STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215331	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Largo Nursing and Rehabiliation Center	600 Largo Road Glenarden, MD 20774

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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44441 Based on observation, resident and staff interviews, and medical record reviews, it was determined that the facility failed to treat residents with dignity and respect as evidenced by: 1) not removing a staff member from resident's assignment after the resident requested it, and 2) failure to ensure timely emptying of a resident's urinal. This was evident for 2 (#72, #11) of 7 residents reviewed for dignity. Additionally, the facility failed to 3) properly transport a resident in the hallway, evident for 1 resident (Resident #114) during a random observation on the facility nursing units. The findings Include: 1) On 1/8/24 at 10:05 AM during an interview, Resident #72 was asked if he/she was treated with dignity and respect by staff. Resident #72 told the surveyor that they did not get along with Staff #49, a Geriatric Nursing Assistant (GNA). Furthermore, Staff #49 would not assist them with turning and repositioning or rolling during the provision of activities of Daily living (ADL) and was nasty to him/her. The resident stated that they reported this issue to the Director of Nursing (DON) about 2 weeks ago and asked to not have Staff #49 take care of them. Resident was asked if that request was accommodated by the facility, and they said that the staff #49 still takes care of them Resident #72 was again interviewed on 1/30/24 at 12:47 PM, s/he stated that staff #49 does not treat them right and has made them cry, Resident said s/he asked staff #49 to assist with turning and that Staff #49 responded That's why they put the railings on your bed. On 1/30/24 at 2:45 PM, the DON was asked if she was aware of these concerns and what she did about them. The DON said that Resident #72 called her on the phone and told her about the incident and that she counseled staff #49 verbally but did not remove her from the resident's assignment. The DON said that she will now remove Staff #49 from taking care of this resident. The DON was asked to provide the prior concern form where she counseled the GNA, she said she only did a verbal counseling, not a written one. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/30/24 at 3:23 PM, Staff #49 was asked if she had refused to help the resident turn and reposition and had asked resident to use the side rails. Staff #49 said that the side rails were installed to help the resident with turning and repositioning, but that the resident would not use them. She said that staff are the ones who turn the resident. She was asked if she had refused to help the resident and she responded: if the resident asked me to help them and I don't, then why am I here. She was asked if she ever talked back to the resident, and she said she did not. She was asked if she was aware that the resident does not want her to take care of them anymore and she said the resident does not like her which is why s/he complains about her. 47200 2) On 1/9/24 at 10:49AM, the surveyor conducted an interview with Resident #11 who reported they had difficulty with facility staff responding to requests made for the emptying of their urinal. On 1/9/24 at 10:51AM, during the interview, the surveyor observed one of two urinals hanging on the bedside trash can in Resident #11's room which was filled to the top with yellow liquid. On 1/31/24 at 9:31AM, the surveyor observed the resident in their room eating their breakfast next to two urinals which were both filled 3/4 of the way with yellow liquid. On 1/31/24 at 9:31AM, the surveyor conducted an interview with Resident #11 who reported to the surveyor it was upsetting to them that the urinals were filled with urine from overnight, and nursing staff had not yet emptied them. On 1/31/24 at 9:39AM, the surveyor shared the concern with Staff #9, Licensed Practical Nurse, who confirmed the observation in the resident's room, and acknowledged the surveyor's concern. 15701 3) During an observation of the 1st-floor nursing unit on 1/12/24 at 12:42 PM, Geriatric nursing assistant (GNA #56) was observed pulling resident #114's Geri chair backwards while pushing an IV/tube feeding pole with the other hand around the nursing station toward the resident's room. The Unit Manager staff #7 was noted to observe the resident being pulled backwards. She was asked if she noticed that the resident was pulled to his/her room. She proceeded to turn resident #114 around in the Geri chair and instructed staff with demonstration to push the resident facing forward.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on review of administrative documents, and interviews of residents and staff, it was determined that the facility failed to ensure that grievances and concerns from the resident group were documented, reviewed, and responses provided to the group in writing. This was evident in review of 7 of 7 resident council meeting minutes. The findings include: An introduction interview was held with the resident council president (resident #272) on 1/18/24 at 1:00 PM. They revealed that they had lived at the facility for [AGE] years and had been the president of the resident council for a long time. A follow up interview was held with the resident council president on 1/25/24 at 8:55 AM. She/he was asked for permission by the survey team to review the resident council minutes. She/he granted permission and indicated that the Director of Activities would have the meeting minutes. On 1/25/24 at 9:16 AM, an interview was conducted with the Director of Activities (staff #18). She was informed that the resident council president granted permission for the survey team to review the resident council meeting minutes. She indicated that she basically informed and reviewed the rights of the residents. She was asked to provide the meeting minutes from the last 6 resident council meetings. Copies of the requested minutes were provided at 9:50 AM on 1/25/24. Review of the documents revealed that seven resident council meeting minutes were provided back to May 18, 2023. The minutes were slim with minimal documentation and only one concern written on August 17, 2023, indicated residents needing metro access cards. The September 21, 2023, minutes revealed that a social worker attended the meeting and provided information regarding Metro Access. The September 2023 resident council meeting minutes were the only month during which a representative from any department was at the meeting. The minutes of 7/20/23 did not reveal any attendance by residents or staff. The minutes from 11/16/23 only revealed that the resident council president and the activity director were in attendance. On 1/26/24 at 11:34 AM, the resident council president was shown the minutes that were provided to the survey team with indication that this was the first time she/he had reviewed resident council meeting minutes. He/she stated that the minutes did not indicate the concerns that residents expressed at the meetings. She revealed that residents had shared concerns related to short staffing on weekends, staff on their phones when in the residents' rooms, and cold water stating the water should be hot all the time. They stated that these concerns were brought up at the council meetings. She revealed that the aides are on their phones while passing out meal trays and were either using ear buds and/or they have been on the phone with the phone on their shoulder with their head tilted to hold the phone in place and passing out the meal trays. The water temperature in the resident council president bathroom water was checked at 12:05 on 1/26/24 after letting the water run for a minute and the water remained cold without heating up. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A meeting was held with the ombudsman from the local office on aging and the resident council president on 2/1/24 at 11:16 AM. The Ombudsman revealed that she could not specifically remember what months she had attended resident council meetings but acknowledged and reviewed with the resident council president that the concerns expressed in council meetings had included issues with cold food, issues with cold water, short staffing especially on the weekends, and staff on their phones while assisting residents. On 2/5/24 at 1:30 PM, an interview was conducted with the facility's nursing home administrator who is the designated grievance officer. He was asked if he has heard of resident complaints and/or grievances related to the lack of hot water, short staffing on weekends, and staff utilizing their phones while providing resident care. He acknowledged that he had heard these concerns. He was asked if staff aware allowed to have their phones on when in the milieu. He stated that staff are not to have their phones and they should be locked up. He also indicated that families needed to get in contact with their loved ones. He was asked if he has attended any resident council meetings and he indicated that he went to 4 meetings last year, but he was not sure of the dates that he attended meetings. He revealed that he had attended resident council meetings that were also attended by the ombudsman. He was shown the resident council meeting minutes that were provided to the survey team and was informed of the concern related to the lack of documentation related to resident concerns and no written follow-up to address the residents' ongoing concerns. None of resident council meeting minutes indicated his attendance or the ombudsman's attendance. It was expressed that the facility failed to have a resident council meeting for December 2023 and January 2024.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44441 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident/responsible party was offered the opportunity to develop an advance directive. This was evident for 1 (#82) of 4 sampled residents for advance directives during an annual survey. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment, (often including a living will,) made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. On [DATE] at 11:13 AM, a chart review for Resident #82 revealed the resident was admitted to the facility on [DATE] and that the resident's MOLST form was initiated that day. Resident had family members who were documented as their emergency contacts and who make decisions for them. However, there was no information indicating that an opportunity to formulate an Advance Directives was recently provided to the resident and/or the resident representatives. An interview was conducted on [DATE] at 11:41 PM with Staff #1 a Social Worker (SW) regarding Advance Directives. The social worker was asked if she discussed living wills, power of attorney, or anything involving advance directives or health care options. The social worker stated that they go over the issue of Advanced Directives and document that they discussed it. She stated that they offer residents, who do not have one, an opportunity to formulate one. If they accept it, an advance directive will be initiated. If residents decline, then they write a note to indicate that resident declined. The SW Staff #1 was asked to check that residents had Advance Directives or to see if one was offered and they declined. She checked the medical records and said she could not find any documentation that an advanced directive was offered to the resident or their representatives. On [DATE] at 11:16 AM, the Director of Nursing (DON) was asked the process for initiating an Advance Directive and she said that when an admission comes, they look for a MOLST form to determine code status and enter it in the orders and SW takes it from there to work on the Advanced Directives. She said that SW were supposed to document in their initial SW note that they discussed Advance Directives with the resident including the outcome of the discussion. The DON was made aware of the concerns.

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 48168 Based on review of surveyor requested documents and interviews, it was determined that the facility failed to provide accurate reports regarding residents who received a Beneficiary Notice. Due to this failure, this required survey task was unable to be completed. The findings include: The Beneficiary Notification survey task requires the facility to produce a list of Medicare beneficiaries who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months prior to the survey. From this list 3 randomly selected residents were chosen, and the facility was requested to complete a Beneficiary Notification Checklist form for each of these 3 residents. The facility was asked 4 times to comply with this request. Each time, verbal and written instructions were given. The first request was made on 1/08/24, the second request was made on 1/09/24, the third request was made on 1/11/24, and the 4th request was made on 1/17/24. For each of the 4 requests, the facility provided inaccurate and incomplete information. The list from which to choose a resident sample incorrectly contained residents who had used all of their skilled days, so the surveyor was unable to investigate the records of residents who met the criteria for this task. The Beneficiary Notification Checklist forms that were returned to the surveyor contained blanks where required information should have been entered. Without accurate and complete information, the surveyor was unable to complete the investigation and the Team Coordinator at the Office of Health Care Quality was consulted on 1/23/24 at 2:57 PM. It was determined that the facility had adequate opportunity to produce accurate records and therefore, the facility was non-compliant with this regulatory requirement. On 1/25/24, the DON was informed that, because after multiple requests inaccurate and incomplete information was provided to the survey team, the facility was non-compliant with the Beneficiary Notice requirement. The DON said she understood and would inform the Administrator.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on surveyor observation and staff interview, it was determined the facility staff failed to keep the building clean, neat, attractive and in good repair. This was evident for 3 of 3 nursing units on both floors of the facility. The findings include: An interview was conducted with the maintenance director (staff #10) on 1/18/24 at 11:25 AM. He revealed that he had been the maintenance director for 3 months beginning mid-October 2023. The maintenance department was comprised of the maintenance director and two assistants. He indicated that a renovation/remodel of the first floor was initiated the first week of his hiring. The mass project was to include all the floors, new lights, painting the hallways and the resident bedrooms, nurse station rehab gym, and lobby areas. Per signage in the lobby, the renovation was expected to be completed by early spring. The renovation was being performed by contractors. On 2/2/24 at 11:05 AM, the maintenance director and surveyor began a tour in the 2nd floor hallway outside of room [ROOM NUMBER]. Two shower room doors across from room [ROOM NUMBER] were noted with excessive discolorations and markings (linear indentations horizontally up to three feet above the floor and predominantly on the first 6 inches above the floor. The maintenance director indicated that the doors need painting. An environmental tour was continued with the maintenance director on 2/2/24 at 2 PM. The maintenance director was informed of the accumulated environmental concerns by multiple members of the survey team during the initial days of the survey beginning on 1/8/24. The following observations were confirmed by the Maintenance director. Starting in the 2nd floor conference room, the maintenance director was shown a 4-plug electric box that was hanging off the wall held by the metal conduit on both side of the box. The outlet originally was held in place by 4 screws with dry wall anchors. The holes remained in the wall with the screws and anchors attached to the outlet box. He was informed that the surveyors list was not comprehensive, but concerns were raised on the three nursing units. In the west wing hallway: paint scraped away and noted white paint blobs, 2 areas on each side of the picture on wall before approach to room [ROOM NUMBER]. The left side had 10 areas of paint scraped away with white showing and the right side approximately 5 white areas (paint blobs on the walls or scraped away). There was an approximately 2 inches by two-inch jagged edged hole in the bumper style molding, 5 inches above the floor. A similar larger jagged edged hole was noted in the bumper molding at the end of the [NAME] wing hallway. Between rooms [ROOM NUMBERS], there were 4 screw holes in the shape of a square and one hole above where something was previously mounted to the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER] - from the hallway the bottom 1/4 of window blinds were warped/mangled in appearance. room [ROOM NUMBER] - Behind the head of the bed close to the door was damage to the wall with exposed wall board. Behind the head of the window bed was damage to the wall with exposed wall board. Behind the head of the bed were 4 mounting holes right of the bed light. The threshold strip under the door into the bathroom was moveable with dark dirty like discoloration. There were grey/black markings along the bathroom wall across from the sink. room [ROOM NUMBER] - Behind the bed was an approximately 5-foot unpainted white spackled area. The window bed was shown to have 2 mounting holes left of the overhead of bed light and 2 screws in the wall to the right of the light. The corner ceiling tiles near the window had 2 brownish stains approximately 5 inches by 5 inch and a 10 by 5-inch stain. There was a taped corner of the wall with white unpainted spackle next to the closet from floor to top of the top of closet door. [NAME] molding of the closet door was separated with metal showing in three areas. Issues with scrapes into the wall paint across from the toilet. room [ROOM NUMBER] - the plastic covering halfway up the door was noted with broken and missing pieces with jagged edges. The wall across from the beds showed various chips in the wall exposing the white wallboard under the paint. There were brown floor tile stains under the closet door (1 ft x 5 inches). Wall was damaged behind head of the window bed 4 feet across and 1 foot tall. There was rust colored drip stain extending from the sink pipes to the floor. [NAME] discoloration in the bathroom door threshold (strip missing). Separation of drywall to left side of sink (approximately 3in by 3in). room [ROOM NUMBER] - various discolored stains in the closet doors. The space between top of two closet doors spackle and tape present 4 inch wide by 4 inch tall in corner of room from top of closet to floor white tape spackle present. Various paint chips in wall across from the beds. There was a loose (0.5-inch separation) 4-socket wall outlet plate. Damaged wallboard behind the head of the beds. Screws in the wall to the right and left of light above the bed closest to the door. In the toilet room, there was paint chips in the wall across from the toilet. Below the hand sanitizer dispenser on left side when entering the room, was a brown cardboard ripped appearance with paint missing in an approximate area of 5-inches by 3 inches. room [ROOM NUMBER] - Observed chips in the door frame entrance paint with exposed bare metal. The protective cover on the surface face of the door shown to have broken chipped off pieces, leaving jagged edges. The protective cover appeared dirty with markings caused by wheelchair tires. The metal and brush like portions of the weather strip around the door frame was bent outwards(approximately 1 foot of the strip on the lower left side). room [ROOM NUMBER] - Observed multiple issues with the entrance door frame with chipped areas of the painted surfaces and exposed bare metal on both sides of the door frame. The protective cover on the surface face up door shown to have broken chip pieces on each side of the panel with horizontal dirty markings approximately 1.5 feet above the floor. The lower bumper molding in the hallway between rooms [ROOM NUMBERS] had a busted indentation and a hole approximately 1.5 feet from the entrance to room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER] - observed discolorations in the door frame and the protective door panel shown multiple dirty like markings across the panel and noted chips in the paint on the corner edges of door frame. Observed from the hallway, there were multiple areas of unpainted white spackle on three of the bedroom walls. The nourishment room across the hall from room [ROOM NUMBER] shown dirty black markings and discolorations near the bottom of the door and above the door handle. The door frame was noted with chipped paint in the corner edges. room [ROOM NUMBER] - The maintenance director acknowledged the previous poor painting of the room as there was multiple ceiling tiles with paint where the walls meet the ceiling. There was an unpainted area that was left of the bed with holes in the wall from a previously removed disposable glove holder. room [ROOM NUMBER] - The maintenance director acknowledged the holes in the wall by the bathroom door indicating that the entrance door bangs into the bathroom door causing damage to both doors and described a solution to prevent the doors from further damage. Additionally, there was damage on the walls behind the three heads of the beds in the room. It was noted that there were not any chairs in the room for residents to sit. During the tour, the maintenance director revealed that he had made a list of what he determined needed to be fixed. He indicated systemic issues that were throughout the building such as door frames at the entrances to rooms, spackled unpainted repairs, screw holes and unpainted areas from items that were previously affixed to the walls. He indicated that the facility was having contractors come in to take care of the more complex issues and his crew to work on the other areas. Further discussion with the maintenance director involved the newly remolded lounge area on the first floor, and the damaged ceiling tiles above the window and the window that had a haze in between the glass panels. He indicated that the window would need to be replaced due to the integrity of the damaged window structure. We discussed the observed tarps and sandbags observed on the roof. He indicated that the last time the roof was replaced the pitch of the roof was not correct causing water damage into the Eagle room on 2nd floor and the lounge area on the 1st floor. On 2/5/24 at 9:56 AM the Environmental services director (staff #13) was shown the air vent above the toilet in the west wing central bath/shower room. The environmental services director noted the thick grey matter dirt and grim accumulated on the air vent grate. He was informed that the survey team observed the dirty vent grate on 1/9/24. He stated that it was the responsibility of his crew, and he was going to take care of it. The area below the hand sanitizer units in nearby bedrooms were observed. He noted the dark dirty stains on the floor directly below the sanitizer in some of the rooms. He indicated that the floors need to be stripped and the task of getting residents and furniture out of the rooms to properly strip the floors and reapply a wax topcoat. A follow-up discussion was held with the maintenance director on 2/5/24 at 11:35 AM. Previously identified areas that were not observed on 2/2/24 were reviewed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER] - In the toilet room on the left side of the mirror were 6 mounting holes in the wallboard with chipped off paint. The wall across from the toilet was noted with black markings along the wall. Concerns were discussed regarding the screw holes and remaining screws in the walls behind the beds to the sides of the lights. Concerns were also discussed related to the chipped plastic door covering and exposed chipped wood in the door. On 2/6/24, it was noted that the following rooms on the first floor had not received renovations. (Rooms #104, 106, 108, 110, 112, and 114) and each room had some of the systemic concerns that were previously discussed with the maintenance director.

