Disease, Peripheral Vascular Disease, and Obesity. Review of the resident electronic medical record on 9/5/24 at 5:00 PM revealed the resident had a documented weight on 5/2/24 of 269 pounds and a documented weight on 6/3/24 that was 253 pounds. Total weight loss of 16 pounds. A change of condition/concurrent review form dated 6/10/24 and it stated, Resident noted with -5.57% significant weight loss x 30 days. Current weight 6/3-253#. confirmation weight 6/3-253.8#. Physician/Nurse Practitioner and POA (Power of Attorney) made aware of weight change on 6/10/24 at 3:47 PM. An interview was conducted with the Dietician (Staff # 36) on 9/5/24 at 8:05 PM and she was asked if any measures were put in place to address the resident's weight loss on 6/3/24, and she stated that on 6/10/24 the POA and the Physician were notified of the weight loss. She was unable to provide documentation of any interventions that were implemented on 6/3/24. She confirmed that the physician was not notified until 6/10/24 and provided an email correspondence to the physician on 6/10/24 at 1:10 PM. During a discussion with the Administrator (Staff # 1) and the DON (Staff # 8) on 9/5/24 at 9:00 PM he provided the survey team with a copy of the physician progress notes dated 8/29/24. An interview was conducted with the Medical Director (Staff # 25) on 9/6/24 at 1:45 PM and he was asked if a resident was noted to have a significant weight loss and the dietician notifies him, how soon would a physician see the resident and he stated that he would normally see the resident within a week and complete an assessment. The MD stated that there have been delays in this process, however, they are working on this. All concerns were discussed with the Administration team at the time of exit on 9/6/24 at 4:45 PM.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50458 Based on observations, staff interviews and record review, it was determined that the kitchen failed to store food items so as to maintain the integrity of the specific item and failed to wear gloves while preparing food. This was observed during the initial tour of the kitchen. The findings include: On [DATE] at 7:55 AM an initial tour of the kitchen was done with the Certified Dietary Manager (CDM) Staff # 76. The following concerns were identified: 1. Unlabeled opened cooking oil container on the shelf in the dry kitchen. 2. The cook (staff #77) was observed not wearing gloves while handling and preparing food on food trays. When asked, he placed gloves on without practicing hand hygiene. 3. A Full container of prepared soup was observed covered with plastic and without a date on top. 4. Cooked stuffed cabbage, ground beef, cheese, and burgers beyond expiration dates were found in the freezer. As this surveyor pointed these things out, Staff #76 was throwing the expired food away. 5. The three compartment sink Sanitizer Test Strips were observed wrapped with aluminum foil with the expiration date not visible. The three compartment sanitizer log for [DATE] PM check was incomplete; [DATE] and [DATE] were not done for AM or PM and [DATE] during observation rounds the at 8AM the AM check had not been done, however the sink was filled with pots and pans. 6. The dish machine temperature log (conveyor or Kitchen Single Tank) [DATE] PM rinse was not documented or documented on [DATE] or [DATE], and [DATE] as of 8:15 AM during observation However dishes were being sent through the dish machine. 7. There was ice build up on the walk-in freezer #4 located in the hallway outside of the kitchen. The above concerns were communicated to CDM Staff #76 during the kitchen tour.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215308	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Crest Village	8800 Walther Boulevard Parkville, MD 21234

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 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. 42782 Based on record review and interview it was determined the facility staff failed to provide documentation to verify a resident received a shower during their admission. This deficient practice was evident in 1 (#123) of 1 resident record reviewed for showers during the survey. The findings include: On 09/05/24 at 2:54 pm during an interview with the Director of Nursing #8 who verbalized normally a shower/skin sheet must be completed. Additionally, the Geriatric Nursing Assistants gives the resident a shower and the assigned nurse must go assess the resident's skin. The nurse completes the skin sheet and there is a place on the form where they can document a shower was given. A copy of the form was requested for Resident #123 for documentation they received a shower. On 09/05/24 at 4:39 pm during an interview with Administrator #1 they verbalized the resident's skin sheets are not a part of the medical record. There was no documentation to verify Resident #123 received a shower.