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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. 31982 Based on record review, and interview with the resident and staff it was determined the facility staff failed to ensure all residents were free from abuse and mistreatment. As a result of this deficient practice, Resident #18 experienced actual harm as evidenced by a laceration requiring 6 sutures to the forehead. This was evident for 1 (#18) of 28 residents reviewed for abuse. The findings include: During an interview on 1/09/24 at 11:04 AM Resident #18 stated that he/she was hit by a receptionist with a phone and had to go to the hospital to get stitches in his/her head. The resident explained that he/she was trying to call the police because we needed our cigarette break to happen, and no one was coming. Review of facility investigation documentation on 1/25/24 at 11:00 AM revealed that on 10/28/23 at approximately 5:00 PM, Resident #18 was in the first-floor dining room attempting to call 911 using the wall phone, in response to a delay in the scheduled smoke break. Staff #29 a receptionist entered the dining room and asked Resident #18 what he/she was doing. The resident indicated that he/she was calling the police. Staff #29 approached Resident #18 and attempted to stop the resident from completing the call. Resident #18 allegedly struck Staff #29. Staff #29 in return struck Resident #18 and an altercation ensued. During the altercation, Resident #18 sustained a laceration on the left forehead as a result of being struck with the phone handset by Staff #29. The resident was assessed by the nursing supervisor on duty and was sent to the hospital emergency room for further evaluation. Resident #18 received 6 stitches to a laceration on the left forehead and returned to the facility. Review of the medical record on 1/25/24 at 11:00 AM revealed a Change in Condition Progress Note written by Staff # 34 a Licensed Practical Nurse (LPN) at 5:26 PM indicated Resident #18 was observed wheeling himself/herself to the nurses station with a bloody face more on left top side of scalp the note described the resident as yelling, cursing and inconsolable. Emergency personnel were on site for an unrelated call. The primary Care Provider was notified and recommended to send the resident via 911 to hospital for evaluation and care. First aid was provided and the resident was sent to the emergency room . Another Change in Condition Progress Note by Staff #66 a Registered Nurse (RN) indicated left forehead laceration measure 4. 0cm(centimeters) x 1.0cm draining to bright red blood moderate in amount pressure dressing applied. unable to measure depth. patient refused whole body assessment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Largo Nursing and Rehabiliation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Largo Road Glenarden, MD 20774	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility investigated the incident and obtained statements from residents and staff. Staff #30 an environmental services assistant supervisor was present in the dining room during the event and witnessed the altercation. In a documented interview on 10/31/23 he reported that Resident #18 entered the dining room to use the phone, speaking loudly, he/she indicated that he/she was going to call the police. Staff #29 entered the dining room to buy something from the vending machine, asked Resident #18 what they were doing. When Resident #18 informed her that he/she was calling the police, Staff #29 said Resident #18 should wait and attempted to unplug the phone. Resident #18 hit Staff #29 who hit Resident #18 back. Staff #30 indicated that during the tussle he told Staff #29 to let it go and allow Resident #18 to call whomever he/she wanted to call. He asked her to stop, and she eventually walked away. Witness #2 and #3 who were not identified by the facility due to their requests to remain anonymous, and provided statements that they were present in the dining room and witnessed Resident #18 and Staff #29 striking each other. In a written statement dated 10/28/23 Staff #29 indicated that Resident #18 approached her requesting to go out to smoke. Staff #29 indicated she responded that she could not leave the front desk. As she walked down the hall, Resident #18 started to dial 911. Staff #29 asked the resident to stop and when she tried to unplug the phone Resident #18 struck her on the head with the phone and scratched her arm. She indicated that as Resident #18 stood up to strike Staff #29 again, the resident hit his/her head on the phone and started bleeding. She indicated that Resident #18 then started saying that Staff #29 hit him/her. Staff #29 denied hitting Resident #18. Staff #30 was interviewed on 1/26/24 at 10:12 AM. He stated that he recalled the above events and when asked, described the above events as per his initial report. He confirmed when asked that Resident #18 sustained the laceration to the forehead as a result of Staff #29 striking him/her with the phone. He indicated that he attempted to intervene and repeatedly told Staff #29 to stop and just allow Resident #18 to call. He added that Resident #18 called 911 frequently and stated: that's part of what he/she does, he/she calls the police for everything like if his/her medications were late. The Administrator and Director of Nursing were made aware of these findings on 1/29/24 at 11:32 AM.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47200 Based on record review and interview with staff, it was determined the facility failed to ensure that allegations of abuse and injuries of unknown origin were reported to the state agency within required timeframes. This was evident for 3 (#87, #7, #18) of 28 residents reviewed for abuse during the facility's Recertification survey. The findings include: 1) On 1/9/24 at 9:37AM, Resident #87 reported to the surveyor the following allegation of abuse: I was pushed to the bed by a head nurse, my knees hit the metal (of the bed,) and I fell to the floor. The nurse left when I hit the floor. Resident #87 further reported that the floor manager reported to their supervisor and x-rays were ordered and had been performed. On 2/1/24 at 10:27AM, the surveyor reviewed the medical record for Resident #87 which revealed a health status note (designated as a late entry) with an effective date of 5/4/23 written by Staff #8, Unit Manager, 2nd Floor, Licensed Practical Nurse, which documented the following information : Upon schedule rounds, resident reported to writer stating three weeks ago I was shoved by my overnight nurse on the side of my bed while sitting in my wheelchair, my knees hit the side of the bed and I fell out of the wheelchair and hit the floor. On 2/1/24 at 11:22AM, the surveyor conducted an interview with Staff #8, who reported to the surveyor that they immediately informed their supervisor, Staff #12, Assistant Director of Nursing, of the allegation of abuse, and then they both informed the facility Administrator, in person. On 2/1/24 at 11:46AM, the surveyor requested the facility's complete investigation file for Resident #87's allegation of abuse from Staff #52, Regional Director of Reimbursement. On 2/1/24 at 2:43PM, the surveyor received the facility's complete investigation file from Staff #48, Regional Nurse. Upon receipt of the complete investigation file, the surveyor asked Staff #48 if the allegation of abuse had been reported to OHCQ, to which they replied: I will check on that. On 2/1/24 at 2:45PM, Staff #48 reported the following information to the surveyor regarding Resident #87's allegation of abuse: It was not reported. 44441 2) On 1/23/24 at 2:30 PM a review of facility reported incident MD00195158 revealed that on 7/28/23, Resident #7's left hand/wrist was noted to be swollen, an X-ray exam was done on 7/29/2023 and the result showed a possible nondisplaced slightly impacted fracture. A repeat x-ray was done on 8/2/23 which showed an acute nondisplaced fracture of the distal radius and ulna (Bones below the elbow or above the wrist). Further review did not show that this incident was reported on 7/28/23 when the swollen wrist was first noted. Rather it was reported on 8/2 23 after the second x-ray result confirmed the fracture. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Nursing (DON) on 1/24/24 at 3:20 PM, she was asked about the facilities process for reporting injury of unknown origin, and she stated, immediately, so that it can be investigated. She said not later than 24 hours after discovery of the incident. She was asked to provide further documentation. On 1/25/24 at 9:00 AM, the DON could not provide the initial incident report which showed that the incident was reported on 7/28/23. The administrator was asked on 1/25/24 at 9:25 AM when an injury of unknown origin should be reported to the State regulatory body, and he stated as soon as possible (ASAP). He was asked why this one was not reported ASAP. He stated that they were unable to identify the cause of the swollen arm immediately and do not report every swollen arm unless they find the cause. He was made aware that this was a concern. 31982 3) Facility Reported Incident MD00197311 was reviewed on 2/1/24 at 9:36 AM. The Facility's investigative documentation revealed a written statement by Staff #55 a Speech Therapist. His statement identified Resident #18 as assailant and Resident #470 as victim, and revealed he was in the Heritage Hall at approximately 12:00 PM on 9/21/23 speaking to Resident #470. Resident #18 exited his/her room approached Resident #470 cursing and calling him/her derogatory names. Resident #18 punched Resident #470 on the left shoulder and accused him/her of sexually assaulting him/her over the previous 4 nights. Staff #55 told Resident #18 to leave the area. Resident #18 went back to their room and closed the door. The facility documentation revealed the facility reported an allegation of sexual assault to the state agency on 9/21/23 at 5:00 PM, not within 2 hours as is required. There was no documentation to reflect that the facility reported that Resident #18 physically assaulted Resident #470 by punching his/her left shoulder on 9/21/23 as reported by Staff #55. The above information was reviewed with Staff #52 a Registered Nurse and the Regional Director of Reimbursement during an interview on 2/1/24. She was asked to provide evidence that the facility reported the physical assault of Resident #470 by Resident #18 as per Staff #55's report. At 11:18 AM on 2/1/24 Staff #52 returned. She explained that the facility focused on the sexual assault allegation and did not report that Resident #18 physically assaulted Resident #470. The Administrator and Director of Nursing were made aware of these findings on 2/2/24 at 1:23 PM.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on interview, review of facility reported incident investigations and policy, it was determined the facility failed to thoroughly investigate allegations of abuse, neglect, misappropriation of resident property, and injuries of an unknown source, and failed to ensure measures were taken to prevent further abuse of the Resident #87 while the investigation was in progress. This was evident for 7 residents (Resident #87, #319, #369, #39, #470, #418, #419) of 28 residents reviewed for abuse. The findings include: 1.) On [DATE] at 9:37AM Resident #87 reported to the surveyor the following allegation of abuse: I was pushed to the bed by a head nurse, my knees hit the metal (of the bed,) and I fell to the floor. The nurse left when I hit the floor. Resident #87 further reported that the floor manager reported to their supervisor and x-rays were ordered and had been performed. On [DATE] at 11:46AM, the surveyor requested the facility's complete investigation file for Resident #87's allegation of abuse from Staff #52, Regional Director of Reimbursement. On [DATE] at 2:43PM, the surveyor received the facility's complete investigation file from Staff #48, Regional Nurse. On [DATE] at 9:42AM, the surveyor conducted further review of the facility's complete investigation file which revealed the following information: 1.) there was no written statement obtained from Resident #87 or any further documented interview of the resident after the allegation had been made, 2.) the nursing investigation form did not reveal who the alleged perpetrator was, 3.) no documentation of an attempt to determine more specific dates/timeframes of the alleged incident, 4.) no documentation of whether or not the facility substantiated the alleged incident, 5.) action to re-assign the nurse was documented on the nursing investigation form, however, review of staffing schedules for [DATE] indicated the alleged perpetrator worked and was assigned to the resident during the course of the investigation which was documented as completed on [DATE], 6.) the nursing investigation form documented notification of the allegation to the Director of Nursing on [DATE] at 12pm, the Administrator on [DATE] at 1pm, and the Medical Director on [DATE], however, notification to the police department was marked as not applicable, 7.) no resident interviews had documented times the interviews were conducted, 8.) two out of three staff statements that were obtained failed to directly address the allegation of abuse made by Resident #87, 9.) there were no documented interviews of facility staff, including the alleged perpetrator, and 10.) 1 of 4 residents documented as having been interviewed on [DATE] had expired prior to [DATE]. During an interview with Resident #87 on [DATE] at 10:49AM, they reported to the surveyor that, to their knowledge, there was not a time where the alleged perpetrator was kept from working, they continued to come into their room and assisted their roommate. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on [DATE] at 12:52PM with Staff #1, Social Services, the surveyor inquired as to how an interview had been conducted on [DATE] with a resident who was documented as having expired prior to the date of the interview. Staff #1 further reported they recalled the interview, and: I believe that was his roommate around that time. At this time, the surveyor shared their concern with Staff #1, who acknowledged the concern. On [DATE] at 1:22PM, the surveyor shared the concern with Staff #46, Regional Social Worker, who acknowledged understanding of the concern. 44441 2). On [DATE] at 11:15 AM, a review of facility reported incident MD00187287 revealed that, on [DATE], Resident #319's spouse alleged that resident told them that while receiving care at bedtime on [DATE], the Nursing Assistant who was assigned to resident came really close to resident's face while talking to them angrily and at the same time used her fingers to 'poke' resident on the chest. Review of the facility's documentation of the investigation revealed that a statement was taken from the Geriatric Nursing Assistant (GNA) that was assigned to the resident and other staff were interviewed. The facility summary stated that other residents were interviewed, but there was no evidence of the interviews provided to the surveyor. There was no other resident interview from any other shift provided to the surveyor. The facility's investigation was not thoroughly done. On [DATE] at 12:00 PM,The Director of Nursing (DON) was made aware that the investigation related to other resident interviews were not found in the chart and was asked to provide the missing documents. She came back to report that she could not find it. She stated that the Social Worker SW- Staff #2 did the investigation and interviews. She asked the surveyor to talk to staff #2 who did the interviews. In an interview on [DATE] at 1:54 PM, The SW #2 was asked if she had documentation of the other resident's interview which she conducted. She stated that she took all the paperwork to DON/Nursing for filing after her investigation and did not keep a copy. She said she would go back and check. She was unable to provide a copy of the other resident's interview to the surveyors. 43096 3). On [DATE] at 10:53 AM, the surveyor reviewed the facility's reported incident, MD00196937. The reported incident revealed documentation that the facility staff noted Resident #369's swelling and pain in his/her right wrist on [DATE]. The facility's investigation documented that the resident was not able to state what happened, and the facility provider ordered an X-ray for the follow-up. The X-ray was ordered on [DATE] at 3 PM and taken on [DATE], and the result was reported to the facility on [DATE] as a distal radius fracture. Further review of the facility's investigation records revealed that the facility conducted interviews with staff who cared for the resident before the incident was reported. However, there were no statements or interviews with other residents who were cared for by the same staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on [DATE] at 11:45 AM, the DON stated that since Resident #369 was in the dementia unit, all other residents were not interviewable due to cognitive level. The surveyor asked how the facility staff documented this. The DON confirmed that the facility had no documentation regarding other residents' interviews/statements. On [DATE] at 12:20 PM, the surveyor informed concerns about the investigation of Resident #369's unknown origin injury to the DON. The DON validated the surveyor's concern. 15701 4) A review of facility reported incident MD00141880 was initiated on [DATE] at 2:01 PM. The facility reported incident dated [DATE] alleged that a nurse had inappropriate sexual behavior with a resident (Resident #39). The facility was only able to provide an investigation summary of the facility reported incident with indication that the nursing home administrator interviewed the resident and the alleged staff person involved, but did not have the actual statements or witness statements from the staff and/or the staff person that alleged the inappropriate activity. [DATE] 10:16 AM, The director of nursing was informed of the regulatory concern that the facility failed to maintain evidence that the allegation of inappropriate sexual conduct was thoroughly investigated. 31982 5) Facility Reported Incident MD00197311 was reviewed on [DATE] at 9:36 AM. The Facility's investigative documentation revealed a written statement by Staff #55 a Speech Therapist. The statement identified Resident #18 as assailant and Resident #470 as victim. Staff #55 described that, on [DATE] at approximately 12:00 PM, he was in the Heritage Hall speaking to Resident #470. Resident #18 exited his/her room approached Resident #470 cursing and calling Resident #470 derogatory names. He witnessed Resident #18 punch Resident #470 on the left shoulder as he/she accused Resident #470 of sexually assaulting him/her during the previous 4 nights. Resident #18 went back to their room and closed the door after Staff #55 told him/her to leave the area. The facility's investigation regarding the allegation of sexual assault included statements from staff. However, no statements were obtained from the alleged victim -Resident #18, the alleged perpetrator -Resident #470, or other residents on the Heritage unit. There was no documentation to reflect that the facility investigated Resident #18's physical assault of Resident #470 as witnessed and reported by Staff #55. In an interview on [DATE] at approximately 10:00 AM, Staff #52 a Corporate Registered Nurse (RN) was asked to provide any additional evidence that the facility investigated the physical assault of Resident #470 by Resident #18. She returned at 11:18 AM on [DATE] and explained that the facility focused on the sexual assault allegation and did not investigate Resident #18's physical assault of Resident #470. On [DATE] at 1:32 PM, Staff #48 a Corporate Regional RN, was made aware that the facility's investigation of the allegation of sexual abuse failed to include statements from the alleged perpetrator, victim, or other residents. No additional statements were provided. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator and Director of Nursing were made aware of these findings on [DATE] at 1:23 PM. 42507 6) On [DATE] at 11:30 AM, review of Facility Reported Incident (FRI), MD00147052, revealed that Resident #418 reported on [DATE] a staff called her/him a nuisance. The facility initiated an investigation and did not determine abuse. Further review of the facility report of the incident revealed that there were witness statements from staff and other residents. However, there were no witness statements from staff and/or resident/other residents on file. There was no statement from the alleged perpetrator and/or any education/sign-in sheet of education provided to staff after the incident. The investigation was not thorough. On [DATE] at 1:30 PM, in an interview with the Director of Nursing (DON), she stated that the staff who completed the report of the above incident, including the alleged perpetrator, no longer worked in the facility. On [DATE] at 10:12 AM in a follow up interview with the DON, she was informed about the investigation not being thorough (no progress notes and/or interview statements on file, no staff training / signed in sheets on file). DON did not provide additional information. 7) On [DATE] at 9:00 AM, review of Facility Reported Incident (FRI), MD00145026, revealed Resident #419 was noted with discoloration to the left eye on [DATE]. The report stated that the resident was assessed by the MD (medical doctor) at bed side, labs and X-ray obtained. The report indicated the X-ray was negative for fracture and blood coagulation tests (aPTT, PT/INR) were abnormal. However, the report did not include the actual results of the ordered labs and/or X-ray. Further review of the facility report of the incident revealed there were witness statements from other residents and staff members. However, there were no statements on file, and no staff training records after the incident. The investigation was not thorough. On [DATE] at 9:35 AM, in an interview with the Director of Nursing (DON), she stated that the staff who completed the incident report on [DATE] at 3:29 PM, and the former Administrator who completed the FRI report no longer worked in the facility. As of [DATE] at 9:50 AM, surveyor was not able to review Resident #419's clinical records, as the facility staff was unable to provide these records. Resident did not have any closed records and Resident #419 was not in PCC (facility's electronic record). Facility administrative staff stated that Resident #419 was in the facility when it was owned by the previous owner and was discharged prior to change of ownership. So, they did not have access to the resident's records. However, they stated they were going to contact the prior owner for Resident #419's medical records. On [DATE] at 10:50 AM, in a follow up interview with Medical Records (Staff #17), she stated that the previous owner was in the process of sending them the resident's records. Staff #17 added that they had contacted the previous owner to grant electronic access for surveyor to get into Resident #419's electronic records. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:10 PM, Medical Records Staff #17 brought surveyor some printed copies of progress notes from [DATE] through [DATE]. She stated that she could not get a copy of Resident #419's face sheet and was following up with the prior owner of the facility. However, there were no progress notes from [DATE] and no change of condition notes to indicate the date and/or time the injury of unknown origin was first observed (discoloration to Resident #419's left eye) On [DATE] at 10:12 AM in an interview with the DON, she was informed about the investigation not being thorough and medical records not complete. Surveyor shared concern with the DON about a lack of evidence for the investigation. DON provided no new information.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on medical record review and interview with staff, it was determined the facility staff failed to permit each resident to remain in the facility unless the transfer/discharge was necessary for the resident's welfare and the residents need could not be met in the facility, failed to ensure appropriate information was communicated to the receiving health care institution and failed to ensure that a resident was sent home with appropriate discharge instruction paperwork. This was evident for 2 (#18, #322) of 4 residents reviewed for hospitalization and discharge The findings include: Resident #18's medical record was reviewed on 1/12/24 at 12:28 PM. The record revealed Resident 18's diagnoses included, but were not limited to, Paranoid Schizophrenia, Major Depressive Disorder and Anxiety Disorder. Resident #18's census record revealed the resident was discharged to the hospital on 6/22/23. A Change in Condition progress note, dated 6/22/23 by Staff #26 a Licensed Practical Nurse (LPN), reflected: Resident allege of being hit by another resident. his/her mental status evaluation indicated No changes observed. His/Her Behavioral Status Evaluation indicated no changes observed, the note did not indicate the time of the note but included that the Clinician was notified on 6/22/23 at 12:10 AM. The Clinicians recommendation was to continue to monitor Resident #18 and keep the two residents away from each other. A Nursing Health Status Progress note, dated 6/22/23 05:15 AM, reflected that the resident reported in the early morning hours another resident struck him/her on the ears. The resident called police and reported the incident. The nurse immediately assessed the resident who had no apparent injury. At 12:32 am police arrived, met with resident at the main lobby and provided him/her a community social service number to call. Another progress note written on 6/22/23 at 9:01 AM reflected the names of the police officers that arrived earlier, a case number and notification of the physician and attempt to notify the resident's representative. It ended with Resident remains in stable condition. Continue to monitor. Several additional progress notes were written on 6/22/23 that pertained to medication administration. The documentation in Resident #18's record did not reflect that the resident's condition became unstable, or any changes occurred with the resident. At 15:38 (3:23 PM) on 6/22/23, a progress note written by Staff #59 a Licensed Practical Nurse (LPN) indicated ER (emergency room) Transfer. Around 2:05 pm, Three sheriffs arrived the facility with court order to transfer resident to ER/psych (psychiatric) unit. (Staff #58, the Physician), present at the facility when they arrived. Paramedics later came with the stretcher to transfer. Sheriffs/Paramedics transferred resident on the stretcher to (the hospital) around 2:30 PM. Resident #18's medical record failed to reflect the circumstances of the court order, or the basis for Resident #18's transfer to the hospital on 6/22/23 by either facility staff or the physician despite Staff #59's documentation that the physician, was present when the police arrived to transport the resident to the hospital. The record failed to reveal that pertinent medical information regarding Resident #18 was provided to the receiving hospital or a physician's order to send Resident #18 to the hospital. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/24/24 at 12:16 PM, Staff #2 confirmed that she was Resident #18's Social Worker. When asked about Resident #18 going to the hospital on 6/22/23 and if she knew anything regarding a petition for emergency evaluation, she indicated that, on 6/22/23, Resident #18 went to the dining room and slammed glassware and silverware onto the floor, picked some up, took it to his/her room and threatened to hurt others. Staff #2 indicated that she completed a petition for the resident to have an emergency evaluation at the hospital and took the petition to the county courthouse around 11 or 12 noon. It was reviewed by a judge. A court order was issued, and the police transported Resident #18 to the emergency room for a psychiatric evaluation. She indicated the process to obtain the court order took about an hour or two. Staff #2 indicated that she did not retain a copy of the emergency petition for Resident #18's medical record. Upon review of Resident #18's medical record, Staff #2 confirmed there was no documentation on 6/22/23 regarding the behaviors she described or the basis for transferring Resident #18 to the hospital. In an interview on 1/25/24 at 9:00 AM, The Director of Nursing (DON) was asked to provide evidence of the documentation that was sent to the hospital with Resident #18 on 6/22/23. She stated, recent labs, a medication list, and progress notes. She confirmed that the facility had a hospital transfer list, but that it was not completed when Resident #18 was sent to the hospital on 6/22/23 and there was no documentation to reflect that pertinent information was communicated to the receiving hospital. In another interview at 10:54 AM on 1/25/24, the DON confirmed that there was no documentation in Resident #18's medical record regarding behaviors Resident #18 was exhibiting on 6/22/23, as well as any interventions attempted by staff. She confirmed that there was no evidence the physician assessed the resident, documented the resident's condition and rationale as to why the residents transfer was necessary. She confirmed the resident was sent to the hospital without a written physician's order. She repeated several times that the resident had a history of behaviors and stated: You have to know (Resident #18), (he/she) can be a handful. On 02/02/24 01:23 PM The above concern was reviewed with the Administrator and Director of nursing. 44441 2) On 2/1/24 at 11:37 AM, Resident #322's closed medical record was reviewed in relation to complaint allegation intake MD00181992. Resident #322 was discharged on [DATE]. The complaint alleged that no discharge paperwork was provided to Resident #322 upon discharge at 11:00 AM as staff were running about talking about they had to prepare the paperwork. A review of the nurse's discharge progress note, dated 5/17/22 on 2/1/24 at 1:35PM, revealed that Resident #322 was discharged in stable condition, all belongings and paper works including medication taken at time of discharge. Further review could not produce copies of all the discharge paperwork that was sent with the resident. The facility was asked to provide these documents. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/1/24 at 3:09 PM, the Social Worker (SW) staff #2 brought a discharge instruction form completed by the Interdisciplinary team (IDT). Staff #2 stated that nurses would go over the discharge instructions with the resident/Resident's representative (RP), sign and have resident/RP sign it prior to discharge. Staff #2 said that the nurse would sign the form to indicate that they reviewed it with the resident. A copy would be given to the resident while the facility kept a copy. Review of the Discharge Instruction IDT form showed that the form was not signed by the resident/RP or the nurse and the SW could not verify that the resident received the discharge form. Staff #5 a License Practical Nurse (LPN) was asked on 2/5/24 at 12:25 PM to explain their process for discharge. She stated that a discharge packet would be completed by the IDT first. Then the nurse goes over the discharge instructions with the resident/RP after which they and the nurse sign all the paperwork . A copy was then placed in the resident's chart and a copy given to the resident to take home. She was asked to explain what type of paper work was given to residents on discharge. Staff #5 stated that these documents include: 1. copy of the Medical Order for Life Sustaining Treatment (Molst) form which covers a variety of end-of-life treatments 2. A discharge packet containing discharge orders, prescriptions (Rx) scripts and referrals 3. Copy of the discharge instruction/post discharge plan of care form which the nurse and resident/RP signs. She explained that all discharge forms are sent to the medical record to be scanned into the resident's records after discharge. Other than the MOLST form and the discharge packet, which was not signed, none of these documents could be found in the resident's medical records. ON 2/6/24 at 10:22 AM- The Director of Nursing (DON) was made aware of the concerns.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 48168 Based on record review and interview, it was determined that the facility failed to provide the required notice of discharge/transfer when a resident was transferred to a hospital. The was evident for 1 resident (Resident #13) of 26 residents reviewed for facility reported incidents. The findings include: On 2/02/24 at 1:01 PM, a review of the facility reported incident for Resident #13 was conducted. On 1/05/24, Resident #13 was found with swelling and limited mobility in his right arm and an x-ray revealed a shoulder fracture. The resident was seen by the Nurse Practitioner who ordered a transfer to hospital and on 1/05/24, the resident was transferred. A review of the medical record revealed no evidence that a transfer notice was provided to the resident or the resident's representative. On 2/02/24 at 1:10 PM, an interview with the Corporate Registered Nurse (RN#48) was conducted and she stated that the notice of transfer/discharge was normally provided by the unit nurse, but if the unit nurse was unable to do so, then social services would provide it, and it would ultimately be mailed by the medical records department, if it was unable to be given at the time of transfer. On 2/02/24 at 2:55 PM, Corporate Registered Nurse (RN#52) informed this surveyor that no Notice of Transfer/Discharge was in the medical record, and that there was no evidence that any Notice of Transfer was provided to either Resident #13 or the resident's representative.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 31982 Based on review of the medical record and interview with staff, it was determined that the facility staff failed to sufficiently prepare and orient residents for their transfer to the hospital. This was evident for 1 (#18) of 3 residents reviewed for hospitalization . The findings include: Resident #18's medical record was reviewed on 1/12/24 at 12:28 PM. Resident #18's census record revealed the resident was discharged to the hospital on 6/22/23. A progress note, dated 6/22/23 15:23 (3:53 PM), by Staff #59 a Licensed Practical Nurse (LPN) Note Text: ER (emergency room) Transfer. Around 2:05 pm, Three sheriffs arrived the facility with court order to transfer resident to ER/psych (psychiatric) unit. (Staff #58, the Physician), present at the facility when they arrived. Paramedics later came with the stretcher to transfer. Sheriffs/Paramedics transferred resident on the stretcher to (the hospital) around 2:30 PM. There was no documentation to indicate that staff informed the resident where he/she was going and took steps to minimize his/her anxiety. In an interview on 1/25/24 at 10:54 AM, the Director of Nursing was made aware of this concern and confirmed there was no other documentation regarding the resident's emergency petition transfer to the hospital on 6/22/23.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 49409 Based on record review and staff interview, it was determined that the facility failed to offer a bed-hold notice to the resident or resident's representative before the facility transferred a resident to the hospital. This was evident for 2 (Residents #173 and #169) of 3 resident records reviewed for hospitalization , and for 1 resident (Resident #13) of 26 residents reviewed for facility reported incidents. The findings include: Bed hold notice includes providing written information to the resident; and bed charges, including the duration, during which the resident is permitted to return and resume residence in the nursing facility. 1) On 01/12/24 at 09:15 AM, the surveyor's record review revealed that Resident (#173) was transferred to hospital on 01/10/24. However, there was no evidence that the resident received a bedhold policy at that time. On 01/12/24 at 9:35 AM, the surveyor's record review revealed that Resident (#173) was transferred to the hospital on 01/24/24. However, the resident received an incomplete bed hold policy as the policy did not include the reserve bed payment policy. On 01/12/24 at 10:00 AM, the surveyor interviewed the Director of Nursing (DON). During the interview, the DON was asked if there was evidence that Resident #173 received a bedhold policy before their hospitalization . The DON was unable to provide such evidence before the end of the survey. The DON was also shown the bed hold policy that had been provided to Resident #173 and validated that the bed hold policy did not include a statement of the facility's reserve bed payment policy. 43096 2) On 1/12/24 at 11:16 AM, a review of Resident #169's medical record revealed that the resident was transferred to an acute care facility on 10/30/23. There was documentation that the resident's status was provided to the physician and Representative Party (RP). However, there was no documentation about the bed hold policy. Also, on 12/21/23, Resident #169 was transferred to the hospital due to further evaluation of unresponsive status. The resident's electronic medical records had a scanned Bed Hold Information containing the resident's name, signature, and date. However, the form did not indicate daily amount of payment for bed hold. During an interview with the Director of Nursing (DON) on 1/18/23 at 1:17 PM, the DON stated that the bed hold policy should be given to residents or RP. The surveyor shared concerns with the DON that Resident #169's bed hold policy, dated 12/21/23, did not have a daily payment amount. Also, the DON was informed that there was no bed hold policy on 10/30/23 when the resident transferred to the hospital. The DON said, Our policy did not list the amount of the money. The surveyor referred to federal regulations regarding the bed hold policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON validated the surveyor's concern. 48168 3) On 2/02/24 at 1:01 PM a review of the facility reported incident for Resident #13 was conducted and revealed that on 1/05/24 Resident #13 was found with swelling and limited mobility in his right arm and an x-ray revealed a shoulder fracture. The resident was seen by the Nurse Practitioner who ordered a transfer to hospital and on 1/05/24 the resident transferred to the hospital. A review of the medical record revealed no evidence that a bed hold notice was provided to the resident or the resident's representative. On 2/02/24 at 1:10 PM, an interview with the Corporate Registered Nurse (RN#48) was conducted and she stated that the bed hold was normally provided by the unit nurse, but if the unit nurse was unable to do so, then social services would provide it, and it would ultimately be mailed by the medical records department if it was unable to be given at the time of transfer. On 2/02/24 at 2:55 PM, Corporate Registered Nurse (RN#52) informed this surveyor that no Notice of Transfer/Discharge was in the medical record, and that there was no evidence that any bed hold notice was provided to either Resident #13 or the resident's representative.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47200 Based on record review and interview, it was determined the facility failed to accurately code significant weight loss of a resident on the Minimum Data Set (MDS) assessment. This was evident for 1 of 7 (#30) residents reviewed for nutrition during the facility's recertification survey. The findings include: On 1/8/24 at 1:52PM, the surveyor reviewed the medical record of Resident #30 which revealed documentation that on 7/4/23, the resident weighed 191.6 lbs (pounds), and on 7/26/23 they were weighed twice, and weighed 168.6 lbs on both occasions, indicating they had sustained significant weight loss of greater than 10% during the month of July 2023. Upon further review of the medical record on 1/11/24 at 12:25PM, the surveyor observed a documented medical order beginning on 7/28/23 which prescribed a medication for the resident that indicated the medication was being used for the purpose of appetite stimulation. Continued surveyor review of the medical record on 1/11/24 at 1:00PM revealed Staff #6, Registered Dietician's progress note on 7/27/23 which documented the resident was triggering for significant, undesirable, unplanned weight loss. On 1/17/24 at 3:32PM, the surveyor conducted a review of the quarterly MDS assessment for Resident #30, (with an assessment reference date of 8/7/23) which revealed Staff #15, MDS coordinator, had coded the resident as no/unknown for section K0300 which asks for the recording of resident weight loss of 5% or more in the last month, or 10% in the last six months. On 1/22/24 at 11:43AM, the surveyor conducted an interview with Staff #15, MDS coordinator, who was unable to provide explanation as to why their coding of section K0300 for Resident #30 did not capture the resident's significant weight loss. On 1/22/24 at 12:25 PM, the surveyor conducted another interview of Staff #15, MDS coordinator, who reported the resident's 7/26/23 re-admission weight looked incorrect. They further reported to the surveyor: The resident was eating and refused to be weighed, I strike it out, we are allowed to do that. Honestly, I don't remember if I got a re-weight.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on review of the medical record and interview with staff, it was determined that the facility staff failed to accurately complete assessments and refer residents for Preadmission Screening and Resident Review (PASRR) level II determination. This was evident for 1 (#18) of 4 residents reviewed for Behavioral-Emotional. The findings include: Per https://health.maryland.gov/mmcp/longtermcare/Pages/Pasrr: Preadmission Screening and Resident Review (PASRR) process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness (SMI) or Intellectual Disability. This is called a Level I Screen. Those individuals who screen positive at Level I are referred to the local health department (LDH), where they receive an in-depth Level II PASRR evaluation. The LHD forwards the results of this evaluation to the Developmental Disabilities Administration or the Behavioral Health Administration as appropriate. The State authority in turn reviews the evaluation findings and issues a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care. Resident #18's medical record was reviewed on 1/30/23 at 10:34 AM. The record revealed Resident #18 was sent to the hospital on an emergency court order petitioned by Staff #2 a Social Worker on 6/22/23 and was discharged from the hospital to the facility on [DATE]. Upon return to the facility, a PASRR Level I Screen was completed by Staff #2. Section C Serious Mental Illness (MI) Indicated Resident #18 was considered to have a SMI requiring completion of Part D of the form. The directions for Part D instructed: If any answer to Part D is Yes, complete the Categorical Advance Group Determination Evaluation Report and attach, Additionally, if questions 1, 2, or 3 are checked Yes, or if all answers in Part D were no the individual must be referred to AERS for a Level II evaluation. The 5 questions in Part D were not answered and the section had a diagonal line drawn across it. Staff #2 failed to accurately complete the PASRR screening. In an interview on 1/30/24 at 3:46 PM, Staff #2 was asked why Part D was not completed, she indicated that it was not required. When asked if Resident #18 should have been referred for a Level II evaluation, she indicated No, that the hospital informed the Director of Nursing that the resident was admitted for behaviors, not psychiatric issues. Staff #2 indicated that she shouldn't have indicated in Part C3 that the resident was hospitalized for psychiatric issues in the past 3 years, that she incorrectly indicated yes. The hospital discharge summary, dated 7/14/23, revealed the reason for Resident #18's hospital admission 6/22/23 - 7/14/23 was Inpatient Psych (Psychiatric) Placement. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/2/24 at 11:25 AM with Staff #46, a Licensed Certified Corporate Social Worker who was providing consultation services for the facility's social work department. He indicated that Staff #2 had received training regarding PASRR. He was asked to review the PASRR, dated 7/14/23, for Resident #18 and made aware that it was completed following hospitalization involving the emergency petition. When asked if it was completed properly, Staff #46 stated that Part D should have been completed because the resident was presenting with mental illness. When asked if the resident should have been referred for a Level II evaluation based on this screen, he stated Yes, correct.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49409 Based on resident interview, review of medical records, and staff interviews, it was determined that the facility failed to provide the resident and their representative with a summary of the baseline care plan within 48 hours of a resident 's admission. This was evident for 3 (Resident #50, #96 and #173) of 48 residents reviewed for baseline care plans. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. 1) On 01/09/24 at 9:05 AM, Resident #173 was interviewed. During the interview, the resident was asked if they had ever received a copy of his/her baseline care plan. The resident stated, no, they never received a copy of the care plan. On 01/11/24 at 10:48 AM, Resident #173's medical record was reviewed. The review revealed that Resident #173 was admitted to the facility in January 2024 and a baseline care plan was developed on 1/6/24. However, the review failed to reveal evidence that the facility offered the resident and their representative a summary of the baseline care plan that included initial goals, physician orders, therapy services, dietary services, and social services within 48 hours of the resident's admission to the facility. On 01/11/24 at 10:57 AM, an interview was conducted with Unit Manager (UM) #54. During the interview, UM #54 stated that the facility is supposed to give a copy of the baseline care plan to residents after the baseline care plan is developed. She stated that it should be scanned into the Documents section of the electronic medical record system. When shown that there was no baseline care plan uploaded for Resident #173, UM #54 confirmed that the baseline care plan was missing from Resident #173's record. On 01/18/24 at 08:18 AM, the surveyor validated with the Director of Nursing (DON) that the facility failed to provide a summary of the baseline care plan to Resident #173 and their representative within 48 hours of the resident's admission to the facility. 43096 2) A review of Resident #96's medical records on 1/22/24 at 8:34 AM revealed that the resident was admitted to the facility in November 2022. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #96's medical record failed to produce a baseline care plan. There was neither documentation under progress notes about the baseline care plan nor an assessment form about the baseline care plan, which included a check-off box for providing documentation to the resident and/or RP. During an interview with the Director of Nursing on 1/24/24 at 8:50 AM, the DON was asked to provide any supportive documentation to prove the facility informed Resident #96 about his/her baseline care plan upon their admission. The DON confirmed that there was no documentation. 48168 3) On 1/16/24 at 1:19 PM, a record review of Resident #50's electronic medical record revealed that the resident was admitted to the facility in December 2023. On 1/16/24 at 3:18 PM, a review of Resident #50's medical records revealed a form signed by the resident that acknowledged a baseline care plan was provided on 12/14/23 which was later than the required 48 hours. On 2/06/24 at 10:10 AM in an interview with the Director of Nursing, the DON was asked about the delay in providing the baseline care plan to Resident#50. The DON did not have any further information or evidence to provide, and no other information was provided by the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31982 Based on observation, medical record review, and interview, it was determined the facility staff failed to develop and initiate comprehensive person-centered care plans for residents residing in the facility. This was evident for 1 (#18) of 4 residents reviewed for Behavioral-Emotional health needs, and 2 (#75, #23) of 48 residents reviewed for comprehensive care plans. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) Resident #18's medical record was reviewed on 1/12/24 at 12:28 PM. The record revealed Resident 18's diagnoses included, but were not limited to, Paranoid Schizophrenia, Major Depressive Disorder, and Anxiety Disorder. Review of the medical record on 1/29/24 at 10:50 AM revealed that a plan of care was developed on 10/24/23 and revised on 11/7/23 for Resident #18 with the focus: The resident has behaviors - being disruptive, belligerent, tobacco product-seeking, using profanity, refusing weights, refusing wound care, urinating in (his/her) room, defecating in (his/her) room, involvement in resident to resident altercation, involvement in resident to staff altercation, smoking in (his/her) room, grinding (his/her) medication and attempting to snort it through (his/her) nostrils, destruction of facility properties, throwing things at nurses, drawing pictures on the wall in (his/her) room, interrupts other peoples' conversation, unaware of other peoples boundaries, invades other people's personal spaces. The resident's goals were: The resident's behaviors will not cause them or other resident's distress thru the review period and (Resident #18) will learn effective coping methods that can address the behavior issues that (he/she) has. The goals did not include objectives staff would measure to determine their effectiveness and need to revise or resolve or the timeframe of the review period. The interventions that were identified for staff to implement to assist Resident #18 in reaching (his/her) goals were: administer medications as ordered, allow resident as many options as possible to empower (him/her) to participate in (his/her) own health care, assign staff members that are familiar or preferred by the resident when possible, Involve resident in activities of choice, give resident opportunity for positive interaction, encourage and educate resident on conflict resolution, Physician review of medication as needed, Provide large picture book and coloring pencil for resident activity, psych services referral as needed, and redirect resident to subjects that matter to (him/her) when behaviors occur. The facility staff failed to identify specific interventions to implement in the plan such as Resident #18's specific activities of choice, how staff would give the resident opportunities for positive interaction, it did not identify what specific subjects staff should attempt to redirect the resident and for which behaviors. The plan did not identify who would educate the resident regarding conflict resolution and how the education would occur. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A plan with the focus: Resident #18 has signs and symptoms of depression and is at risk for adverse reactions was developed on 10/18/23. The resident's goal was identified as: The resident will not have any adverse effects from depressive symptoms. The interventions included Activities of resident choice, Administer medications as ordered, Notify MD as indicated, PHQ9 (Patient Health Questionnaire) screening as indicated, Referral to psych services. PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression. The staff failed to identify objectives they would measure to determine the effectiveness of the plan's interventions. The interventions did not identify what was meant by adverse effects from depressive symptoms and it was unclear how the interventions would assist the resident in reaching their goal. Another plan of care was developed 10/18/23 for the focus: Antipsychotics - at risk for adverse reactions related to the use of antipsychotics secondary to diagnosis of bipolar disorder, schizoaffective disorder. The resident goals: will be free from adverse effects related to antipsychotic use thru review period. The interventions staff were to implement to assist the resident in reaching (his/her) goal were: AIMS (Abnormal Involuntary Movement Scale) assessment as indicated (AIMS assessments are used to evaluate for movement disorders associated with the use of antipsychotic medications), Labs as ordered, monitor for behaviors related to medication use, and NONPHARMACOLOGICAL INTERVENTIONS. Resident #18's diagnoses did not include schizoaffective disorder or bipolar disorder. Further review of the record revealed that no plans of care were developed to address the residents goals and care needs related to his/her diagnoses of Anxiety Disorder, or Schizophrenia. In an interview on 2/2/24 at 11:25 AM, Staff #46 the Regional Corporate Social Worker was asked who was responsible for overseeing the development of behavioral care plans. He indicated the MDS (Minimum Data Set) nurse and the Social Worker. He indicated that, although Staff #2 was not an licensed certified social worker, she had been educated to develop a care plan. He added that the Psychogeriatric services progress notes should be reviewed by the interdisciplinary team and incorporated into the plan of care. The Administrator and Director of Nursing were made aware of the surveyor concerns on 1/29/24 at 11:32 AM. 42507 2) A suprapubic catheter is a hollow flexible tube that is used to drain urine from the bladder. It is inserted into the bladder through a cut in the tummy, a few inches below the navel (tummy button). Hospice is a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease. Hospice offers physical, emotional, social, and spiritual support for patients and their families. The main goal of hospice care is to control pain and other symptoms of illness so patients can be as comfortable and alert as possible. It is usually given at home, but may also be given in a hospice center, hospital, or nursing home. On 1/9/2024 at 8:28 AM, the surveyor observed Resident #75 lying in bed. Resident #75 had a suprapubic catheter and stated that s/he went to an acute care facility every 30 days for it to be changed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Largo Nursing and Rehabiliation Center	600 Largo Road Glenarden, MD 20774

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 1/10/2024 at 10:25 AM, a follow up observation was made of Resident #75. The suprapubic catheter was in place draining clear yellow urine.

During a review of Resident #75's medical record conducted on 1/11/2024 at 9:10 AM, surveyor noted active physician orders, dated 11/1/2023, for: Suprapubic Foley catheter 24F, 10ml balloon for neuromuscular Dysfunction of Bladder every shift and Re-admit to Capital Caring Hospice service for senile degeneration of brain dated 11/2/2023.

On 1/11/2024 at 10:18 AM, a review of Resident #75's care plan failed to reveal that a suprapubic catheter care plan and a hospice care plan were developed with measurable goals and nursing interventions/evaluations.

On 1/18/2024 at 12:41 PM, in an interview with the Director of Nursing (DON), surveyor reviewed Resident #75's care plan. DON confirmed that there was no focus, goal, or interventions on the care plan for both suprapubic catheter and hospice. However, DON stated that there were multiple care plans in the system that got canceled when a resident transfers to the hospital, and this could account for why the resident's current care plan was missing hospice and suprapubic catheter. DON reviewed with surveyor Resident #75's care plan, dated 9/27/2022, with next review date of 1/4/2024: The plan addressed hospice care, that was created on 3/7/2023, but revised/canceled on 10/31/2023. The suprapubic catheter plan created on 12/15/2022 was revised and canceled on 10/31/2023. DON stated that the staff failed to go back and make sure that all aspects of the care plan were carried forward when the current care plan was created. DON added that she was going to follow up with her staff.

49409

3) C-diff, formerly also known as Clostridium difficile, is a germ that causes diarrhea and colitis, an inflammation of the colon, transmitted from person to person, via the fecal-oral route. C-diff spreads when people touch surfaces that are contaminated with feces from an infected person, or when people don't wash their hands with soap and water. It can also happen when one healthcare facility fails to notify another when it transfers a patient with C. diff.

To prevent C. diff, facilities must rapidly identify and isolate patients with C. diff, and have staff wear gloves and gowns when treating patients with C. diff. They must also clean surfaces in rooms where C. diff patients are treated with EPA-approved, spore-killing disinfectant.(Center for Disease Control and Prevention)

On 01/25/24 at 09:39 AM, a review of Resident #23' s medical record revealed that the resident had an order for antibiotics from 01/10/2024 to 01/22/2024, to treat C Diff.

Further review of Resident #23's progress notes revealed a note from 1/10/24 at 4:30 PM as Patient and [name of the resident's RP] notified of lab results c-diff positive, room change for isolation, contact isolation education given. Antibiotic therapy. Both verbalized understanding.

However, a review of the care plan for Resident #23 on 1/25/24 at 9:45 AM revealed that there was no comprehensive care plan for C Diff.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Practical Nurse (LPN #9) on 1/25/24 at 11:20 AM, LPN #9 verified when the provider orders a new medication or adds a new diagnosis, nurses would document in a progress note and communicate with the supervisor to add/ update care plans. Also, LPN #9 stated that the C. diff care plan should be developed. On 01/25/24 at 11:29 AM, an interview was conducted with the Infection Control Preventionist (ICP). During the interview, the ICP validated that no care plan had been developed for the C. Diff infection and resulting antibiotic usage for Resident #23.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 44441 Based on medical record review and interviews with staff and a resident, it was determined that the facility failed to ensure that an interdisciplinary team, which included the resident and or the resident's representatives, contributed to the resident's comprehensive care plan as evidenced by the failure to conduct a care plan meeting for residents at quarterly intervals. Additionally, facility staff failed to document and evaluate each care plan to ensure the interventions continued to be appropriate for the resident's condition. This was evident for 5 residents (Resident #5, #75, #17, #39, #96) reviewed for care planning. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 1/9/24 at 10:07 AM in an interview, Resident #5 was asked if they go to care plan meetings or was invited. Resident told the surveyor that they had not had a care plan meeting for a while and thought it had been longer than 3 months. A medical record review was conducted for Resident #5 on 1/30/24 at 9:17 AM. There was no evidence that a care plan meeting had been held with the resident/residents' representatives with the interdisciplinary team. The last documented care plan meeting was held on 5/17/2023. On 1/30/24 at 9:24 PM, an interview was conducted with the Social Worker, Staff #1. Staff #1 was asked how often a care plan meeting was being held for resident or with their RP and she stated, every 3 months or as needed. She was asked the last time a care plan meeting was held for resident #5. Staff #1 admitted that she did not have anymore care plan meetings with the resident or their RP since May 2023 On 1/30/24-at 10:01AM the Director of Nursing (DON) was made aware of this concern. 42507 2) A midline (also called a midline catheter) is a long, thin, flexible tube that is inserted into a large vein in the upper arm. It is used to safely administer medication into the bloodstream, similar to a cannula (a small tube that is inserted into a vein, usually in the back of your hand or arm). On 1/9/2024 at 8:28 AM, surveyor observed Resident #75 lying in bed. Resident did not have a midline and/or any IV (intravenous) access. On 1/11/2024 at 9:10 AM, a review of Resident #75's active orders were completed. There were no physician orders for a midline. Further review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for January 2024 did not reveal the resident had a midline. There was no nursing documentation of the presence of a midline on the MAR and/or TAR. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/11/2024 at 10:18 AM, a review of Resident #75's care plan revealed a care plan focus for the resident has a Midline venous access site created on 11/2/2023 with goals and interventions. On 1/11/2024 at 10:25 AM, in a follow up interview and observation of Resident #75, the resident confirmed that s/he did not have a midline and/or any IV access. The surveyor observed resident's upper extremities, but there was no midline. Resident had a small gauze dressing in the right antecubital area where s/he had blood drawn the day before (as per the resident's report). On 1/18/2024 at 12:41 PM, an interview was completed with the Director of Nursing (DON). She stated that care plans were updated/revised quarterly and as needed by unit managers. Surveyor reviewed Resident #75's care plan with the DON: The care plan focus indicated Resolved: the resident has a midline venous access site (Created on 11/2/2023, Revision on 1/11/2024, and Resolved date 1/11/2024). The care plan goal and interventions for a midline were also revised and resolved on 1/11/2024. DON confirmed that as of 1/11/2024, the care plan still had resident as having a midline venous access site (created on 11/2/2023) and acknowledged that the care plan was revised and resolved after surveyor's intervention/request for a printout of the care plan on 1/11/2024. 48168 3) The Resident Assessment Instrument (RAI) delineates the process that long term care facilities follow to screen residents, assess resident strengths and needs, plan for resident care delivery, and evaluate the residents progress and needs on an ongoing basis by returning to additional, periodic screening, assessment and planning throughout a resident admission. The RAI process is the basis for the accurate assessment of each resident. The Minimum Data Set (MDS) assessments are an integral part of the RAI and include completion of standardized assessment questions. There are comprehensive MDS assessments and periodic non-comprehensive MDS assessments which facilities conduct to maintain an accurate understanding of each resident's most current needs and strengths, and to ensure care planning remains current and effective. An Assessment Reference Date (ARD) is the date that shows the end of the look back (observation) period. This date is used to base responses to all MDS coding items during the MDS assessment. On 1/10/24 at 11:42 AM, a review of complaint #MD00175251 alleged that resident #17's last care plan meeting was over a year ago. A review for Resident #17's medical record revealed that there was no documentation that any care plan meeting was held for the following MDS ARD dates of 4/16/23, 7/17/23, 9/05/23, or 12/06/23. On 1/12/24 at 9:38 AM, an interview with the Social Worker (SW#1) was conducted. She stated that Resident #17's last care plan meeting occurred before she started working at the facility in March 2023. When asked the process for care plan meeting scheduling, SW#1 said that the MDS reports would indicate when care plan meetings were due and that she had access to this information and that care plan meetings are held either in person or by phone. When asked why this resident did not have care plan meetings held, SW#1 could not give any explanation. When asked if the Director of Nursing verified that care plan meetings were held as scheduled, she replied No. On 2/06/24 at 10:10 AM, an interview with the DON was conducted to review concerns regarding missed care plan meetings. The DON did not offer any additional evidence or explanation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15701 4) Resident #39 was admitted to the facility in January 2018. Resident #39 was interviewed on 1/31/24 at 10:28 AM. Resident #39 was asked if he/she was involved in planning of care with invites to care plan conferences. Resident #39 indicated that care plan meetings are few and far in between and he/she could not remember the last time a care plan meeting was held. Resident #39 indicated that care plan meetings are just a formality and they do not mean anything. Resident #39's electronic health record was reviewed on 1/31/24 at 12:20 PM. Using the custom search feature in the progress note section indicated that the last documented care plan meeting for resident #39 was held on 11/3/22. On 2/2/24 at 1:14 PM the social work consultant (Staff #46) was asked to review resident #39's medical record to determine the last care plan conference that was conducted with resident #39. He found and confirmed in his review that the last care plan meeting documentation was dated 11/3/22. He stated unless it is under a different tab, and he reviewed the information with the social service staff #2 for her to check for the date of the last care plan meeting with resident #39. She found a note that she had written on 3/10/23, with an indication that the resident's code status was reviewed, and a note written by the social worker Staff #1 on 10/12/23. Neither note revealed documentation that the resident was involved in a care plan meeting. 43096 5) A review of Resident #96's medical records on 1/22/24 at 8:34 AM revealed that the resident was admitted to this facility in November 2022. The facility assessed the resident's MDS upon admission (11/20/22) and quarterly (2/20/23, 6/13/23: delayed due to readmission, 9/13/23, and 11/30/23). The medical record failed to reveal documentation of care plan meetings to these MDS assessments. Further review of medical records revealed that there were progress notes that documented related care plan meetings on 12/13/22, 1/31/23, 4/11/23, and 12/19/23 which were not met within the seven-day window after the MDS assessment was completed. Also, no care plan meeting documentation existed between June 2023 and September 2023. During an interview with the Director of Nursing (DON) on 1/24/24 at 8:50 AM, the surveyor requested supportive documentation that the facility held a care plan meeting for Resident #96. The DON submitted copies of the sign sheet for the care plan dated 12/13/22, 2/15/23, and 4/11/23. However, there was no care plan meeting sheet between June 2023 and September 2023. The surveyor shared concerns about the care plan meeting documentation with the DON on 1/24/24 at 2 PM. The DON validated the surveyors' concerns.

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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. 42507 Based on observation, record review, and interview, it was determined the facility failed to meet professional standards of practice by failing to ensure staff followed physician orders for administration of medications and documentation. This was evident for 1 (Resident #12) of 4 residents observed for medication administration during a recertification survey. The findings include: On 1/25/2024 at 10:05am, surveyor met the nurse, Licensed Practical Nurse, LPN #28, at a medication cart on the 2nd floor Independence Unit. LPN #28 reported she was preparing medications for Resident #12. LPN #28 was observed removing some medications from the medication cart including 2 tablets of Acetaminophen 325 mg. LPN #28 then signed the medications prior to giving them to Resident #12. A review of the medical record revealed that Acetaminophen was ordered to be given three times a day for pain and was scheduled to be given at 6:00 AM, 1200 noon, and 8:00 PM. However, LPN #28 had removed 2 tablets of Acetaminophen from the medication cart at 10:05 AM and gave them to the resident with the other morning meds. When asked why the Acetaminophen was given at that time, LPN #28 stated that Resident #12 always wanted the medication given early because at noon s/he (Resident #12) will be in the dining room for lunch and would not come back to the unit just to take the Acetaminophen. On 1/26/2024 at 10:08 AM, an interview was completed with the 2nd floor Unit Manager (UM #8). When asked what the expectation was during med pass, UM #8 stated that nurses were expected to follow the five rights of medication administration (right patient, right drug, right dose, right route, and right time). She stated that medication administration had a two-hour window (an hour before and up to an hour after the scheduled time of administration). Regarding residents requesting ordered meds prior to the scheduled time, UM #8 stated that the nurse should get a PRN (as needed) order for the med if the resident requested to have the med early. UM #8 further stated that nurses should sign medications after administration and not before. UM #8 was informed of surveyor's med pass observation on 1/25/2024 for Resident #12. She stated that she was going to investigate. On 1/26/2024 at 2:23 PM, surveyor reviewed with the Director of Nursing (DON) the observations on 1/25/2024 medication pass with LPN #28. DON stated she hoped there would be little, or no medication pass errors by her staff. On 1/29/2024 at 9:05 AM, a review of the facility's policy on Medication Administration (effective date 9-2018 with revision date of 8-2020) revealed: Under Procedures #4 - At a minimum, the 5 Rights- right resident, right drug, right dose, right route, and right time- should be applied to all medication administration . Under Administration: #12 - Medications are administered within 60 minutes of the scheduled administration time, except before, with, or after meal orders, which are administered based on mealtimes. Under Documentation (including electronic): #1- The individual who administers the medication dose records the administration on the resident's MAR (Medication Administration Record) directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure that necessary doses were administered and documented (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor shared concerns regarding the observations during medication administration by LPN #28 with the Administrator, the DON, and corporate staff prior and during the time of survey exit on 2/6/2024 at 2:15 PM.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 15701 Based on observation, medical record review and interview, it was determined that the facility failed to provide activity services to meet the needs of the resident. This was found to be evident for 1 (Resident #39) of four residents reviewed for activities during the investigative portion of the survey. The findings include: On 1/9/24 at 1:06 PM, Resident #39 was asked about his/her activity participation here at the facility. The resident indicated that there were not enough staff to transport the resident to and from activities. Resident #39's medical record was reviewed on 1/31/24 at 12:20 PM. Review of Activity Notes revealed that the last activity note was documented on 11/2/2022. The 11/2/22 note was written by the Director of Activities (Staff #18) with indication that resident #39 preferred to engage in independent activities within the comforts of his/her room . the resident enjoys listening to music, emailing, listening to audio books, and news updates on his iPad. The note further indicated the resident exercises every morning, enjoys socializing with staff, refuses in-person activities, and did not request any supplies. The note concludes, The activity department will continue to provide support as needed. Review of resident #39's care plan revealed an activity focus area created on 1/29/18 stating the resident prefers limited group activities, the resident enjoys activities such as listening to books, music, group activities, religious/spiritual. The goal that was created on 1/29/18 remained unchanged as [name of resident] will participate in independent/group activities of choice daily. The goal has remained the same since the creation of the care plan on 1/29/18 even though the revision dates were changed. The original care plan interventions, dated 1/29/18, remained as 1) provide/read the daily activity flyer, 2) Assist to and from activities of choice, 3)Provide supplies/materials for leisure activities as needed/requested, 4) provide adaptations of activities/environment to accommodate participation and activities of choice. On 7/31/18, two interventions were added and remain as 5)Assist in planning/encourage to plan own leisure-time activities, 6) respect choice in regard to limited/no activity participation. On 10/11/18, the last intervention was added as resident likes to go to the patio provided with walkie-talkie in the event (he gets turned around) for assistance. Medical record review on 1/31/24 revealed resident #39 was a long-term care resident with diagnoses that included but were not limited to diabetes, acquired absence of left leg below knee, hypertension and blindness. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39 was interviewed on 2/1/24 at 1:27 PM to review the activities care plan. He indicated that most activities do not appeal to him/her as the activities are not adaptable to the resident's blindness. He/she described certain games that are played, and he/she cannot participate. He/she indicated that the facility used to have a happy hour with DJ, and he/she could hear the music from his/her bedroom. This form of entertainment was much better than the staff just playing music. He/she indicated that the staff do not take him/her out the patio, and he/she has not been outside on the patio for 4 years. He/she described the time that the staff person who had taken the resident outside, went home at change of shift leaving the resident alone without a way to get back into the building. Resident #39 indicated that he/she does not have a device to listen to books. He/she indicated that the activity staff do not read the daily activity flyer. Resident #39 was asked about what type of adaptive equipment would he/she want, and he/she indicated a document reader. The director of activities was interviewed on 2/6/24 at 10:41 AM. She was asked how the resident gets informed of activities. She indicated that the resident would call her, and they would go to his/her room and bring the resident to the activity room. She revealed that the resident will let you know what he/she wants. She indicated that her staff are supposed to read the daily menu to the resident, but she is not with her staff to know that her staff have read the menu to the resident. The surveyor indicated that what she described as the resident's activity routine was not documented in the activity care plan. She responded in a way that she did not know she had to document everything. She stated [name of resident] is aware and has contacted the Light house for the blind, they can give him what he/she wants. She indicated that the resident is very independent and does not want to be bothered, she has given him the information for the light house and if the resident needs something, the resident will let them know. She stated that the resident prefers books on tapes and the tapes come to the resident, she does not order the books on tape. The surveyor revealed that the resident indicated not having a device to listen to tapes. She said she goes to the resident's room and the resident is listening to tape. The director of activities was questioned about her documentation related to resident #39's care plan evaluations and/or the last time she wrote a progress note, as the last activity's note in resident #39's medical record was written on 11/2/22. She indicated that she did not know what date she wrote on the resident, but she indicated that it was recently. The director of activities left the conference room with an indication that she was going to print her documentation for review. Upon the director of activities return, she did not provide documentation of progress note or an evaluation related to the resident's status with the activity program.

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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** 44441 Based on complaints, reviews of medical records, and interviews, it was determined that the facility failed to: 1) ensure right orders for treatment were put in and documented on, and 2) identify and implement interventions for a resident with significant weight loss. This was evident for 2 (#55, #324) of 66 residents reviewed during a recertification/complaint survey. The findings include: 1) On 1/19/24 at 9:15 AM, a review of a complaint intake MD00175326 revealed allegations concerning Resident #324's appearance and weight loss. On 1/19/24 at 9:43 AM- a review of the weight log from admission to discharge showed a weight loss of over 20lbs. Resident #324 had a weight of 172 lb. on admission (11/5/21) and on discharge (12/3/21), his weight was 150.4 lb. Further review showed that the significant weight loss was not reported to the doctor or the dietitian, nor was the issue addressed by the facility staff. On 1/29/24 at 10:05 AM review of the Skilled evaluation form under Nutrition evaluation' from 12/3/21 to 12/7/21 did not mention the weight loss. A Review of the care plan with initiation date of 11/5/21 on 1/29/24 at 11:16 AM did not show that a care plan for weight loss was initiated nor was it mentioned in the nurses and doctors progress notes. On 1/29/24 at 11:34 AM in an Interview with staff #51 a License Practical Nurse (LPN). She was asked about the process for weighing residents and reporting weight loss and she said that new residents are weighted weekly x 4 and then monthly or as needed. The Geriatric Nursing Assistants (GNA's) do the resident's weight and reports to the nurse. If there was a discrepancy, the weight is redone. The dietitian is made aware so she can monitor resident's weights and follow up with interventions. The Physician was also notified. Staff #6, a Dietitian, was asked in an interview on 1/31/24 at 12:28 PM how she tracks resident's weight. She stated that she runs different reports and gets them from the electronic medical record in Point Click Care (PCC) (a software used by the facility) to document resident's care. She explained that she ran reports every time she does an assessment on a resident or when something triggers weight loss. She was asked if the GNA's report significant weight losses directly to her and what she does about it. She said they do and that she would normally request a redo of the weight and then implement an intervention based on that. She was asked if she was made aware of Residents #324's weight loss from 150-170lb in a space of one month. She stated that she was not working in the facility at that time, and that the GNA should have reported it, so that interventions could be implemented to address the weight loss. On 2/6/24 at 10:12 AM, the Director of Nursing (DON) was made aware of the concern. 42507 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Largo Nursing and Rehabiliation Center	600 Largo Road Glenarden, MD 20774

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Medical record review on 1/22/2024 at 9:27 AM revealed Resident #55 was admitted to the facility on [DATE] with medical diagnoses that included, but were not limited to Alzheimer's disease, Schizophrenia, Adjustment disorder with Anxiety, and adjustment Insomnia. Review of psychogeriatric services notes, dated 1/31/2024 at 23:28 (11:28 PM), revealed Resident #55 was seen and evaluated by psych CRNP (Certified Registered Nurse Practitioner) for agitation and anxiety. Further review of the notes revealed under treatment plan/recommendations the following:D/C Risperdal 1 mg bid Mon thru Sat, Start Risperdal 0.5 mg bid Mon thru Sat, Cont. Risperdal 0.5 mg q am Sun, Risperdal 1 mg q hs Sun . However, a review of the orders as of 2/1/2024 revealed the following active orders: Risperdal Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth two times a day for Dementia with psychosis. Order date 1/31/2024. (days of administration not indicated) Risperdal Oral Tablet 1 MG (Risperidone) Give 1 tablet by mouth at bedtime every Sun for Dementia with psychosis. Order date 7/24/2023, and Risperdal Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth in the morning every Sun for Dementia with psychosis. Order date 7/24/2023. On 2/1/2024 at 12:46 PM, a review of Resident #55's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for February 2024 revealed a dose of Risperdal 0.5 mg was administered at 0900 (9:00 AM) with open slots for administration of the medication for the rest of the days including Sundays. Based on the way the order was transcribed in the MAR, there was the potential for Resident #55 to be given a double dose of the same medication on Sundays, if not rectified. On 2/1/2024 at 1:18 PM, in an interview with Resident #55's nurse, Licensed Practical Nurse, LPN #4, surveyor reviewed the resident's Risperdal orders, MAR for February 2024, and psych notes of 1/31/2024. LPN #4 verified and confirmed that the order for Risperdal Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth two times a day for Dementia with psychosis was not specific regarding the days of administration, thus creating the potential for duplicate medication administration on Sundays. LPN #4 stated that she was going to follow up with the Psych CRNP for order clarification. On 2/1/2024 at 1:50 PM, in an interview with the Director of Nursing (DON), surveyor reviewed the psych notes dated 1/31/2024, active orders and MAR for February 2024 related to Risperdal administration. DON confirmed that, based on the orders, there was the potential for Resident #55 getting double doses of Risperdal on Sundays. She stated she was going to follow up right away. On 2/1/2024 at 2:05 PM, the surveyor observed that Resident #55's active orders had been revised and the order for Risperdal 0.5 MG modified to reflect days to be given: Risperdal Oral Tablet 0.5 MG (Risperidone) Give 1 tablet by mouth two times a day every Mon, Tue, Wed, Thu, Fri, Sat for Dementia with psychosis, order date of 2/01/24.

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NAME OF PROVIDER OR SUPPLIER: Largo Nursing and Rehabiliation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 Largo Road Glenarden, MD 20774	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on observation, medical record review, and interview, it was determined the facility failed to: 1) implement preventative measures to prevent the development of pressure ulcers. This was evident for 3 (Resident #169 and #370, #30) out of 9 residents reviewed for pressure ulcers during the survey; and 2) ensure the Hoyer lift sling was removed from under a resident (Resident #31) when the Hoyer lift was used to assist the resident's transfer between surfaces. This was evident for 1 of 23 complaints investigated during the survey. The findings include: A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). Deep tissue injury (DTI) pressure ulcers are defined as 'purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear' (Centers for Diseases Control and Preventions) 1) On 1/09/24 at 12:36 PM, the surveyor observed that Resident #169 had a dressing on the right ear and was lying on the left in a tilted position. On 1/12/24 at 11:34 AM, a review of the medical record for Resident #169 revealed that the resident was admitted into the facility in October 2023 with a stage 3 pressure ulcer on sacrum and DTI pressure ulcer on left heel. The facility's wound documentation revealed that a wound evaluation was conducted weekly upon the resident's admission and the sacrum ulcer was unstageable and worsening. A wound note, dated 12/05/23, indicated that a new stage 2 pressure wound was noted on Resident #169's left ear, and the sacrum pressure wound was evaluated as stage 4 on 12/19/23. Also, the record review revealed that Resident #169 was transferred to hospital on 12/21/23 and readmitted on [DATE] with several wounds: stage 4 on sacrum, DTI on right and left heels, state 3 pressure wound on right ear, stage 3 pressure wound on left ear, DTI on right medial knee, and skin abrasion on right and left legs. On 1/17/24 around noon and 2:30 PM, two surveyors observed that Resident #169 was lying on a left tilted position. An interview was conducted with Licensed Practical Nurse (LPN #20) on 1/17/24 at 11:32 AM. LPN #20 confirmed that the GNAs did the position changes for the residents. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 10:16 AM and 12:20 PM on 1/22/24, the surveyor observed Resident #169 was lying in a left tilted position which was exactly same as was observed on 1/17/24. A Geriatric Nurse Assistant (GNA # 21) was interviewed on 1/22/24 at 12:30 PM. GNA #21 stated she turned Resident #169 every 2 hours, and said I did at 8 AM, 10 AM, and just now I turned him/her on right side. The surveyor informed GNA #21 that the resident was exact same position as 10:16 AM. GNA #21 responded, she/he may turn her/himself While the surveyor interviewed GNA #21 on 1/22/24 at 12:30 PM, the unit manager (Staff #7) joined. GNA #21 asked Staff #7, did you turn Resident #169? Then, both them told the surveyor that the resident preferred to turn left side. The surveyor asked them since Resident #169 was nonverbal how the resident indicated his/her preference. Both of GNA #21 and Staff #7 answered, she/he can turn her/himself. The surveyor asked Staff #36 (Director of Rehab) on 1/22/24 at 12:36 PM whether Resident #169 had capability to do position change or rolled over. Staff #36 confirmed that the resident was totally dependent, unable to change their position. During an interview with a Wound nurse (Staff #25) on 1/22/24 at 1:26 PM, she confirmed that Resident #169 was not able to turn him/herself at all. She said, even through during the dressing changes, we need to turn him/her. Also, Staff #25 stated that since Resident #169 had multiple wounds, repositioning would be the best way to prevent wound worsening. On 1/22/24 at 2:10 PM, the Director of Nursing (DON) was informed of the above concerns. 2) On 2/01/24 at 7:47 AM, the surveyor investigated one complaint in which that the complainant claimed that Resident #370 had an unstageable wound on the sacrum and Deep Tissue Injury (DTI) on both heels, which were avoidable. Further review of Resident #370's medical record revealed that the resident had a 9.0 cm x 4.0 cm open area on Right buttock and 6.0 cm x 2.0 cm open area on sacrum, upon admission on 12/07/21. Additionally, the wound consult team assessed Resident #370 on 12/14/21 and listed: suspected DTI on Right heel and Left heel, and unstageable pressure ulcer on sacrum. A progress note documented by a wound nurse on 12/15/21 stated, pressure reduction and turning precaution discussed with staff at time of visit recommended, including heel protection and pressure reduction to bony prominences. Staff educated on all aspects of care. However, there was no documentation to support that the facility applied an intervention to reduce Resident #370's heel pressure as wound nurse recommended. During an interview with Licensed Practical Nurse (LPN #25) on 2/01/24 at 9:05 AM, LPN #25 stated that DTI would be preventable with floating heels and repositioning frequently. During an interview with the Director of Nursing (DON) on 2/01/24 at 2:00 PM, the surveyor shared concerns regarding Resident #370's preventable heel wound. The DON validated the above concerns. 47200 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 1/29/24 at 1:48PM, the surveyor reviewed the medical record of Resident #30 which revealed documented history of a stage 3 pressure ulcer to their heel. On 1/30/24 at 12:53PM, the surveyor conducted an interview with Staff #25, Wound Nurse, Licensed Practical Nurse, who reported to the surveyor that Resident #30 had off and on plantar (sole of the foot) wounds. On 1/30/24 at 1:04PM, Staff #9, Licensed Practical Nurse, accompanied the surveyor to observe Resident #30, who was in their bed with one specialty boot on their right lower extremity, no specialty boot on the left lower extremity and their heel was not elevated. At this time, Resident #30 asked the surveyor: Can you please order me another boot? Staff #9 reported to the surveyor: s/he only has one boot. The surveyor then observed a second specialty boot located in the corner of the resident's room. The surveyor observed Staff #9 obtain the boot and place it on the Resident's left lower extremity. On 1/30/24 at 1:09PM, the surveyor reviewed the medical record which revealed the following active medical orders signed off by nursing staff on the January 2024 treatment administration record for Resident #30: Specialty boots to be worn at all times every shift, and Float bilateral heels at all times while in bed and in wheelchair to off load pressure from heels, every shift for monitoring, and Turn and reposition every 2 hrs and prn (as needed.) 4) On 1/11/24 at 11:07AM the surveyor conducted an interview of Resident #31, who was sitting in their wheelchair, repeating: it hurts, it hurts. At this time, the surveyor observed the resident was sitting directly on the hoyer sling, canvas type material and canvas type straps wrapped under their thighs with two hard rectangular plastic type pieces. The surveyor observed a pressure relief cushion located beneath the canvas material the resident was sitting on. On 2/5/24 at 11:46AM the surveyor observed Resident #31 sitting directly on the hoyer sling canvas type material with the hard rectangular pieces attached to it. On 2/5/24 at 11:58AM the surveyor requested Staff #9, Licensed Practical Nurse, to observe Resident #31. At this time, the surveyor shared their concern, and Staff #9 observed and acknowledged the concern. Staff #9 reported the following to the surveyor: It's difficult to remove that (hoyer sling) from under her/him once s/he is in the chair, but we will have to figure out a way to do that because s/he is sitting on that with the skin issues. On 2/5/24 at 11:59AM, the surveyor conducted an interview with Staff #8, Unit Manager, 2nd floor, Licensed Practical Nurse and shared their concern. Staff #8 confirmed understanding of the concern at this time. On 2/5/24 at 1:07PM, the surveyor reviewed the medical record which revealed that, on 10/28/23, the Nurse Practitioner documented the resident was staying in their wheelchair most of the day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record on 2/6/24 at 11:27AM revealed Resident #31's hospital discharge summary dated 10/17/23, which documented their history of the following diagnoses: 1.) Decubitis ulcer of buttock, 2.) skin irritation, and 3.) Decubitis ulcer of thigh. Further review of the medical record revealed various skin observation tools which documented history of rashes to the resident's bilateral buttocks and rear thighs and the following active medical order in place: Pressure redistribution devices: Cushion in wheelchair, check q (every) shift for pressure redistribution.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47200 Based on observation, record review, and interview of facility staff, it was determined the facility failed to: 1) ensure medications and hazardous items were safely and securely stored and limit access to authorized personnel only. This was evident for two of three units observed; 2) investigate the root cause of the falls and initiate nursing interventions to prevent further falls, and 3) assess resident's fall risk regularly before actual fall incidents. This was evident for two (Resident #38 and # 323) of five residents reviewed for falls during the annual survey. As a result of the findings of unsecured medications and hazardous items, a state of immediate jeopardy was declared on 1/12/24 at 4:45 PM and communicated to the facility Administrator at 4:48PM. An immediate jeopardy summary tool was provided to the facility at 4:51PM. The facility submitted a plan to remove the immediacy on 1/12/24 at 6:59PM that was rejected; another plan at 10:04PM that was rejected; another plan at 11:03PM that was rejected; another plan at 11:21PM that was rejected; and another plan was presented at 11:31 PM and was accepted by the state agency 11:59 PM on 1/12/2024. After removal of the immediacy, the deficient practice remained with a scope and severity of E. The findings include: 1. On 1/12/24 at 9:53 AM Staff #8, Unit Manager, 2nd floor, Licensed Practical Nurse, showed the surveyor to a room labeled the central supply room located on floor 2, on the Independence hallway and proceeded to push the door open and enter the room without use of the keycode pad located on the front of the door. Staff #8 verbalized to the surveyor that this room was the medication room. On 1/12/24 at 9:53 AM the surveyor observed various medications and supplies in the room labeled the central supply room located on floor 2, on the Independence hallway; including but not limited to: aspirin, acetaminophen, naproxen, guaifenesin oral solution, vitamin C, vitamin B, vitamin D, vitamin E, milk of magnesia, Dakin's solution, calcium tablets, povidone iodine 10% solution, multivitamins, multivitamins with iron, Claritin, senna, aspercreme, fexofenadine, carbamide peroxide, bacitracin zinc ointment, hydrogen peroxide 3%, simethicone, acetaminophen suppositories, melatonin, iron, folic acid, bisacodyl, sodium chloride tablets, calcium citrate, cetirizine, insulin needle supply, hypodermic needle supply, tuberculin syringes, packages of twin blade shaving razors supply, and bandage scissors. On 1/12/24 at 9:56AM the surveyor observed Staff #16, Staffing Coordinator, immediately open the door to the room labeled the central supply room located on floor 2, on the Independence hallway without use of the keypad. On 1/12/24 the surveyor observed Resident #91 utilizing their wheelchair to leave the [NAME] Wing Unit hall. Upon record review the resident was noted to have a history of stroke, and dementia diagnosis documented in the medical record on 10/6/23 as well as a BIMS (brief interview of mental status, an assessment of cognitive impairment) score of 9 out of 15, indicating moderate cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/12/24 at 10:11AM surveyors conducted a dual observation of the contents of the central supply room located on floor 2, on the Independence hallway. On 1/12/24 at 10:12AM surveyors observed all units for medication storage. On 1/12/24 at 10:20AM surveyors approached the first-floor medication room door and found the door had not been shut and was left ajar, allowing the door to easily be pushed open for entry. Upon entry to the room, surveyors observed the medication refrigerator with a padlock hanging on the left side which was unlocked and able to be opened. Upon opening the refrigerator, surveyors observed it to contain the following: insulins, lidocaine injection, pneumovax, flu vaccines, TB test solution, triamcinolone, and bags of intravenous intralipids 20%. On 1/12/24 at 10:36AM surveyors approached the first-floor supply room door which was observed to be shut, with a keypad present, however, the door handle freely allowed entry to the room without use of the keypad, allowing entry. Surveyors observed the following supplies within the room: syringes, blood test tubes/vacutainers, bag containing heparin lock flushes 50 USP units/5ml, and needles On 1/12/24 at 11:23AM the surveyor conducted another observation of the door to the 2nd floor central supply room on the Independence hallway, which did not require keypad use to open the door despite the door being tightly shut. The keypad was observed to light up when keys were pressed, however, the door was unable to lock. On 1/12/24 at 12:25PM the surveyor conducted an interview with, Licensed Practical Nurse (LPN) #9, who reported that Resident #69, was among other residents on the unit who have the ability to ambulate, required supervision due to cognitive deficits. Upon record review Resident #69 was noted to have a BIMS score of 0 out of 15 indicating severe cognitive impairment as documented in the medical record on 12/28/23. On 1/12/24 at 12:33PM the surveyor observed the 2nd floor maintenance log which revealed on 6/27/23 the keypad to the 2nd floor central supply room was reported as not working. On 1/12/24 at 12:40PM the surveyor conducted another interview with LPN #9 who confirmed they reported the request in the maintenance log. LPN #9 reported to the surveyor that the 2nd floor central supply room door had not been locking for approximately two months. On 1/12/24 at 12:45PM the surveyor observed Resident #69 ambulating without the use of an assistive device into the central bath/shower room. The unlocked central supply room was accessible at this time in the adjacent hallway. On 1/12/24 at approximately 3:19PM, surveyors observed Resident #88 ambulating in the hallway near the central supply storage room. Upon review of the medical record, Resident #88 was noted as an elopement/wander risk with impaired cognitive functioning, dementia diagnosis, and a BIMS score of 5 out of 15 indicating severe cognitive impairment , whose room was found to be located near the central supply room. On 1/12/24 at 4:54PM the Director of Nursing (DON) communicated to the surveyors that the facility had decided to use the 2nd floor medication room instead of the central supply room for medication storage. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of these findings, a state of immediate jeopardy was declared on 1/12/24 at 4:45PM. The provision of the plan to remove the immediacy had a completion date of 1/14/24 and included: a A 100% audit of all medication rooms and supply rooms have been conducted by the Administrator, Maintenance Director and DON to ensure medications and hazardous items were safely and securely stored. This was completed on 01.12.2024. b. The lock to the central supply room on the 2nd floor located on Independence unit has been replaced with a new code by maintenance staff on 01.12.2024 and is currently secured. Only authorized staff will be allowed access to this room. c. The nurse managers immediately removed all the over-the-counter medications from the central supply room on Independence unit and secured them in the 2nd floor medication room nearest to the nurses' station on 01.12.2024. d. All insulin needles, hypodermic needles, tuberculin syringes, twin blade shaving razors, and bandage scissors are all currently safely secured in the 2nd floor central supply room on the Independence unit as of 01.12.24. e. The door to the 1st floor medication room has been repaired and is secured. Education with all licensed nurses has been initiated effective 01.12.24 and will be completed by 01.14.24. Training is being conducted by the Staff development nurse, ADON, and DON to ensure the refrigerator is kept locked when not in use. f. The door to the 1st floor supply room across from rehab gym is repaired, locked, and code changed. Education with all licensed nurses has been initiated effective 01.12.24 and will be completed by 01.14.24. Training is being conducted by the Staff development nurse, ADON, and DON to ensure the supply room is kept locked when not in use. g. As a result of the findings of the audit conducted by the facility staff on 01.12.24, a Staff member was immediately stationed outside each door that did not lock appropriately until the repairs were completed by maintenance. h. Training with licensed nurses, housekeeping staff, and Maintenance staff was initiated by the Staff Development nurse on 01.12.24 to make certain that the staff pulls the door shut when exiting to ensure all medications and hazardous items are kept safe and secure, and to notify the Administrator and Maintenance director immediately if any door is identified as in need of repair. This will be completed by 01.14.24. i. The Administrator and Maintenance director will validate all supply rooms and medication room doors are repaired and secured effective 01.12.24. j. The Unit managers and nursing supervisors will inspect all supply rooms and medication rooms to ensure all medications and hazardous materials are properly secured and in compliance every shift X 7 days, then daily X30 days. k. Results of the audits will be submitted to the QAPI committee for further review and recommendations as needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After on-site confirmation of the completion of the facility's plan of removal on 1/18/2024, the Immediate Jeopardy was removed on 1/14/2024. 43096 2. Reviewing Resident #38's medical record on 02/01/24 revealed that the facility documented a form named 72 hours. Post fall documentation on 10/11/23. The form indicated that Resident #38 had a fall from a bed on 9/24/23 at 6 AM. Further review of the resident's progress note revealed that a Licensed Practical Nurse (LPN) documented that Resident was noted with an open area and swelling to the left upper cheek close to the eye area and opening to the left knee on 9/24/23 at 10:30 AM. However, no documentation was found to indicate the cause of Resident #38's swelling and openings near the eyes. During an interview with the Director of Nursing (DON) on 2/05/24 at 9:25 AM, the DON stated that a night shift nurse who initially found Resident #38's changes on 9/24/23 did not report a fall. The DON explained, When a day shift nurse brought this issue to me, I contacted the night nurse and confirmed that the resident had a fall which resulted in swelling to the left cheek to the knee on 9/24/23. Also, the DON added that whoever has a fall, the facility would do a fall assessment, notify the provider and responsible party, and document details. However, there was no documentation to support this injury caused by a fall and/or investigation of the fall incident and interventions to prevent possible falls. 3. A review of Resident #323's medical record on 02/02/24 revealed that Resident #323 was found by nursing staff on 3/29/23 around 6:45 PM lying face down on the floor noted with left forehead bump and a small laceration on the right upper-end eyebrow with small amount of blood. Further review of Resident #323's medical records revealed that the facility assessed the resident's fall risk with a tool named Morse falls scale as below: On 2/25/22, the score was 35 as a moderate risk for fall On 5/25/22, the score was 35 as a moderate risk for fall. On 7/16/22, the score was 50, which was a high-risk fall. On 8/03/22, the score was 20, which was a low-risk fall. On 8/18/22, the score was 20, which meant it was a low-risk fall. On 12/12/22, the facility assessed Resident #323 with a form named falls risk tool. This form included the resident's medication category, orthostatic changes with vital signs, admitted , and date of last fall. However, the form did not list mobility status, unsafe behavior, and fall risk level or score. During an interview with the Director of Nursing (DON) on 2/02/24 at 10:30 AM, the DON stated that the facility staff assessed each resident's fall risk quarterly and documented it under electronic medical records. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/05/24 at 9:30 AM, the surveyor reviewed Resident #323's fall assessments with the DON. The most recent fall assessment prior to the fall incident (3/29/23) was 12/12/22, which did not indicate the level of fall risk and/or the resident's health condition, which could affect the resident's fall risk. The surveyor asked DON how the facility staff recognized Resident #323's fall risk from the 12/12/22 fall assessment. The DON stated, We did fall assessment quarterly, but the form name changed. The surveyor pointed out that the assessment date was 12/22/22, and the incident occurred on 3/29/23 (more than 3 months ago). No additional documentation was submitted to the surveyor team, and the DON validated the surveyor's concerns regarding the lack of fall assessment for Resident #323.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on medical record review, staff interview, and observation, it was determined that the facility failed to provide appropriate treatment and services upon admission for the care of a resident with an indwelling catheter. This was evident for 1 (Resident #57) of 4 residents reviewed for Foley catheter during the survey. The findings include: A Foley catheter is a thin, sterile tube inserted into the bladder to drain urine. Always place the drainage bag below the level of the bladder and off the floor to prevent infections. (Foley catheter definition on www. merriam-webster.com) A review of Resident #169's medical record on 1/17/24 at 11:51 AM revealed that the resident was readmitted to the facility on [DATE] from an acute care facility with a Foley catheter. A review of the resident's discharge summary from the hospital, dated 1/05/24, indicated that the resident's urine culture grew Proteus Mirabilis (a common pathogen responsible for complicated Urinary Tract Infections). Further review of Resident #169's medical records revealed that an admission note written by a provider, dated 1/05/24, listed the indwelling catheter as catheter 16French (size of the catheter). Prevention of contamination of a wound. However, the order was placed on 1/09/24 for Foley catheter care every shift. There was no other supportive documentation that the facility staff provided the Foley catheter care for Resident #169 from 1/05/24 to 1/08/24. During an interview with a Licensed Practical Nurse (LPN # 20) on 1/18/24 at 11:29 AM, LPN #20 stated that nurses did Foley catheter care, including changing, site cleaning, and in-place check, and nurse assistants emptied the bag. Also, LPN #20 confirmed that orders were required for the Foley catheter care. During an interview with the Director of Nursing (DON) on 1/18/24 at 1:19 PM, the surveyor shared concerns about Resident #169's Foley catheter care. The DON validated the concerns.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 48168 Based on observations, record review, and interviews, it was determined that the facility failed to recognize, evaluate, and manage residents' pain. This was evident for 1 Resident (#50) reviewed for pain during the survey. The findings include: On 1/08/24 at approximately 10:00 AM, Resident #50 was observed moaning and yelling out, with a facial grimace, and although the resident opened their eyes they did not respond in any other way. Staff were observed nearby in the hallway, but did not enter the room. On 1/08/24 at 2:00 PM, Resident #50 was observed in their room and their moaning could be heard in the hallway. Licensed Practical Nurse (LPN#5) was in the hallway and was asked if she knew about the resident's moaning. She replied that the resident had a pressure ulcer and was probably in pain. On 1/09/24 at 10:30 AM, another observation outside Resident #50's room was made. The door was closed, and the resident could be heard moaning. Staff entered the resident's room and closed the door. The resident continued moaning and the moaning became louder. On 1/10/24 at 8:52 AM, a record review revealed that Resident #50 was admitted in December 2023. The admission nursing assessment indicated that the resident had nearly constant severe pain. On 1/10/24 at 9:50 AM in another observation of Resident #50, the resident was lying in bed with their eyes closed and they were moaning. When the surveyor called the resident's name, there was no response, the resident continued moaning. The surveyor immediately left the resident room and informed the Unit Manager (LPN#53) that the resident was observed moaning multiple times since 1/08/24. Staff #53 said she would follow up. On 1/12/24 at 8:35 AM, a record review revealed that Resident #50 was transferred via 911 to the hospital on 1/10/24 at 5:20 pm due to being slow to respond. Further record review revealed that only 2 pain assessments were documented in the medical record: 12/11/23 and 1/10/24. A review of the resident's Medication Administration Record (MAR) revealed that the resident received pain medication one time per day prior to their pressure ulcer dressing change, and although there was on order to give additional pain medication on as needed basis, as often as every 8 hours, the resident received only 2 of these as needed doses, once on 1/02/24, and once on 1/09/24. On 1/22/24 at 11:26 AM, an interview with the Director of Nursing (DON) was conducted. The surveyor asked about Resident #50's transfer to the hospital on 10/10/24. The DON stated that, on 1/10/24 after the surveyor questioned the resident's frequent moaning, the DON called Resident #50's physician. The DON explained that the physician gave orders for a psychiatric consult, bloodwork, and a medication for behavior management. The DON also explained that later that same day the resident was assessed to be less responsive, so the nurse practitioner (NP) was notified, and the NP gave an order to transfer the resident to the nearest emergency room for evaluation. When asked for additional evidence of pain assessments for the resident, the DON said she would look. No additional evidence was provided by the end of the survey.

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F 0710

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.

31982

Based on medical record review and interview with staff, it was determined the facility staff failed to ensure that the care of each resident was supervised by a physician. This was evident for 1 (#18) of 3 residents reviewed for hospitalization , and for 1 (#96) of 7 residents reviewed for nutrition during the survey.

The findings include:

1) Resident #18's medical record was reviewed on 1/12/24 at 12:28 PM. The record revealed the residents diagnoses included but were not limited to Paranoid Schizophrenia, Major Depressive Disorder and Anxiety Disorder.

A progress note, written 6/22/23 at 15:23 (3:23 PM) by Staff #59 a Licensed Practical Nurse (LPN), indicated ER Transfer. Around 2:05 pm, Three sheriffs arrived the facility with court order to transfer resident to ER/psych unit. (Staff #58, the Physician), present at the facility when they arrived. Paramedics later came with the stretcher to transfer. Sheriffs/Paramedics transferred resident on the stretcher to (the hospital) around 2:30 PM.

The record failed to reveal documentation by a physician regarding resident #18's condition or transfer to the hospital on 6/22/23.

In an interview on 1/24/24 at 12:16 PM, Staff #2 confirmed she was Resident #18's Social Worker. She explained when asked, that on 6/22/23, Resident #18 went to the dining room and was slamming glassware and silverware onto the floor, picked some up, took it to his/her room and was threatening to hurt others. Staff #2 indicated she completed a petition for the resident to have an emergency evaluation at the hospital, took the petition to the county courthouse at approximately 11AM or 12 noon. It was reviewed by a judge and court order was issued. The police arrived around 3 PM and transported Resident #18 to the emergency room for a psychiatric evaluation.

On 1/24/24 at 1:15 PM, the Director of Nursing (DON) failed to provide evidence that the residents care was supervised by a physician during the events leading up to and resulting in his/her hospital transfer including, but not limited to, an assessment, discharge summary and a physician order for transfer.

On 1/25/24 at 10:54 AM, the DON referred to the nursing progress note written 6/22/23 at 15:23 (3:23 PM) by Staff #59 and indicated that the physician, Staff #58, was present in the facility when the 3 sheriffs arrived. She confirmed when asked, that there was no evidence the physician supervised the resident's care on 6/22/23 such as an assessment of the resident, the resident's condition, the need for a hospital evaluation, or an order to transfer Resident #18 to the hospital.

On 02/02/24 01:23 PM The above concerns were reviewed with the Administrator and Director of nursing.

43096

(continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During an interview with Resident #96 on 1/08/24 at 10:30 AM, the resident stated that he/she experienced some weight loss. On 1/22/24 at 8:34 AM, a review of Resident #96's medical record revealed that the resident was admitted to the facility in November 2022 and had a new diagnosis of Oral cancer in July 2023. Further review of Resident #96's body weight records revealed that the resident's initial body weight was 131 lbs. (pounds) on 11/17/22. And further body weight was documented as below: 1/11/23: body weight was 122 lbs. (6.87% loss) 1/18/23: body weight was 117.4 lbs. 8/02/23: body weight was 124.8 lbs. 9/03/23: body weight was 108.2 lbs. (15.34% loss within a month) 10/01/23: body weight was 105.8 lbs. 10/16/23: body weight was 119.6 lbs. (13.04 % weight gain within two weeks) 11/02/23: body weight was 137.4 lbs. (14.88% weight gain within two weeks) 12/12/23: body weight was 105.4 lbs. (23.29 % weight loss within 40 days) On 1/22/24 at 10:00 AM, a review of Resident #96's medical records revealed that a dietitian wrote a nutrition/dietary note dated 1/25/23 indicating the resident's significant weight loss and recommended providing fluid and hydration. Also, the dietitian mentioned that notify MD (provider) and RP (Representative Party). Another note from the dietitian, dated 9/07/23, stated that Resident #96's weight loss was identified and continued plan of care and continued to monitor. The note, dated 12/18/23, written by the dietitian indicated that the resident's weight loss was related to cancer of the mouth and recommended to continue to monitor the resident's nutrition. However, there was no documentation from the provider about Resident #96's significant weight loss. During an interview with a Licensed Practical Nurse (LPN #51) on 1/22/24 at 10:18 AM, the LPN explained that residents' weight changes should be reported to the dietitian, and the dietitian would call doctors and receive orders and interventions. Also, LPN #51 stated the dietitian and doctors would document details. In an interview with a dietitian (Staff #6) on 1/22/24 at 10:36 AM, Staff #6 recalled Resident #96's status as the resident was expected to have significant weight loss due to mouth cancer. Also, Staff #6 stated that the facility's care team, including nursing staff, social workers, and doctors, reported residents' weight loss to the dietitian, and the issue would be discussed with the care team at the risk meeting and documented in the resident's medical record. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/24 at 1:18 PM, an interview was conducted with the Medical Director (Staff #22). Staff #22 insisted that residents' significant weight changes (including weight loss and gain) should be reported to the attending physician, and he/she was supposed to document them in the medical record. However, Resident #96's medical record review on 1/22/24 revealed no documentation from the physician about the resident's weight changes. During an interview with the Director of Nursing (DON) on 1/24/24 at 1:53 PM, the DON provided a copy of the provider's note, dated 12/05/23, that referenced Resident #96's weight loss. However, the electronic medical record revealed documentation of the resident's body weight on 12/12/23, which was seven days after the provider's note was written. The surveyor reviewed the note with the DON, and the DON validated the above concerns.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 47200 Based on record review and interview, it was determined the facility failed to ensure physician evaluation of a resident's current medication regimen. This was evident for 1 out of 7 (Resident #1) residents reviewed for unnecessary medications during the facility's recertification survey. The findings include: On 1/19/24 at 2:33PM, the surveyor conducted a review of the medical record which revealed documentation by Staff #43, Physician, for Resident #1's visit note, dated 12/21/23, for a chief complaint of Diabetes Mellitus. The surveyor noted the provider's documented current medication list on their visit note did not match the active medical orders for medications for the resident. Upon further review, the visit note was found to document discussion of the treatment plan with the resident, which included the following: DM (Diabetes Mellitus) well controlled, continue with diabetic diet, continue with Lantus (Insulin medication) and Metformin (medication.) However, upon surveyor review of the resident's medication orders, they were no longer taking these medications. On 1/30/24 at 3:10PM, the surveyor conducted an interview with Staff #43. During the interview, Staff #43 confirmed with the surveyor that the resident was not taking the following medications: Lantus, and Metformin, and the medication list in their note was inaccurate.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 43096 Based on interviews with residents and staff interview, and a review of the facility's documentation, it was determined that the facility failed to have sufficient nursing staff to meet the needs of the residents. This was evident for 3 of 23 complaints submitted to the Office of Health Care Quality (OHCQ), the regulatory agency and 7 (Resident #3, #18, #39, #67, #72, #109, and #272) of 10 interviewable residents, and 3 out of 5 staff interviews. The findings include: 1) Three of twenty-three complaints that the Office of Health Care Quality (OHCQ) received and reviewed on this complaint survey alleged the facility did not have sufficient nursing staff to provide essential care to the residents who resided at the facility. The surveyor reviewed these complaints on 1/24/24. a) A portion of a complaint revealed that Resident #2 was left in the room for more than 2 hours wet with urine. b) A complaint reported in August 2022 stated that Resident #318 did not receive medication timely. A family member witnessed it and verified that there was only one nurse was available for the multi-floor facility. c) A complainant reported in April 2023 that Resident #29 was found heavily soiled and insisted the facility staff did not change the resident. 2) Resident interviews: 2a) During an interview with Resident #72 on 1/08/24 at 10:29 AM, the resident stated, Sometimes he/she didn't get bathed or changed. Staff who worked 11 PM -7 AM, I didn't even see them till about 5-5:30 AM. 2b) On 1/08/24 at 10:54 AM, Resident #109 reported that she/he needed to call the staff with their cell phone, but they hung up on them. It took two hours to get a response from the staff. 2c) In an interview with Resident #18 on 1/09/24 at 11:09 AM, he/she stated it took about 2 hours or longer to respond to the call bell. 2d) On 1/09/24 at 1:10 PM, Resident #39 said, I did not get medication on the 3 PM -11 PM shift. Put the call light on at 3 AM, but nobody came to the room till 6 AM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2e) On 1/26/24 at 11:34 AM, an interview was conducted with the resident council Present (Resident #272) and Resident #3, who had been attending meetings regularly. Resident #272 stated that residents shared concerns about short staffing on weekends. Additionally, Resident #3 stated that he/she had asked staff to get out of bed during weekends, but they did not have staff who could do it for them. Resident #3 said, Weekend staffing was short, and the residents who are dependent on staff remained in bed all weekend. 3) Staff Interviews: a) On 1/31/24 at 10:52 AM, an interview was conducted with Licensed Practical Nurse (LPN) #4. LPN #4 stated that sometimes the facility staff needed to expand their work by a few hours to complete their assigned work. He/she said, Several times, I stayed until 5 PM when I worked the day shift (7 AM- 3 PM) to finish my charting. When we are short staff, I don't have enough time to give medications to residents. b) During an interview with Geriatric Nurse Assistant (GNA) #45 on 1/31/24 at 11:09 AM, GNA #45 confirmed that the facility assigned two or three GNAs for the unit even though they were supposed to have four GNAs on the shift. GNA #45 insisted, We experienced burnout while caring for residents due to low staffing. It is common to assign just one GNA when the unit has 38 residents. c) In an interview with GNA #44 on 1/31/24 at 11:22 AM, GNA #44 stated that he/she experienced low staffing in the building commonly. GNA #44 insisted that low staffing issues affected residents' care, like changing, assisting with feeding, and/or responding to call bells. During an interview with the Director of Nursing (DON) on 1/31/24 at 1:59 PM, the surveyor shared concerns about insufficient staffing with the DON. The DON validated the surveyor's concerns.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43096 Based on a review of employee files and interviews, it was determined that the facility failed to put a system in place to ensure Licensed Practical Nurses (LPNs) and Geriatric Nursing Assistants (GNAs) were competent with their skill sets. This was found to be evident for 3 (one LPN and two GNAs) out of 5 employee files reviewed for competencies and skill sets. The findings include: On 1/30/24 at 9:04 AM, a review of employee files was conducted for GNAs #40 and #42, LPN #5, #41, and #53. The review of employee files reveals that they did not have documentation to support that they completed their competency skills and techniques to provide safe care to the residents. a. GNA #42 was hired in October 2021. However, there was no competency skills and techniques evaluation in his/her employee file. b. GNA #40 was hired in July 2019. No competency skills and techniques evaluation were in his/her file. c. LPN #41 was hired in April 2020. LPN #41 had competency skills evaluation records for some areas. However, there was no supportive evidence to prove medication administration, physician order, and foley insertion skills were validated or not. During an interview with Staff #23 (Educator) on 1/30/24 at 11:56 AM, Staff #23 explained that the facility had competency tools for GNAs and nurses. Also, Staff #23 confirmed that they evaluated the newly hired staff's competency (the Director of Nursing provided) and annual and additional competencies offered by the educator. The surveyor informed Staff #23 that the employee files did not have GNAs' and nurses' competencies. Staff #23 said, Competency evaluation should be done yearly. However, when I started, there was no previous documentation. I started to catch up. Staff #23 verified that she started her educator role at this facility in May 2023. In an interview with the Director of Nursing (DON) on 1/30/24 at 4:14 PM, the DON stated that prior to Staff #23 starting in May 2023, the DON provided education, and Human Resources filed the records. The DON stated, I will ask HR to find these competency records. On 1/31/24 at 8:21 AM, the DON submitted copies of nurses' competency records. However, there was no record for LPN #41. The DON validated the surveyor's concern about competency records.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 43096 Based on a review of Geriatric Nursing Assistant (GNA) employee records and staff interviews, it was determined the facility failed to conduct yearly performance reviews at least every 12 months. This was evident for 2 (GNA # 40 and #42) out of 2 GNAs records reviewed during this survey. The findings include: On 1/30/24 at 9:04 AM, in an interview with the Director of Nursing (DON) and Human Resources (Staff #47), the surveyor requested employee files for two randomly selected facility GNAs. A review of these records revealed that: GNA #40 was hired in July 2019. There was only one performance evaluation in 2019, and no further evaluations were documented. GNA #42 was hired in October 2021. There was one performance evaluation in January 2024 and no additional evaluation since his/her hire. On 1/30/24 at 3:10 AM, in an interview with Staff #23 (educator), she stated that the educator did GNA's performance review yearly, and the records were filed in the employees' chart. During an interview with the Director of Nursing (DON) on 1/30/24 at 4:14 PM, the DON confirmed that nurse aides' performance should be reviewed annually. Also, the DON verified that before the facility hired Staff #23, the DON conducted a performance review. The surveyor requested the DON to submit a performance evaluation for GNA #40 and #42. No additional records were submitted to the surveyor team. The DON validated the above concerns on 1/31/24 at 1:59 PM.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 48168 Based on observations and interviews, it was determined that the facility failed to post nursing staffing for the entire building. This was observed during the survey. The findings include: On 1/08/24 at 9:01 AM, an observation of the facility's main lobby was conducted. No staffing posting was found in the lobby at that time. On 1/26/24 at 8:37 AM, a tour of the 1st and 2nd floor nursing units was conducted to look for Nursing Staffing Posting. No posting was seen on any of the 1st or 2nd floor nurses stations. On 1/26/24 at 8:53 AM, in an interview with the Minimum Data Set (MDS) Registered Nurse (Staff #14) who was standing near the 1st floor nursing station, Staff #14 was asked if he knew where the facility staffing was posted and he replied that he did not know. On 1/26/24 at 8:55 AM, an interview with the Staffing Coordinator, Staff #16, was conducted. When asked where the Federal staffing posting was, he said that he had all the nursing staff schedules on his computer, and he also invited the surveyor to the staff room where he showed the surveyor the nursing staff assignments posted on the wall. He explained staff referred to this posting to know which unit to report to when they arrived for work. He also stated that each unit posts nursing staffing for each shift on their respective units. Staff #16 said that he does not post the staffing numbers for the entire facility in one place, I have not been told to do that. On 1/26/24 at 10:14 AM, an interview with the receptionist, Staff #57 was conducted. When asked where the staffing was posted, she took a paper that was stuck to the wall behind her desk and handed it to the surveyor. The form contained a printed list of staff assignments broken down by each unit and each shift and included staff names, credentials, and shift hours, and it also indicated the shift supervisor's name and hours worked. Staff #57 said that there was no other type of staffing posting. The total number of staff by their credential nor the resident census, was readily apparent when viewing the form. On 1/26/24 at 11:12 AM, in an interview with Administrator regarding where the federal staffing posting was located, he answered that staffing was posted on each unit and since there were renovations going on, it might be in a different place than usual. When the surveyor explained that the facility postings on each unit met the state required posting but not the federally required posting, he said he would look into it. No federal staffing posting was found in the facility. No additional information was provided by the end of the survey.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 31982 Based on review of the medical record and interview with staff, it was determined the facility staff failed to identify and provide appropriate treatment and services to assist residents in attaining their highest practicable mental health. This was evident for 1 (#18) of 4 residents reviewed for Behavioral-Emotional. The findings include: Resident #18's medical record was reviewed on 1/12/24 at 12:28 PM. The record revealed Resident 18's diagnoses included, but were not limited to, Paranoid Schizophrenia, Major Depressive Disorder and Anxiety Disorder. A nursing progress note, dated 6/20/23 20:07 (8:07pm), indicated that Resident #18 was sitting in a wheelchair in the hallway, stood up and exposed his/her buttocks to other residents and started cursing at staff and making finger sign. Patient made aware behavior unacceptable, keeps on saying I need my cigarettes, per Aide, patient doesn't have a cigarettes in the cart. A nursing progress note on 6/20/23 at 21:15 (9:15pm) indicated the resident inquired about a 2 liter soda when restaurant food was delivered. When staff informed him/her that it was not delivered, the resident became very agitated, went into the nurse's station and threw a garbage can to the staff while yelling out give me my 2 liters soda. The resident's family member was contacted and indicated the resident didn't have money. The resident went to his/her room while cursing at staff. Another progress note, written on 6/22/23 at 15:23 (3:23pm) by Staff #59 a Licensed Practical Nurse, indicated that 3 Sheriffs presented a court order to transfer the resident to the ER/psych unit (emergency room /Psychiatric unit). The physician was present. Paramedics arrived later with a stretcher and the resident was transferred to the hospital by the paramedics/sheriffs at approximately 2:30 PM. In an interview on 1/24/24 at 12:16 PM, Staff #2 a Social Services Coordinator stated that, prior to being transferred to the hospital on 6/22/23, Resident #18 went to the dining room, was slamming glassware on the floor was throwing silverware glasses, picked some up, took them to his/her room threatening to hurt others and that she petitioned the court for an order for an emergency hospital evaluation. The record failed to reflect the resident's behaviors on 6/22/23, the interventions implemented by staff in response to the behaviors and the effectiveness of the approaches used, or the circumstances that led to Staff #2 petitioning the court for an order to have Resident #18 transferred to the hospital for an emergency psychiatric evaluation. There was no documentation by the attending physician regarding an assessment of the resident, or the need for an emergency petition to transfer the resident to the hospital including the basis for transfer. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/25/24 at 10:54 AM the Director of Nursing (DON) confirmed there was no documentation of the resident's behaviors or staff interventions on 6/22/23. She referred to Staff #59's progress note and indicated that the physician was present. She then confirmed when asked that there was no documentation by the physician regarding an assessment of the resident, his/her condition, the need for a hospital evaluation or an order to transfer Resident #18 to the hospital. She repeated several times that the resident had a history of behaviors. She stated, You have to know (Resident #18), he/she can be a handful. Further review of Resident #18's medical record on 1/30/23 at 10:34 AM revealed that, upon Resident #18's return from the hospital on 7/14/23, Staff #2 failed to accurately complete a Preadmission Screening and Resident Review (PASRR) Level I screening which resulted in Resident #18 failing to receive the required Level II evaluation for specialized mental health services. The record revealed a psychiatric services progress note, dated 6/7/23, which included Past Psychiatric History: Psychiatric hospitalization , Schizophrenia, Anxiety disorder. The Chief complaint comments reflected Resident #18 was: acting very paranoid and delusional and was causing disruption on the unit. The Treatment Plan/Recommendations included: Psychiatric team will monitor mood and behavior, Patient counseled and provided coping techniques to deal with social isolation due to the Covid19. Continue current meds, tapering meds is not indicated. However, the same note later reflected Antipsychotic Medication: a change in medications - Prozac will be tapered off (Reduced to 20 mg for 5 days and then DC (discontinue)) and perphenazine will be increased to 3 times a day to help with the psychosis. It was not clear from the progress note how the psychiatric team would monitor the resident's mood and behavior and if any of the coping techniques provided to the resident were shared with the clinical nursing staff to incorporate into Resident #18's plan of care. Resident #18's Medication Administration Record (MAR) revealed entries with a physician's order date 5/4/2023: Page 7 of 14 indicated: 1=Compulsive 2=Pacing continuously 3=Continuously Screaming and Yelling 4=Danger to others 5=Danger to self 6=False Beliefs 7=Finger painting feces 8=Spitting 9=Other every shift interventions. 1=redirect 2=1:1 3=Offer fluids 4=Reassure 5=Back rub 6=sit with pt and hold hand 7=Offer snacks Outcome: 1= Improved 2=same 3=Worsened. Page 8 of 14 indicated: 1=Mood Swings 2=Sad 3=Continuous Crying 4=Withdrawn 5=Depressed 6=Angry 7=Poor eye contact 8=Other Every shift interventions. 1=redirect 2=1:1 3=Offer fluids 4=Reassure 5=Back rub 6=sit with pt and hold hand 7=Offer snacks Outcome: 1=improved 2=same 3=Worsened (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Page 9 of 14 included: Behaviors 1=Agitated 2=Afraid and Panic 3=Angry 4=Anxious 5=Biting 6=Compulsive 7=Extreme Fear 8=Jittery and Nervous 9=Pinching 10=Other Every shift Interventions. 1= redirect 2=1:1 3=Offer fluids 4=Reassure 5=Back rub 6=sit with pt and hold hand 7=Offer snacks Outcome: 1= Improved 2=same 3=Worsened. Single spaces were provided for staff to document Day, Evening and Night. All entries from 6/1/23- day shift on 6/22/23 contained check marks and initials of the staff signing off the entry. No space was provided for staff to enter codes for interventions implemented or to evaluate the effectiveness of the interventions. The MAR did not reflect that Resident #18 had any behavior problems during 6/2023 including the behaviors noted in the nursing progress notes on 6/20/23 and 6/22/23. There was no documentation in the MAR or in the nursing progress notes to reflect that staff implemented any non-pharmacological interventions to assist Resident #18 with their behaviors or the effectiveness of any such interventions. The plan of care in place on 6/22/23 included plans for: risk to be abused by others due to: wandering, intrusive behavior, frequent loud outbursts, socially inappropriate behavior, physically abusive, verbally abusive; A plan for smoking in room, 2 plans for resident to resident altercations, A plan for: behaviors related to bipolar disorder related to depressive disorder related to schizophrenia - disruptive behavior (attention seeking, manipulative behavior, delusional behavior, refusing showers, resident altercation, cursing staff and cursing other residents, throwing water on staff, pushing the medication cart, taking the supervisor key and hiding it in his/her room; Plans for risk for side effects from antipsychotic medications, use of antianxiety, antidepressant and antipsychotic medications and verbalization of ideas of harm to self with no plan, and behavior problems including refusing bathing/personal hygiene, using hand sanitizer over whole body, refusing to allow housekeeping to clean room. This plan of care did not include the objectives staff were to measure to determine if the interventions were effective. It was discontinued on 6/23/23. The facility staff failed to ensure the behaviors identified in Resident #18's plan of care were monitored, or that interventions were appropriately implemented and evaluated for effectiveness. Review of the medical record on 1/29/24 at 10:50 AM revealed a current plan of care developed on 10/24/23 for Resident #18 related to numerous problematic behaviors included but were not limited to refusing care, disrespect of the personal space of others, resident to resident altercations, urinating/defecating in his/her room. The behavior monitoring on the MAR did not include the behaviors identified in the resident's plan of care. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One of Resident #18's goals was to learn effective coping methods to address his/her behaviors. There was no indication how it was to be done, and no evidence that staff provided the resident with education including which coping methods the resident was taught, to ensure consistent staff reinforcement. The facility staff failed to develop a current plan of care was to address Resident #18's goals and care needs related to Schizophrenia and Anxiety. During an interview on 1/30/24 at 2:48 PM Staff #53 an LPN indicated she was familiar with and provided care for Resident #18 including day shift on 1/30/23. She was asked how she monitored Resident #18's behavior. She stated, It depends on how his/her day is going, there are days that he/she is fine, other days he/she has outbursts. She was asked what staff did in response to problematic behavior. She stated, we redirect him/her. When asked if the resident's specific behaviors were identified, she responded again that the resident had outbursts. Staff #53 was asked to describe the behavior the resident displayed and what interventions were identified for staff to implement when the resident displayed the behavior. She indicated that she was not sure. When asked to describe what the resident does during the outbursts, she stated: Sometimes (he/she) yells and screams, yelling and screaming, and cursing. When asked if the resident had any physical behaviors she stated, not that I'm aware of. She was not able to identify any specific plan related to Resident #18's behaviors. There was no evidence the facility staff developed and implemented consistent resident centered interventions including non-pharmacological approaches to assist Resident #18 in managing his/her behaviors and behavior health needs. The Administrator and Director of Nursing were made aware of these concerns on 1/29/24 at 11:32 AM.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 31982 Based on review of the medical record and interview with staff, it was determined the facility failed to ensure it had sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents by failing to implement person-centered care approaches and non-pharmacological interventions designed to meet the individual behavioral health goals and needs of each resident. This was evident during review of 1 (#18) of 28 residents reviewed for Abuse. The findings include: During an interview on 1/09/24 at 11:04 AM, Resident #18 indicated when asked, that he/she was hit by a receptionist with a phone and had to go to the hospital to get stitches in his/her head. Resident #18's medical record was reviewed on 1/12/24 at 12:28 PM. The record revealed Resident #18's diagnoses included, but were not limited to, Paranoid Schizophrenia, Major Depressive Disorder and Anxiety Disorder. Review of facility investigation documentation on 1/25/24 at 11:00 AM revealed that on 10/28/23 at approximately 5:00 PM, Resident #18 was in the first-floor dining room attempting to call 911 using the wall phone, in response to a delay in the scheduled smoke break. Staff #29 a receptionist entered the dining room and asked Resident #18 what he/she was doing. The resident indicated that he/she was calling the police. Staff #29 attempted to stop the resident from completing the call by unplugging the telephone. An altercation ensued, Resident #18 was struck with the phone by Staff #29 and sustained a laceration to his/her forehead which required 6 stitches. Staff #30, an environmental services assistant supervisor, was interviewed on 1/26/24 at 10:12 AM. He confirmed that he was present and witnessed the incident on 10/28/23. He indicated that he attempted to intervene and repeatedly told Staff #29 to stop and just allow Resident #18 to call. Staff #29's employee file was reviewed on 1/29/24 at 12:53 PM. Staff #29 was hired on 7/30/19. as a Geriatric Nursing Assistant and began working as a full-time receptionist at the facility in November 2021. A Skills and Techniques Evaluation (Nursing Assistants), dated 8/19/2019 included a list of skills with a column for a facilitator to sign off and date when the listed skill was validated or demonstrated. 17 skills were not signed off for Staff #29. They included but were not limited to: Alerts to report to nurse which included behaviors; and Behavior: Identification, documentation, non-pharmacologic approaches. The individual skills that were initialed by the facilitator were not dated but the bottom of the form was signed by Staff #29 and the facilitator and dated 8/8/19. Staff #29's record of training since hire was reviewed and revealed she received 1/2 hour of RELIAS (an electronic training software) on 10/24/23 related to Managing Aggressive Behaviors. There was no record that Staff #29 received any Behavioral Health training. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The review of Resident #18's medical record on 1/12/24 at 12:28 PM also revealed nursing progress notes dated 6/20 23 at 8:07 PM and 9:15 PM indicating Resident #18 displayed behaviors such as cursing and exposing his/her buttocks to other residents demanding cigarettes; and became agitated and while yelling, threw a garbage can at staff. There was no documentation that staff implemented interventions. Another progress note dated 6/22/23 indicated that Resident #18 was sent to the hospital after the sheriff arrived with a court order. The record failed to reflect that staff documented the event including any behaviors related to the need for a hospital transfer and whether interventions, including non-pharmacological interventions, were attempted by the facility staff including the residents response to the interventions, prior to obtaining a court order. In an interview on 1/24/24 at 12:16 PM Staff #2 a Social Worker indicated that she petitioned the court for an order to transfer Resident #18 to the hospital on 6/22/23 after the resident threw silverware and glassware onto the dining room floor, returned to his/her room with some of the pieces and threatened to hurt others. Upon review of Resident #18's medical record, Staff #2 confirmed there was no documentation on 6/22/23 regarding the behaviors she described or the basis for transferring Resident #18 to the hospital. In an interview on 1/25/24 at 10:54 AM the Director of Nursing (DON) also confirmed the facility staff failed to document Resident #18's behavior as well as documentation of interventions by staff. During an interview on 1/30/24 at 2:48 PM Staff #53 an LPN indicated she was the nurse assigned to Resident #18 and that she was familiar with Resident #18. When asked how she monitored Resident #18's behavior. She stated, It depends on how his/her day is going, there are days that he/she is fine, other days he/she has outbursts. She was asked what staff did in response to problematic behavior. She stated, we redirect him/her. When asked if the resident's specific behaviors were identified, she responded again that the resident had outbursts. Staff #53 was asked to describe the behavior the resident displayed and what interventions were identified for staff to implement when the resident displayed the behavior. She indicated that she was not sure. When asked to describe what the resident does during the outbursts, she stated: Sometimes (he/she) yells and screams, yelling and screaming, and cursing. When asked if the resident had any physical behaviors she stated, not that I'm aware of. She was not able to identify a specific plan to address Resident #18's specific behavioral health needs. The facility's bed capacity was 130 and the resident census at the beginning of the survey was 127 residents. The facility's most recent Facility Assessment was provided by the Administrator and reviewed on 1/31/24 at approximately 2:00 PM. Table 1.4 summarized the most common conditions and combinations of conditions the facility may accept as admissions or that current residents may develop. The table indicated that at the time the assessment was completed there were 60 residents were identified for Care Planned Behavioral Health Needs. Behavior Management Program was blank. The Psychiatric/Mood Disorders section reflected 26 residents with Schizophrenia, 47 residents with Depression, 75 residents with Anxiety Disorder, 43 residents with Psychosis (hallucinations/delusions) 0 with PTSD (Post Traumatic Stress Disorder), and 28 with Bipolar Disorder. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 1/30/24 at approximately 3:15 PM with Staff #23 the Staff Development Nurse. She was asked what specialized training was provided for the staff related to caring for residents with mental and psychosocial disorders. She indicated they received the training from RELIAS (an online training app)-behavior health for older adults for GNA's and Nurses. She was made aware that there were residents with psychiatric disorders including schizophrenia and that the surveyor was looking for specific training for staff to be able to provide care and services to meet the needs of residents with Psychiatric problems. She was unable to describe any specialized training.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 48168 Based on interviews and record reviews, it was determined that the facility failed to provided Medically related Social Services This was evident for 1 complaint (MD00175251) of 23 complaints investigated during the annual survey. The findings include: On 1/10/24 at 11:42 AM, a review of complaint MD00175251 was conducted and revealed an allegation that a request had been made for Resident #17's to transfer to another nursing facility closer to their home. Although steps were taken, no beds were available and no further follow up was provided. On 1/12/24 at 9:38 AM an interview with Social Worker (SW#1) was conducted. SW#1 stated that a few months ago she assisted Resident #17's family with their wish to transfer the resident to another facility. She called the facility, sent documentation, called the family, but did not reach them. The desired facility did not have a bed available, and SW#1 said she notified the resident's family by voice mail message and has not heard back from them. When asked if SW#1 had reached out again to the family, SW#1 said no. On 2/02/24 at 11:26 AM an interview with the Regional Social Worker (SW#46) was conducted. SW#46 said he was a Licensed Clinical Social Worker and has had oversight of the facility social services since 2022. SW#46 was asked about the process when residents requested transfer to another facility but no beds were available at that facility. He replied that social services should follow up and offer other settings, and they should continue to follow up with the full facility to know when a bed became available. When asked regarding Resident #17's request to transfer, he said was not aware of the transfer request and was not aware it was not followed up on. He acknowledged that this was a deficient practice.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47200 Based on observation, record review, and interview it was determined the facility failed to act upon multiple pharmacy drug problems that were identified. This was evident for 1 of 5 residents (#1) reviewed for unnecessary medications. The findings include: On 1/19/24 at 10:36AM the surveyor reviewed the medical record for Resident #1 which revealed on 12/12/23 and 1/11/24 the pharmacy medication regimen reviews noted to refer to a report for irregularities and/or recommendations. On 1/22/24 at 11:29AM the surveyor requested copies of the last three months of medication regimen reviews and pharmacy recommendations for Resident #1 from the Director of Nursing (DON.) On 1/25/24 at 11:58AM the surveyor noted the documentation received was not as requested; the surveyor was only given documentation for the months of September, November, and December 2023, which reflected the resident had no recommendations made during those months. The surveyor inquired to the DON and Staff #48, Regional Nurse as to why the documentation given to the surveyor was different from what was requested. At this time, the surveyor made a second request for the documentation. On 1/25/24 at 2:36PM the surveyor reviewed the pharmacist recommendation documentation dated 10/16/23 which revealed the following information needed to be updated on the medication administration record: Fosamax should be taken in the morning with 6 to 8 oz of water at least 30 minutes before any other beverage or food. The resident should not lie down for 30 minutes after taking the medication to prevent irritation to the esophagus. Fosamax should NOT be sucked, chewed, or crushed. On 1/25/24 at 2:36PM the surveyor conducted a review of the active medical order for the Fosamax medication and the January 2024 medication administration record. No documentation could be found in the medical record that the facility acted upon the following recommendation: Fosamax should NOT be sucked, chewed, or crushed. On 1/26/24 at 2:23PM the surveyor conducted an interview with the DON and inquired as to the process the facility has in place to ensure medication regimen review recommendations made by the pharmacy are acted upon. The DON reported to the surveyor that the receptionist puts the recommendations into the physician's box, the physician signs with their recommendations and returns to the receptionist who then send them to nursing to change the orders; unit managers are responsible for review and changes that need to be made. At this time, the surveyor shared concerns with the DON, who acknowledged understanding of the concerns. On 1/30/24 at 11:17AM the surveyor conducted an interview with Staff #61, Consultant Pharmacist, who reported to the surveyor that the resident's physician has access to the reports in their entirety. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Largo Nursing and Rehabiliation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Largo Road Glenarden, MD 20774	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/30/24 at 11:48AM the surveyor reviewed the medical record and noted they shared concerns on 1/26/24, however, no further action had been taken to institute the recommendation for the Fosamax medication. On 1/31/24 at 10:30AM, the surveyor conducted another interview with Staff #61, Consultant Pharmacist, who reported that a re-admission review of medications had been performed in May, 2023 by Staff #60, Consultant Pharmacist, who made recommendations at that time due to clinically significant medication issues that were found. On 1/31/24 at 10:34AM the surveyor requested the May 2023 medication regimen review and recommendations made by the pharmacy from Staff #8, Unit Manager, 2nd Floor, Licensed Practical Nurse. On 1/31/24 at 11:28AM the surveyor reviewed the May 2023 pharmacy recommendations which identified 3 clinically significant drug therapy problems, 3 high risk drug therapy problems, and 2 medium risk drug therapy problems. The surveyor noted that the report included the following information: Please consider the following Pharmacist recommendations in assessing this Resident's drug regimen. The prescriber and/or nursing staff should respond appropriately. Recommendations marked CLINICALLY SIGNIFICANT should be resolved by midnight the next calendar day, copied to the MDS Coordinator, and filed in the Resident's chart appropriately. At this time, the surveyor requested to Staff #8, any and all documentation of responses made to the May 2023 pharmacy recommendations. Staff #8 reported to the surveyor that they were unsure of what responses were made. On 2/1/24 at 11:13AM the DON gave the surveyor another copy of the May 2023 pharmacy recommendations. Upon receipt of this documentation, the surveyor conducted an interview with the DON who reported the facility does not have physician responses for this, if the recommendations don't make it into the mailbox for the physician, then they may not get the recommendations. The recommendations had not been responded to. On 2/1/24 at 11:16AM Staff #52, Regional Director of Reimbursement reported to the surveyor that they had confirmed there was no follow up for the physician recommendations. As of the date of surveyor exit from the facility on 2/6/24, no documentation of responses made to the pharmacy recommendations was provided.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on record review and staff interview it was determined the facility failed to: 1) ensure a resident was free from unnecessary medications. This was evident for 1 (Resident #1) of 5 residents reviewed for unnecessary medications; and 2) reconcile and transcribe medication orders accurately to the medication administration record as evidenced by transcribing a medication twice. By failing to reconcile and transcribe orders accurately the resident received up to twice the amount of medication ordered. This was identified for 1 (#12) of 66 residents; and 3) ensure physicians orders for pain medication clearly identified when staff were to give each of 2 medications as needed for pain, and administered as needed pain medications when the resident indicated their pain level was low or absent. This was evident for 1 (#18) of 1 resident's reviewed for Psychiatric/Opioid Side Effects during a recertification survey. The findings include: 1) On 1/19/24 at 10:13AM the surveyor conducted a review of the medical record which revealed Resident #1 had the following active medical order: Levothyroxine Sodium tablet 112mcg, give one tablet via g-tube one time a day for low thyroid hormone. Further review by the surveyor of the medical record on 1/19/24 at 10:13AM revealed that the last lab result for monitoring of the TSH (thyroid stimulating hormone) level for the resident was on 4/14/23 and the level was 13.5, indicating this was elevated. Upon further review of the resident's TSH level result from 2/28/23 it was found to have been 10.6, indicating this was elevated. On 1/26/24 at 2:23PM the surveyor conducted an interview with the Director of Nursing (DON,) and inquired as to how often the TSH level is monitored, and what actions had been taken by the facility regarding the elevated results. At this time, the surveyor shared their concern. On 1/29/24 at 3:29PM the surveyor observed a completed lab order dated 1/27/24, for the monitoring of the resident's TSH level. On 1/30/23 at 9:26AM the surveyor conducted another interview with the DON who reported the following information regarding the monitoring of the resident's TSH levels: It's been almost a year, I was surprised myself it was not done since February, lab providers were changed. After surveyor intervention on 1/26/24, the DON further reported the lab test for TSH had been ordered, and was performed the following day. On 1/30/24 at 10:16AM the surveyor observed a health status note dated 1/26/24 in the medical record indicating that labs were ordered to occur on 1/27/24, which included the TSH level. 42507 2) On 1/25/2024 at 10:05 AM, during medication pass observation, surveyor observed Licensed Practical Nurse, LPN #28, pull and administer some medications to Resident #12 including the following eye drops: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cosopt PF Ophthalmic Solution 2- 0.5% (Dorzolamide HCL-Timolol Maleate) and Dorzolamide HCL-Timolol Mal Solution 22.3- 6.8 mg/ml. The Medication Administration Record (MAR) for January 2024 was reviewed on 1/25/2024 at 1:04 PM with the second floor Unit Manager (UM #8): It revealed a duplicate transcribed medication order for Dorzolamide HCL- Timolol Maleate Solution (Cosopt) eye drops: The first order was written as Cosopt PF Ophthalmic Solution 2- 0.5% (Dorzolamide HCL- Timolol Maleate) Instill 1 drop in both eyes two times a day for Glaucoma order date 3/10/2023 at 15:48 (3:48 PM). The second order was Dorzolamide HCL- Timolol Mal Solution 22.3- 6.8 MG/ML. Instill 1 drop in both eyes two times a day for Glaucoma order date 12/6/2021 at 17:14 (5:14 PM). The orders for Dorzolamide HCL- Timolol Maleate Solution (Cosopt) eye drops were transcribed to the MAR twice at different times and showed documentation of the staff administering the medication at 0900 (9:00AM) and at 2100 (9:00 PM) for the first order, and at 0900 (9:00 AM) and at 1700 (5:00 PM) for the second order. UM #8 stated that she was going to follow up with the physician and verify if the resident was to be on both medications. On 1/26/2024 at 8:41 AM, Review of physician orders for Resident #12 revealed the discontinuation on 1/25/2024 at 14:18 (2:18 PM) of the first order dated 3/10/2023 for Cosopt PF Ophthalmic Solution 2-0.5 % (Dorzolamide HCl-Timolol Maleate)with notation Pt already on Cosopt. The second order dated 12/6/2021 for Dorzolamide HCl-Timolol Mal Solution 22.3-6.8 MG/ML was maintained. On 1/26/2024 at 8:59 AM, Review of Resident #12's medical record revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to unspecified Glaucoma, Type 2 Diabetes Mellitus with other diabetic ophthalmic complication, other age-related incipient cataract, unspecified eye. On 1/26/2024 at 10:08 AM, in a follow up interview with the 2nd floor Unit Manager (UM #8), she stated that she called the Nurse Practitioner after reviewing Resident's #12's chart and got an order to discontinue the Cosopt eye drops ordered on 3/10/2023. UM #8 stated that they reviewed the discharge instructions from the resident's eye appointment with the eye doctor in John Hopkins on 3/10/2023 and that doctor had recommended that the resident continue Dorzolamide HCL-Timolol Mal Solution 22.3-6.8 mg/ml. UM #8 validated that Resident #12 was given more medication (Cosopt eye drops) than necessary. On 2/1/2024 at 10:00 AM, Review of nursing progress notes revealed the following documentation: 1/29/2024 14:24 Health Status Note Text: John Hopkins hospital I regarding resident visit on 3/10/23 on eye drops Dorzolamide-timolol and visit consultation. all documentation received and reworded to attending NP for review. Np Optum reviewed and advised on resident to continue Dorzolamide-timolol {Cosopt} 22.3-6.8 mg/ml ophthalmic solution to both eyes as per doctor/hospital orders. On 2/1/2024 at 10:38 AM, a review of the discharge instructions from John Hopkins Ophthalmology visit on 3/10/2023 revealed the following medication changes that included but not limited to: Changed: dorzolamide-timolol (Cosopt) 22.3-6.8 mg/ml ophthalmic solution Place 1 drop into both eyes 2 (two) times daily, Both eyes. Previously 1 drop left eye 2 times daily. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	All concerns regarding the observations during medication administration by LPN #28 were reviewed with the Administrator, the Director of Nursing (DON), and corporate staff prior and during the time of survey exit on 2/6/2024 at 2:15 PM. 31982 3) Review of Resident #18's medical record on 1/30/24 at 12:59 PM revealed a physician's order dated 11/9/23 12:41 for Oxycodone HCl Oral Capsule 5 mg (milligrams). Give 1 capsule by mouth every 12 hours as needed for pain. Oxycodone is a narcotic pain medication. Another order dated 11/3/23 14:20 (2:20 PM) was written for Acetaminophen (Tylenol) 325 mg. Give 2 tablets by mouth every 6 hours as needed for pan. Not to exceed 3 gm (grams) in 24 hours. The as needed pain medication orders did not contain clear instructions or parameters for staff to determine which of the 2 medications they should give if the resident complained of pain. A numeric 0-10 pain scale is a universal scale commonly used by staff to determine the level of pain a resident is experiencing. 0 = no pain, 10 = worst pain ever. For resident's incapable of rating their pain, a corresponding scale using facial expressions is used. Resident #18's Medication Administration Records (MAR's) from 11/2023 - 1/2024 revealed: During 11/2023 facility nurses administered Acetaminophen 325 mg as needed 1 time for pain level of 7, 4 times for a pain level of 4, 1 time for pain level of 3, 2 times for pain level of 1, and 2 times when the resident rated his/her pain level as 0 (no pain). During the same month the facility nurses administered the as needed Oxycodone 5mg 1 time for a pain level of 7, 1 time for pain level of 5, 12 times for pain level of 3, and 2 times when the resident's pain level was 0. In 12/2023 Acetaminophen 325 mg was administered as needed - 1 time for pain level of 6, 1 time for pain level of 3 and 4 times for pain level of 0. Oxycodone 5 mg was administered 1 time for pain level of 7, 2 times for pain level of 6, 3 times for pain level of 5, 1 time for pain level of 4, 4 times for pain level of 3, 7 times for pain level of 2, and 5 times for a pain level of 0. During 1/2024, the as needed Acetaminophen was signed off as administered to Resident #18 1 time for pain level of 2. The Oxycodone was signed off as administered to the resident 8 times for pain level of 3, 20 times for pain level of 2, 2 times for pain level of 1 and 1 time for pain level of 0. Resident #18's record revealed an Administration progress note dated 1/30/24 at 10:59 AM by Staff #53 an LPN. The note documented that Staff #53 administered Oxycodone 5 mg to Resident #18 on 1/20/24 at 10:59 for pain level of 1. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/30/24 at 2:48 PM, Staff #53 identified that the electronic MAR prompted staff to use a numerical 0-10 pain scale to assess resident pain levels when administering as needed pain medication. She confirmed that she administered Oxycodone to Resident #18 as documented at 10:59 AM for a pain level of 1 and that the resident also had an order for Acetaminophen as needed for pain. When asked how she determined which of the 2 pain medications to administer to the resident when he/she complained of pain, she was not able to explain however, she confirmed that there were no parameters in the pain medication orders. When asked why she administered Oxycodone instead of Acetaminophen for a pain level of 1 she indicated that the resident said he/she was having pain in his/her legs, but Staff #53 did not provide rationale for administering one medication over the other or why a narcotic pain medication was administered for a low pain level. On 1/30/24 at 2:58 PM the Director of Nursing was made aware of the concern that staff were administering as needed pain medications with no clear indication of when to give each, and that staff administered as needed pain medications including a narcotic when the residents documented pain level was 0.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42507 Based on observation, interview, and medical record review, it was determined the facility failed to ensure that its medication error rates are not 5 percent or greater. This was found to be evident based on errors identified during medication administration for one (Resident #12) out of four residents observed. The observations were made on one of two nursing units and involved one of two different nurses. The findings include: On 1/25/2024 at 10:05 AM, surveyor met the nurse, Licensed Practical Nurse, LPN #28, at a medication cart on the 2nd floor Independence Unit. LPN #28 reported she was preparing medications for Resident #12. LPN #28 was observed removing the following medications from the medication cart: 2 Acetaminophen 325 mg 1 Duloxetine 20 mg 1 Tramadol 50 mg 1 Ferrous Sulfate 325 mg 1 Hydrochlorothiazide 25 mg 1 Losartan Potassium 50 mg Brimonidine Tartrate Ophthalmic Solution 0.2 % (eye drops) Cosopt PF Ophthalmic Solution 2- 0.5% (Dorzolamide HCL-Timolol Maleate) (eye drops), and Dorzolamide HCL-Timolol Mal Solution 22.3- 6.8 mg/ml (eye drops). LPN #28 then signed the medications prior to giving them to Resident #12. A review of the medical record revealed that Acetaminophen was ordered to be given three times a day for pain and was scheduled to be given at 6:00 AM, 1200 noon, and 8:00 PM. However, LPN #28 had removed 2 tablets of Acetaminophen from the medication cart at 10:05 AM and gave them to the resident with the other morning meds. When asked why the Acetaminophen was given at that time, LPN #28 stated that Resident #12 always wanted the medication given early because at noon s/he (Resident #12) will be in the dining room for lunch and would not come back to the unit just to take the Acetaminophen. This constituted an error as the medication was given at the wrong time. This represented 2 errors out of 30 opportunities for error (error rate of 6.67 %). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/26/2024 at 10:08 AM, an interview was completed with the 2nd floor Unit Manager (UM #8). When asked what the expectation was during med pass, UM #8 stated that nurses were expected to follow the five rights of medication administration (right patient, right drug, right dose, right route, and right time). She stated that medication administration had a two-hour window (an hour before and up to an hour after the scheduled time of administration). Regarding residents requesting ordered meds prior to the scheduled time, UM #8 stated that the nurse should get a PRN (as needed) order for the med if the resident requested to have the med early. UM #8 further stated that nurses should sign medications after administration and not before. UM #8 was informed of surveyor's med pass observation on 1/25/2024 for Resident #12. She stated that she was going to investigate. On 1/26/2024 at 2:23 PM, surveyor reviewed with the Director of Nursing (DON) the medication pass observations on 1/25/2024 with LPN #28, including the Med error rate of 6.67 %. DON stated she was hoping there would be little, or no medication pass errors by her staff. On 1/29/2024 at 9:05 AM, a review of the facility's policy on Medication Administration (effective date 9-2018 with revision date of 8-2020) revealed: Under Procedures #4 - At a minimum, the 5 Rights- right resident, right drug, right dose, right route, and right time- should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and the medication is put away Under Administration: #12 - Medications are administered within 60 minutes of the scheduled administration time, except before, with, or after meal orders, which are administered based on mealtimes. The total medication error rate for the four medication pass observations was 6.67 % (over 5%). This was reviewed with the Administrator, Director of Nursing, and corporate staff at the time of survey exit on 2/6/2024 at 2:15 PM.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

48168

Based on observations and interviews it was determined that the facility failed to properly store medications. Medications were stored in an area where residents and unauthorized staff could access them. This was evident on 2 of 3 nursing units.

The findings include:

On 1/12/24 at 9:53 AM Staff #8, Unit Manager, 2nd floor, Licensed Practical Nurse, showed the surveyor to a room labeled the Central Supply Room located on floor 2, on the Independence hallway and proceeded to push the door open and enter the room without use of the keycode pad located on the front of the door. Staff #8 verbalized to the surveyor that this room was the medication room.

On 1/12/24 at 9:53 AM the surveyor observed various medications and supplies in the room labeled the central supply room located on floor 2, on the Independence hallway; including but not limited to: aspirin, acetaminophen, naproxen, guaifenesin oral solution, vitamin C, vitamin B, vitamin D, vitamin E, milk of magnesia, Dakin's solution, calcium tablets, povidone iodine 10% solution, multivitamins, multivitamins with iron, Claritin, senna, aspercreme, fexofenadine, carbamide peroxide, bacitracin zinc ointment, hydrogen peroxide 3%, simethicone, acetaminophen suppositories, melatonin, iron, folic acid, bisacodyl, sodium chloride tablets, calcium citrate, and cetirizine.

On 1/12/24 at 9:56AM the surveyor observed Staff #16, Staffing Coordinator, open the door to the room labeled Central Supply Room located on the 2nd floor on the Independence hallway without use of the keypad.

On 1/12/24 at 10:20AM surveyors approached the first-floor medication room door which was observed to be locked, however, unlatched, allowing entry. Upon entry to the room, surveyors observed the medication refrigerator with a padlock hanging on the left side which was unlocked and able to be opened. Upon opening the refrigerator, surveyors observed it to contain the following: insulins, lidocaine injection, pneumovax, flu vaccines, TB test solution, triamcinolone, and bags of intravenous intralipids 20%.

On 1/12/24 at 10:21 AM the surveyor asked Licensed Practical Nurse (LPN #64) where the 2nd floor medication room was located. LPN #64 showed the surveyor to a locked room behind the 2nd floor nurses station, used a key to unlock the door and allowed the surveyor to enter the room. There were base cabinets which contained random items, but no medications, and wall cabinets which were empty. There was a small refrigerator that contained only insulin vials.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/12/24 at 1:47 PM an interview with the Director of Nursing (DON) was conducted regarding unlocked medication/storage rooms. When asked if she was aware that the 2nd floor storage room labeled Central Supply Room contained medications and was unlocked, she said that she was made aware of the issue today and the maintenance director had fixed the door and was conducting tests on other doors. When asked who had access to the 2nd floor Central Supply Room, she said Geriatric Nursing Assistants (GNAs), nurses, and 2 ancillary staff who stock and deliver supplies. She further explained that the room was the central supply for the whole facility. When asked why the medications were not stored in the medication room, she said we have always done it that way. The surveyor asked the DON for a copy of the facility's medication storage policy. On 1/12/24 at 2:54 PM the DON provided a copy of the facility's medication storage policy which stated that Only persons authorized to prepare and administer medications shall have access to the medication room, including any keys. On 1/12/24 at 4:54 PM the DON informed the surveyor that she decided to move the medications from the Central Supply Room to the medication room near the 2nd floor nurses station. Cross reference F689.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on interviews and medical record review, it was determined that the facility failed to ensure that residents who required dental services on a routine or emergent basis received necessary or recommended dental services in a timely manner. This was evident for 1 (Resident #96) of 4 residents reviewed for dental service, and 1 complaint of 23 complaints investigated during the annual survey. The findings include: 1) On 1/08/24 at 10:39 AM, an interview was conducted with Resident #96. The resident stated that he/she had jaw pain and needed to follow up with the dentist. A review of Resident #96' s medical records on 1/22/24 at 11:12 AM revealed that the resident was diagnosed with mouth cancer in July 2023 while he/she resided in this facility. An oncologist for chemotherapy and radiology therapy has followed up with the resident. Further review revealed that the resident had a dental referral to an oral surgeon on 10/30/23 for evaluation and treatment. Oral exam and extraction. On 1/24/24 at 2:10 PM, the Director of Nursing (DON) was asked about Resident #96's dental appointment, and she submitted the resident's progress notes (part of the medical records narrative residents' status) regarding dental appointments. The note dated 11/01/23 stated, writer spoke to [a nurse name] and informed her of resident's dental appointment for November 14 at 3 PM. Also informed her that his/her insurance was active. [nurse's name] will call back and give update for his/her next chemotherapy. Resident and his/her sister, [name] were notified. Another note dated 12/26/23 said, Patient arrived from dental appointment with no procedure performed this PM. Dental office requesting a new referral. Resting quietly in bed at this time. However, no further records existed about Resident #96's dental appointment. In an interview with a Unit Manager (Staff #7) on 1/25/24 at 10:19 AM, Staff #7 stated that due to Resident #96's insurance issue, the facility needed to contact several different dental offices to arrange his/her initial. Staff #7 verified that the most recent dental visit of Resident #96 was on 12/26/23, and there was no further documentation in the resident's chart about the current status of the appointment. During an interview with the Director of Nursing (DON) on 1/25/24 at 12:50 PM, the DON explained that Resident #96's first course of therapy was done. For further therapy, the oncologist needed consultation from a dentist. The surveyor shared concerns about the absence of Resident #96's dental follow-up since 12/26/23. The DON validated the surveyor's concerns. 48168 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Largo Nursing and Rehabiliation Center	600 Largo Road Glenarden, MD 20774

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 1/10/24 at 11:33 AM in a review of complaint, which alleged that Resident #17 did not receive needed dental care. The complainant was contacted by phone and also shared that the resident's teeth had deteriorated and did not look like they were brushed or cared for and there had been no communication from the facility staff regarding the resident's dental care. On 1/26/24 at 12:13 PM an interview with Resident #17's Licensed Practical Nurse (LPN#28), she said she was unaware of any issues with the resident's mouth or teeth. She also stated that the resident's assigned Geriatric Nursing Assistant (GNA) provided daily mouth care using a sponge and that the resident has only a few teeth. On 1/29/24 at 12:05 PM in an interview with LPN#8, she said she was not aware that Resident #17 had any dental issues. She was unaware if the resident had any dental visits and said that there was a dental group that comes to the facility on ce per month and any residents who needed dental care were placed on a list at the nursing station. She also stated that dental care was provided regardless of insurance coverage. On 1/31/24 at 10:45 AM the surveyor observed GNA#40 provide mouth care to Resident #17 who was in a Geri chair next to his bed. A toothette sponge dipped in mouthwash was used, with verbal prompting for the resident to open their mouth. The resident resisted initially, and GNA#40 said that at times the resident fights care, but if the resident is familiar with the staff person, the resident is more cooperative. She also said that sometimes the resident's gums bleed when mouth care is given. The resident's teeth were partially visible, no apparent broken or missing teeth observed but the observation was limited. After the observation, the surveyor asked LPN#8 for the resident's dental visit notes. She said she would look for them and also said she just requested a dental visit for the resident. On 1/31/24 at 3:15 PM a record review of Resident #17's medical record reviewed the following dental documentation: dental visits attempted on 12/03/22 and 12/30/22 and resident refused. Dental visit on 2/03/23 made recommendations for a special mouth wash, next exam on 8/02/23, next annual exam 2/03/24. Dental note dated 3/02/23 attempted but resident tried to bite - recommended sedation and [LPN#8] said she would get it ordered for next visit. Dental visit note dated 5/12/23 - exam, indicated resident very uncooperative with exam, doubt [Resident #17] will let hygienist clean [their] teeth. On 2/01/24 at 11:15 AM LPN#8 was asked if the physician was asked about the recommendation for Resident #17 to use Peridex mouth rinse, and for the resident to have sedation ordered so that dental care could be provided. LPN#8 said she will check. On 2/01/24 at 1:25 PM a follow up interview with LPN#8 was conducted and she said that she reviewed the medical record and did not find any notes that indicated the resident's physician was contacted regarding the recommendations for peridex mouth wash and sedation. She restated that she had requested a dental visit for the resident.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 47200 Based on observation, record review, and interview it was determined the facility failed to have an effective process in place for the kitchen to accurately serve according to medical orders and effectively institute dietary changes when they are made, and provide documentation in the medical record for rationale of nutritional changes. This was evident for 3 out of 10 residents (#87, #11, #30) reviewed for food concerns during the facility's recertification survey. The findings include: 1.) On 1/23/24 at 11:01AM the surveyor reviewed the medical record for Resident #87 which revealed a nutrition progress note dated 9/18/23 which documented the resident's past medical history of: unspecified severe pcm (protein calorie malnutrition) and further documented the following recommendation: house supplement 4oz BID (2 times per day.) On 1/23/24 at 11:29AM the surveyor conducted an interview with Staff #3, Food Service Manager, and requested a copy of the snack and supplements list. Staff #3 provided this list and confirmed with the surveyor that the list accurately reflected the days and times the snacks and supplements/shakes are currently being provided to residents from the kitchen. On 1/23/24 at 12:10PM the surveyor conducted a review of the snacks and supplements list which revealed Resident #87 was currently being provided with the supplement two times per day, at 10am and 2pm, and a snack at bedtime. On 1/23/24 at 12:30PM the surveyor conducted an interview of Resident #87 who reported to the surveyor that they receive several supplement shakes per day, usually at breakfast and lunch time, and they typically do not eat meat prepared by the facility. On 1/31/24 at 11:24AM the surveyor reviewed the medical record which revealed that on 11/20/23 the medical order regarding the supplement shake was decreased from two times per day, to one time per day, and no documentation for rationale of why the change was made at that time could be found in the medical record. Continued review of the medical record revealed on 12/14/23 the following recommendation was documented: mighty shake 4oz QD (every day) for po (by mouth) supplementation and weight loss prevention. No documentation could be found on the 12/14/23 or 9/18/23 nutritional notes regarding the bedtime snack. On 2/1/24 at 1:48PM the surveyor conducted an interview with Staff #63, Registered Dietician. When the surveyor inquired to Staff #63 as to why the supplement decrease had been made on 11/20/23, they reported the following: The Resident had a good appetite, supplement audits happen, someone may have audited the intake and made the decrease, it was decreased in November. At this time, the surveyor observed the 11/20/23 medical order for supplement decrease and noted that Staff #63 was documented as having made this dietary order change. Staff #63 further confirmed with the surveyor that the facility requires further documentation to be written when changes to a resident's nutritional orders are made. When asked by the surveyor if they documented regarding the 11/20/23 supplement change, they responded: no ma'am. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 1/9/24 at 10:49AM the surveyor conducted an interview with Resident #11 who reported to the surveyor that the portions of food they were receiving were too small and they felt hungry. Resident #11 further reported they made nursing staff aware approximately four days ago and were told that the dietician was who could handle their concern, but they were told the dietician was not available. On 1/22/24 at 10:26AM Resident #11 reported to the surveyor that they showed Staff #6, Registered Dietician, this morning, their plate of food and asked them why they are receiving such small portions when they are ordered to have double portions of food. They further reported that Staff #6 acknowledged their concern and was going to check on this. During the interview with Resident #11 on 1/22/24 at 10:26AM, the surveyor observed the physical meal ticket on the resident's breakfast tray which indicated they were to receive double portions. On 1/22/24 at 10:50AM the surveyor conducted an interview with Staff #6, Registered Dietician. When the surveyor inquired as to the reason for their visit with Resident #11 in the morning, they replied: We had a conversation about double portions, s/he did not address any concerns with me, s/he wanted some cold cereal with their milk. I need to put my note in about the conversation, s/he was saying s/he requested double portions, s/he wasn't having a concern this morning, I don't know if s/he was confused about receiving them. On 1/23/24 at 11:29AM the surveyor conducted an interview with Staff #3, Food Service Manager, and requested a copy of the snack and supplements list. Staff #3 provided this list and confirmed with the surveyor that the list accurately reflected the days and times the snacks and supplements/shakes are currently being provided to residents from the kitchen. On 1/23/24 at 12:10PM the surveyor conducted a review of the snacks and supplements list which revealed Resident #11 was currently being provided with a supplement shake two times per day, at 10am and 2pm, and was not receiving snacks. Upon review of the active medical orders dated as beginning on 11/20/23, the Resident was to receive the house supplement shake one time per day and snacks two times per day. On 1/23/24 at 2:39PM the surveyor conducted an interview with Staff #9, Licensed Practical Nurse, who reported it was not documented in the medical record, but they had a verbal conversation in person with Staff #6 regarding the resident's concern about the double portions, on approximately 1/15/24. They further reported to the surveyor that they did not know why Staff #6 had not addressed the concern previously. On 1/24/24 at 11:18AM the surveyor's review of the medical record revealed Resident #11 weighed 170.8lbs on 9/1/23, and then weighed 156.46lbs on 10/22/23, indicating they had sustained a significant weight loss. Review of the quarterly nutrition assessment documented by Staff #63, Registered Dietician, listed the following recommendations on 12/12/23: House supplement qd (every day) for wt (weight) loss prevention, snacks BID (twice per day.) The surveyor noted that double portions was not documented on the assessment, however, the active medical order for their diet which included double portions began on 10/22/23. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) Upon surveyor review of the medical record on 1/11/24 at 12:25PM for Resident #30, the surveyor noted their active medical order for diet was last updated on 11/20/23 by Staff #63, Registered Dietician, (RD) to implement the resident's need for double protein portions. On 1/18/24 at 11:27AM the surveyor conducted an interview with Staff #3, Food Service Manager. During the interview, the surveyor observed the Resident's menu ticket did not have double protein portions listed. Staff #3 reported to the surveyor that Resident #30 was not receiving double protein portions and stated the following: The kitchen menu changed a few months ago, the company transferred information for the new menu, everything including preferences needed to be transferred over. In response to the surveyor sharing their concern, Staff #3 reported they did not recall being communicated with regarding the double protein needs of Resident #30 and were going to consult with the dietician. On 1/22/24 at 10:50AM, the surveyor conducted an interview with Staff #6, Registered Dietician, who stated the following: Just one meal hadn't had the double protein, I don't know how it happened, maybe communication? Staff #6 further reported they communicate with Staff #3 via phone but this is not always documented in the medical record. When the surveyor inquired as to how only one meal could have been affected, when the kitchen did not have the intervention in place, Staff #6 confirmed with the surveyor that the issue could not only have affected one meal. At this time, the surveyor shared the concern with Staff #6 who acknowledged understanding. Staff #6 reported the facility expects them to document their communication made to the food service manager.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 15701 Based on interviews of facility staff, it was determined that the facility failed to ensure a full-time clinically qualified nutrition professional for the oversight of food preparation and the daily kitchen operation. All the residents in the facility have the potential to be affected by not having a qualified nutritional professional with the appropriate competencies and skill sets to carry out food and nutrition services. The findings include: An interview was conducted with the Food Service Manager (staff #3) on 1/8/24 at 8:41 AM. She revealed that she has has been the facility's Food Service Manager for a few years. The Food service manager was hired in March of 2021. She was asked if she was a certified dietary manager (CDM) and she replied that she was not. On 1/8/24 at approximately 9:30 AM, the Food service manager was provided a Nutritional Department Information Request List that included a request for the Food service manager's credentials and copies of the facility's certified dietary manager's credentials. Additional information was received on 1/10/24. The food service manager provided documentation indicating she had completed a Nutrition and Foodservice Professional Training Program, and no documentation related to a dietary manager certification. On 2/5/24 at 2:22 PM, during an interview with the Nursing Home Administrator he stated that the registered dietician (staff #6) was not full time at the facility. The concern that the food service manager did not meet the qualifications to oversee the dietary department was reviewed with the nursing home administrator.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on medical record review, resident and staff interviews it was determined that facility failed to assess a resident's needs and preferences and respond to resident that expressed dissatisfaction with the food provided by the facility and was eating food provided by family members. This was evident for 1 (Resident #109) of 10 residents that were reviewed with expressed concerns with the food provided by the facility. The findings include. Resident #109 was admitted to the facility on [DATE]. Resident #109 was interviewed on 1/8/24 at 12:02 PM. The resident was questioned if the food looked and tasted good, and resident #109 indicated that he/she does not eat the facility's food and his/her family brings food into the facility. The resident was asked if he/she has met with the dietitian to review his/her food preferences and the resident indicated he/she had not met with the dietitian. Resident #109's medical record was reviewed on 1/19/24 at 2:12 PM. The dietitian's (staff #6) nutrition assessment of 12/4/23 and the related 12/4/23 Nutrition/Dietary note. The dietitian's note indicated for the resident to continue with a double portions diet as ordered with indication that resident #109 was at risk for weight loss related to compromising chronic diagnoses. She indicated goals of care for the resident to maintain weight to 5% up or down, resident to eat at least 50% for 2-3 meals daily, and the resident will not have signs or symptoms of malnutrition or dehydration. The nutrition assessment and the nutrition note did not reveal if the resident had food preferences or food dislikes. Review of the nutrition plan of care created on 12/7/23, revealed a focus area regarding resident #109 at risk for weight loss or malnutrition related to chronic disease with a goal the resident will have optimal nutrition and hydration status. Interventions to meet the goals, included 1) encourage to eat, 2) record meal percentage intake, 3) therapeutic diet as ordered, 4) weights as ordered and 5) dietitian consults as needed. The dietitian wrote a second Nutritional/Dietary Note on 1/10/24 with indication that the resident was seen for monthly high risk nutrition assessment. Her note did not indicate that she interviewed the resident and there was not documentation related to the resident's likes or dislikes. The dietitian's documentation was related to documentation in the resident's medical record, such as Edema: no edema per note 1/9/24, GI (gastrointestinal symptoms): no N/v/d/c or abdominal pain noted 1/9/24. She documented Food Preferences as desired. A brief interview was conducted with the dietitian on 1/22/24 at 2:35 PM. She was informed that the resident does not eat the food that is provided by the facility and her documentation in the medical record did not reflect that the facility made reasonable efforts to provide food that the resident would eat. She indicated that she would follow-up with the resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of resident #109's medical record on 1/23/24 at 1:16 PM revealed, the dietician wrote a late entry progress note on 1/22/24 at 2:51 PM for effective date 1/16/24. Her note indicated that food preferences were updated with the resident per the food service manager and the unit manager. She documented that the resident does not want the food provided. Resident likes to order outside food or has family bring him/her food he/she likes. The dietitian wrote a 2nd note on 1/22/24 at 2:52 PM indicating the resident orders outside foods and has family bring in foods, and the resident is not interested in snack at this time then she revealed that she attempted to speak with the resident, but the resident was not available. It was noted that resident #109 was transferred to the hospital on 1/22/24. A phone interview was conducted with the same dietitian on 1/31/24 at 12:42 PM. She was asked how the facility determines what the food preferences, and dislikes are for newly admitted residents or any other resident. She indicated that she, the remote dietician, or the food service manager will obtain the information. She was asked if the food service manager documents in resident medical records and she responded she did not know. She was informed that the surveyor did not find documentation in resident #109's medical record by the remote dietitian or the food service manager. The surveyor reviewed the psychogeriatric certified registered nurse practitioner's progress note dated 12/4/23 documented the resident's dissatisfaction with the food provided at the facility and has been eating food brought by his/her brother. The surveyor shared the concern that her documentation did indicate reasonable efforts by the facility to provide food the resident would have preferred. She responded that she understood.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 48168 Based on interview, observation and record review, it was determined that the facility administration failed to provide effective oversight for the facility to ensure that resident needs were met as evidenced by failing to: 1) ensure that the facility had sufficient nursing staff, 2) ensure that the facility was kept clean and in good repair, 3) ensure residents were protected from potential hazards in the environment, 4) employ qualified kitchen and Dietitian staff, 5) ensure residents' social services needs were met, and 6) ensure an effective Quality Assurance and Performance Improvement (QAPI) program. This was evident during the survey and had the potential to affect all residents. The findings include: Quality Assurance and Performance Improvement (QAPI): Nursing home QAPI is the coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving. In an interview with the Administrator on 1/30/24at 9:03 AM, the Administrator said that he had been the facility Administrator for 4 years. 1) Staffing and Staff Posting: During an interview with Resident #72 on 1/08/24 at 10:29 AM, the resident stated, Sometimes he/she didn't get bathed or changed. Staff who worked 11 PM -7 AM, I didn't even see them till about 5-5:30 AM. On 1/08/24 at 10:54 AM, Resident #109 reported that she/he needed to call the staff with their cell phone, but they hung up on them. It took two hours to get a response from the staff. In an interview with Resident #18 on 1/09/24 at 11:09 AM, he/she stated it took about 2 hours or longer to respond to the call bell. On 1/09/24 at 1:10 PM, Resident #39 said, I did not get medication on the 3 PM -11 PM shift. Put the call light on at 3 AM, but nobody came to the room till 6 AM. On 1/26/24 at 11:34 AM, an interview was conducted with the resident council Present (Resident #272) and Resident #3, who had been attending meetings regularly. Resident #272 stated that residents shared concerns about short staffing on weekends. Additionally, Resident #3 stated that he/she had asked staff to get out of bed during weekends, but they did not have staff who could do it for them. Resident #3 said, Weekend staffing was short, and the residents who are dependent on staff remained in bed all weekend. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/31/24 at 10:52 AM, an interview was conducted with Licensed Practical Nurse (LPN) #4. LPN #4 stated that sometimes the facility staff needed to expand their work by a few hours to complete their assigned work. He/she said, Several times, I stayed until 5 PM when I worked the day shift (7 AM- 3 PM) to finish my charting. When we are short staff, I don't have enough time to give medications to residents. During an interview with Geriatric Nurse Assistant (GNA) #45 on 1/31/24 at 11:09 AM, GNA #45 confirmed that the facility assigned two or three GNAs for the unit even though they were supposed to have four GNAs on the shift. GNA #45 insisted, We experienced burnout while caring for residents due to low staffing. It is common to assign just one GNA when the unit has 38 residents. In an interview with GNA #44 on 1/31/24 at 11:22 AM, GNA #44 stated that he/she experienced low staffing in the building commonly. GNA #44 insisted that low staffing issues affected residents' care, like changing, assisting with feeding, and/or responding to call bells. On 1/30/24 at 9:53 AM as part of the Extended Survey task, an interview with the Regional Director of Operations (Staff #62) was conducted. When asked how staffing levels were determined, Staff #62 said that staffing levels were determined based on a combination of budget, census, special needs - such as a wound nurse, and other factors. The facility itself could not determine their own staffing levels, and the Administrator and the Director of Nursing (DON) had the responsibility to let corporate know if they needed more staff. Cross Reference F725 On 1/26/24 at 11:12 AM during an interview with the Administrator regarding how the facility was deficient in meeting the federal staffing posting requirement, the Administrator said that he was unaware of the federal staffing posting regulation. Cross Reference F732 2) Environment & 3) Potential Hazards During interview on 2/05/24 at 2:08 PM, when asked about his oversight of the facility's physical environment, the Administrator stated that he made daily rounds of the building to identify any issues. He also said there were rounds sheets from Maintenance and Environmental Services that he reviewed every day, and that he ensured follow up was done. When asked about the multiple resident care areas that were in disrepair throughout the building, he acknowledged that there were things that needed to be repaired but said the building was old. When he was asked about the survey team finding of unsecured storage room doors, which resulted in an Immediate Jeopardy situation, he said that he did not know about it before the survey team brought it to his attention. Cross reference F584; F689-J 4) Kitchen and Dietitian (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Also, in the same interview on 2/05/24 at 2:08 PM, the Administrator was asked if there were any concerns with qualified dietary staff, he replied no issues there. When informed that the surveyor had evidence that the facility's Food Service Manager, Staff #3, was not a Certified Dietary Manager, he said he was not aware that she was not qualified to run the kitchen. Cross Reference F801 5) Social Services On 2/02/24 at 11:26 AM the Regional Licensed Clinical Social Worker (SW #46), was interviewed. He said he had oversight of the social services at the facility and had been in his position since 2022, and that his oversight consisted of in person meetings with the social services team 2 x month and as needed. He said he provided virtual training and education, and that he was accessible to social services staff as needed. When asked how he ensured the facility's social services met residents' needs, he explained that he did audit scans through the electronic medical record system, he looked at completed social work assessments, and he asked about assessments that were not completed. When asked if he would know if a care plan meeting was missed, he said not necessarily, it would depend on if it was scheduled, or if there was an invite. When he was informed that the survey team identified multiple instances of missed care plan meetings, he said he was unaware of this concern. He acknowledged that he was responsible for the facility's social services oversight and acknowledged that the oversight was lacking. Cross Reference F657, F745 6) QAPI In an interview with the Administrator on 2/05/24 at 2:08 PM the Administrator said he was the Chairperson of the QAPI Committee, but when asked, he was unable to describe any formal QAPI process. During the same interview he explained some corrected issues re-occurred. When asked about the re-occurrence the Administrator said it was due in part to a lack of accountability. The Administrator was asked if the facility had done any QAPI projects for staffing, environment, kitchen/dietitian, or social services, and he replied no to each area of concern. Cross reference F865

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2024
NAME OF PROVIDER OR SUPPLIER Largo Nursing and Rehabiliation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Largo Road Glenarden, MD 20774	

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F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31982

Based on medical record review, interviews, and observations it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident: 1) for 1 (#18) of 3 residents reviewed for hospitalization , 2) for 1 out of 9 residents (#30) reviewed for wounds, 3) for 1 (Resident #323) out of 3 residents reviewed for hospital visits, and 4) 1 (MD00145026) of 23 facility reported incidents reviewed during the survey.

The findings include:

1) Resident #18's medical record was reviewed on 1/12/24 at 12:28 PM. The record revealed Resident #18's diagnoses included but were not limited to Paranoid Schizophrenia, Major Depressive Disorder and Anxiety Disorder. Resident #18's census record revealed the resident was discharged to the hospital on 6/22/23.

A progress note dated 6/22/23 at 15:38 (3:23 PM) by Staff #59 a Licensed Practical Nurse (LPN) indicated ER (emergency room) Transfer. Around 2:05 pm, Three sheriffs arrived the facility with court order to transfer resident to ER/psych (psychiatric) unit. (Staff #58, the Physician), present at the facility when they arrived. Paramedics later came with the stretcher to transfer. Sheriffs/Paramedics transferred resident on the stretcher to (the hospital) around 2:30 PM.

No documentation was found in Resident #18's medical record related to the circumstances of the court order including any changes in the resident's condition leading up to the transfer or the basis for the resident's transfer by facility staff or the physician. The record failed to reveal that pertinent medical information regarding Resident #18 was provided to the receiving hospital or a physician's order to send Resident #18 to the hospital.

Staff #2 a Social Services Coordinator was interviewed on 1/24/24 at 12:16 PM. She indicated that on 6/22/23 Resident #18 slammed glassware and silverware onto the floor in the dining room. He/She picked some up, took it to his/her room and threatened to hurt others. Staff #2 indicated that she completed a petition and obtained a court order for the resident to have an emergency evaluation at the hospital and the police transported Resident #18 to the emergency room for a psychiatric evaluation.

Staff #2 indicated that she did not retain a copy of the emergency petition for Resident #18's medical record. Upon review of Resident #18's medical record, Staff #2 confirmed there was no documentation on 6/22/23 regarding the behaviors she described or other pertinent information including the basis for transferring Resident #18 to the hospital.

An interview was conducted with the Director of Nursing (DON) on 1/25/24 at 10:54 AM. She confirmed there was no documentation in Resident #18's medical record regarding the behaviors Resident #18 was exhibiting on 6/22/23 or interventions attempted by staff. She confirmed that there was no evidence the physician assessed the resident, documented the resident's condition or rationale as to why the transfer was necessary, nor a written order to send Resident #18 to the emergency roiagnom on [DATE].

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 additional nursing progress notes dated 6/20/23 at 8:07 PM and 9:15 PM also indicated Resident #18 was exhibiting problematic behaviors. Resident #18's Medication Administration Record (MAR) for 6/2023 included 3 separate sections for staff to document resident behaviors on Day, Evening and Night shifts each day. The MAR included codes related to the resident's identified behaviors, and interventions implemented in response to the behaviors. Each shift from 6/1/23 through day shift on 6/22/23 contained a checkmark and staff initials. The MAR did not reflect codes related to the resident's behaviors, staff interventions nor was the effectiveness of the interventions documented for 6/20/23 or 6/22/23. On 02/02/24 01:23 PM The above concern was reviewed with the Administrator and Director of nursing. Cross Reference F 740. 47200 2) On 1/29/24 at 1:48PM the medical record of Resident #30 was reviewed by the surveyor revealing the following active medical order in place: Apply skin prep and foam dressing for protection, Q (every) daily and prn (as needed) one time a day for wound treatment. At this time, the surveyor noted the order failed to include a location for where the skin prep and dressing was to be applied. On 1/30/24 at 12:53PM the surveyor conducted an interview with Staff #25, Wound Nurse, Licensed Practical Nurse who confirmed that the medical order should include the location of application. On 1/30/24 at 1:01PM the surveyor conducted an interview with Staff #9, Licensed Practical Nurse, who reported the skin prep and dressing was to be applied to the resident's left plantar area (sole area of the foot.) On 1/30/24 at 1:16PM the surveyor observed that the medical order had been revised to reflect the location of application. 43096 3) On 2/02/24 at 08:10 AM, the surveyor reviewed Resident #323's medical records. The records review revealed that a progress note documented that the resident was found on the floor on 3/29/23 around 6:25 PM lying face down. The resident was noted with a left forehead bump and a small laceration on the right upper and eyebrow with a small amount of blood. Further documentation from the provider on 3/29/23 at 7:48 PM stated that Resident #323 was transferred to the hospital for further evaluation of a headache due to a fall. A progress note dated 3/30/23 at 3:14 PM documented that Resident #323 was returned from the hospital at 10 AM with a bruise on the Right eye and raised swelling on the frontal lobe of the head. However, there was no documentation from the hospital in Resident #323's electronic medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 2/02/24 at 10:30 AM, the DON stated the facility expected to receive residents' hospital visit records, and nurses needed to reach out to hospitals to get the documentation. The DON also confirmed that the documentation required to be scanned and saved on the residents' charts. On 2/04/24 at 9:30 AM, the surveyor informed the DON there was no documentation on Resident #323's medical records regarding his/her hospital visit on 3/29/23. The DON said, Resident #323 did not bring his/her ER note, he/she only brought antibiotic prescriptions. We assumed that the resident's daughter kept the discharge summary notes. We called ER but were unable to connect them. The DON also stated that she discussed this issue with the Medical Director, and he read Resident #323's hospital record via the website. However, the medical director was not able to print out them. The DON verified that there was no documentation supporting the medical director reviewing Resident #323's records from the hospital. 42507 4) On 2/5/2024 at 9:00 AM, review of Facility Reported Incident (FRI), MD00145026, revealed Resident #419 was noted with discoloration to the left eye on 9/6/2019. The report stated that the resident was assessed by the MD (medical doctor) at bed side, labs and X-ray orders obtained. The report indicated the X-ray was negative for fracture and blood coagulation tests (aPTT, PT/INR) were abnormal. However, the report did not include the actual results of the ordered labs and/or X-rays. Further review of the facility report of the incident revealed there were witness statements from other residents and staff members. However, there were no statements on file, and no staff training records post the incident. On 2/5/2024 at 9:35 AM, in an interview with the Director of Nursing (DON), she stated that the staff who completed the incident report on 9/6/2019 at 3:29 PM, and the former Administrator who completed the FRI report no longer worked in the facility. As of 2/5/2024 at 9:50 AM, the surveyor was not able to review Resident #419's clinical records, as the facility staff was unable to provide these records. The Resident did not have any closed records and s/he was not in PCC (facility's electronic record). Facility administrative staff stated that Resident #419 was in the facility when it was owned by the previous owner and s/he was discharged prior to change of ownership. So, they did not have access to Resident #419's records. However, they stated they were going to contact the previous owner for the medical records. On 2/5/2024 at 10:50 AM, in a follow up interview with Medical Records (Staff #17), she stated that previous owner was in the process of sending them Resident #419's records. Staff #17 added that they contacted the previous owner to grant electronic access for surveyor to get into Resident #419's electronic records. On 2/5/2024 at 12:50 PM, Medical Records (Staff #17), gave surveyor a typed sheet of paper with information to access the previous owner's electronic record (PCC) for Resident #419's medical records. However, surveyors were unable to find any records of the resident using the previous owner's login information provided by Staff #17. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/2024 at 1:13 PM, in an interview with the regional nurse, Staff #48, she confirmed that they could not find any records for Resident #419 using the login information provided to the surveyor. Staff #48 acknowledged that it was the facility's responsibility to keep medical records for their residents. However, she stated that Medical Records Staff #17, told her (Staff #48) that the previous owner took all the documents of residents who were no longer in the facility when the ownership changed (present company took over). On 2/5/2024 at 1:55 PM, Medical Records Staff #17 informed the surveyor that they were able to get into the previous owner's electronic system but were unable to print any document. She stated that they have called the previous owner and were still waiting to get information from them on how to print documents. On 2/5/2024 at 2:10 PM, Medical Records Staff #17 brought surveyor some printed copies of progress notes from 9/8/2019 through 9/15/2019. She stated that she could not get a copy of the resident's face sheet. However, there were no progress notes from 9/6/2019 and no change of condition notes to indicate the date and/or time the injury of unknown origin was first observed (discoloration to Resident #419's left eye) On 2/6/2024 at 10:12 AM, in an interview with DON, she was informed about Resident #419's incomplete medical records, lack of closed records, and surveyor not being able to access electronic records for the resident. The DON provided no new information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 48168 Based on interview and record review it was determined that the facility failed to have an effective Quality assurance and performance improvement (QAPI) program. This was evident during the QAPI facility task investigation during the recertification survey and had the potential to affect all residents, families, and visitors. The findings include: On 2/05/24 at 1:30 PM the Administrator was asked about the facility's QAPI program and who was responsible for it. He stated that he was the person responsible for the QAPI program at the facility. The surveyor asked the Administrator to meet to discuss the QAPI program and invited the Administrator to bring the QAPI binder and any other information regarding the facility's QAPI activities. On 2/05/24 at 2:08 PM an interview with the Administrator was conducted. The Administrator brought a 3-ring binder which contained QAPI information and sign in sheets for the 2023 monthly QAPI meetings. When asked about the QAPI process he said each department head was responsible for identifying and bringing issues to the monthly QAPI meetings. He further stated that any tracking was informal, and it was up to the department heads to ensure changes were sustained over time. When asked if the facility had completed any Performance Improvement Projects (PIP) within the past year, the Administrator stated that in May 2023 the facility did a PIP on baseline care plans. He said that social services brought the concern to the QAPI meeting, education was done, and there was noted improvement in the following month. When asked how he knew that this improvement was sustained, he said the social worker discussed the concern at morning meetings periodically and reminded the team to work on it. When asked if any audits were done, he said he was not aware of any audits. When the Administrator was informed that the survey team's investigation found that baseline care plans were missed or late, he stated he was unaware. The surveyor asked for any additional evidence for QAPI program tracking and auditing that the Administrator could provide but no evidence of tracking was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49409 Based on record review and staff interview, it was determined that the facility failed to maintain an effective infection control program by failure to: 1) place an order for isolation precautions for those diagnosed with C-diff, which was evident for 1 (Resident #23) of 4 residents reviewed for transmission-based precautions; 2) perform hand hygiene while conducting wound dressing, which was evident for 2 (Resident #103 and #175) of 9 residents' reviews for wound dressing; 3) keep linens from contamination, which was evident for 1 (Arcadia unit) of 1 linen closet and laundry room observation; 4) conduct an annual review of infection control policies; and 5) ensure consistent infection prevention monitoring of waterborne infection, which was evident by incomplete water temperature monitoring logs reviewed during the survey. The findings include: Clostridioides difficile (also known as C-diff), is a germ that causes diarrhea and colitis, an inflammation of the colon, transmitted from person to person, via the fecal-oral route. Centers for Disease Control recommended contact precautions for the C.diff patients. Contact Precautions are intended to prevent the transmission of infectious agents, which are spread by direct or indirect contact with the patient or the patient's environment. (Centers for disease control and prevention) 1) On 1/19/24 at 10:30 AM, the surveyor reviewed Resident #23's record. The review revealed that the resident tested positive for Clostridium difficile colitis (C.Diff) on 01/10/2024, however, the review failed to reveal an order for contact precautions. On 01/25/24 at 11:29 AM, during an interview with the Infection Control Preventionist (ICP), the ICP stated that residents who require contact precautions should have an order for contact precautions. The surveyor shared concerns about Resident #23 not having an isolation order for C-diff. The ICP validated that the facility had not initiated an order for contact precautions after Resident #23 tested positive for C. Diff. 2) On 01/23/24 at 09:41 AM, the surveyor conducted a wound treatment observation with Licensed Practical Nurse (LPN) # 38 for Resident #103. LPN #38 failed to perform hand hygiene before and after applying gloves while performing dressing changes for the resident's wound. On 01/23/24 at 10:00 AM, the surveyor conducted another wound treatment observation with LPN #38 for Resident #175. Again, LPN #38 failed to wash or sanitize her hands after removing the soiled dressing and before performing a clean treatment of the wound. On 01/23/24 at 10:21 AM, Staff #38 said in an interview, It is not required to wash or sanitize hands after removing the soiled dressing. Since I had gloves on. On 01/23/24 at 2:00 PM review of the facility policy Infection prevention & control policies & procedures, Handwashing Requirements listed that hand hygiene is required after removing gloves or aprons (under A.1. r.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/23/24 at 02:41 PM, an interview was conducted with the ICP. During the interview, the ICP confirmed that staff were required to wash or sanitize their hands after removing the soiled dressing and before performing a clean treatment of the wound. The surveyor informed the hand hygiene concerns to the ICP. 3a) On 01/12/24 at 10:15 AM the surveyor observed the linen closet in the Arcadia unit. Most of the bottom portion of the closet was noted to be stained and soiled with dust. Also, the surveyor observed some of the linen and a fabric shopping bag on the floor under the last shelf. In an interview with LPN #4 on 01/12/24 at 10:25 AM, LPN #4 validated that since the linen and fabric shopping bag on the floor was contaminated, she would discard them. 3b) On 1/23/24 at 10:19 AM, the surveyor observed the laundry room with the attending Laundry Assistant (Staff #24) and noted untied soiled linen bags were in a linen bin. On 1/23/24 at 10:25 AM during an interview with Staff #24, the staff stated that the staff from residents areas put the used lines in a bag and tied them before putting them in the Laundry chute. The surveyor asked about untied used linen bags. Staff #24 said, Nursing staff knew that they were supposed to tie the bags before sending. On 01/29/24 at 02:06 PM Interview with ICP validated issues with soiled linen. 4) On 01/29/24 at 9:10 AM, the surveyor reviewed the facility's policies. The review noted that the facility's infection control policies & procedures were not revised annually. The copies of the facility's Infection Prevention & Control Policies & Procedures were provided to the survey team were as below: Infection Prevention & control policies & procedures, Antibiotic Stewardship program effective date: 10/24/22 Infection Prevention & control policies & procedures, handwashing requirements effective date: 02/06/20 Infection Prevention & control policies & procedures, Infection prevention & control subcommittee, effective date: 02/06/20 On 01/29/24 at 3:00 PM, an interview was conducted with the ICP and the DON (Director of Nursing). During the interview, both staff confirmed the surveyor's concern that infection control policies were not reviewed annually. 5) On 1/25/24 at 2:05 PM, the Maintenance Director (Staff #10) was interviewed. During the interview, Staff #10 asked how the facility monitors water safety to prevent waterborne infection. Staff #10 responded that the facility had an outside contractor coming once a year to do specific water testing and the maintenance team checked daily water temperature. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/25/24 at 2:50 PM, Staff #10 submitted copies of the temperature logs from June 2023 to September 2023. The log was in table format with the name of the unit, time (8-10 am, 11 am-1 pm, 2-4 pm, and 5-7 pm), and date. A review of the log revealed periods of gaps in the data where no data was recorded for 14 days within the 3 month period. Also, the surveyor reviewed the binder for water temperature logs for recent dates. It was noted that no temperature was recorded since 1/05/24. Also, the logs did not indicate who performed the water temperature check and which location. Many of the dates also did not match the day of the week they were documented for the log. Additionally, the log was written in only one person's handwriting for all columns. Further interview with Staff #10 on 1/25/24 at 2:55 PM, Staff #10 insisted the temperature log was recorded by one maintenance tech (Staff #39). Staff #10 stated that Staff #39 worked 5 days a week 8 AM to 4:30 PM. On 1/26/24 at 8:25 AM, the surveyor obtained copies of Staff #39's timecard details for the period of the above temperature logs. A review of the timecards demonstrated that the employee was not working during several days of the water checks were documented as performed On 01/29/24 at 9:10 AM, shared the above concerns with ICP and the Director of Nursing.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 49409 Based on interviews and the review of the facility records and residents' medical records, it was determined that the facility failed to monitor and track antibiotic usage and resistance data. This was evident by 1) the indications for antibiotic use were not documented for their orders, and 2) the facility's antibiotic stewardship program failed to document essential elements for antibiotic use. This was found to be true for 2 (Resident #3 and #53) of 3 residents reviewed for antibiotic use, and a review of the facility's antibiotic stewardship program during the annual survey. The findings include: 1) On 1/19/24 at 10:00 AM, the surveyor reviewed three resident records with antibiotic orders. For 2 of the 3 resident records, the facility failed to include the diagnoses in the orders of the residents' antibiotics. This was evidenced by: 1a) Resident # 53 had an order dated 11/15/2023 for Clindamycin HCl 300 MG Capsule by mouth three times a day for seven (7) days. There was no diagnosis listed in the order. 1b) Resident #3 had an order dated 12/10/23 for Ceftriaxone Sodium Solution Reconstituted 1 gram intravenously every 24 hours for infection for five (5) Days. There was no specific diagnosis identifying what kind of infection was being treated listed in the order. On 01/25/24 at 11:29 AM, an interview was conducted with the Infection control preventionist (ICP). The ICP confirmed that during daily clinical meetings, the facility staff including providers reviewed that all new antibiotic orders had an appropriate indication, including required supporting lab reports. During an interview with the Director of Nursing (DON) on 1/25/24 at 11:49 AM, the surveyor shared concerns about residents' antibiotic orders that did not have their indication or diagnosis. The DON validated the above concerns. 2) On 1/25/24 at 2:36 PM, the Infection Control Preventionist (ICP) submitted a printed electronic medical record, system generated generic report/form named Infection Surveillance Monthly Report, which included the residents' name, room number, infection onset, infection, sign & symptoms, status, pharmacy order-order name, order date, prescriber, and comments. However, the form did not present a facility specific report for antibiotic surveillance, including the duration of antibiotic use and resistance data. On 01/29/24 at 02:06 PM, an interview was conducted with the ICP. The ICP stated that the facility used Infection Surveillance Monthly Report Form (able to sort data from the electronic medical record system). The facility did not have a specific report for antibiotic surveillance to monitor/track residents' antibiotic use. On 01/29/24 02:15 PM, during an interview with the Director of Nursing (DON) the surveyor shared the above concerns about antibiotic surveillance programs. The DON validated the above concerns.

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F 0908

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Keep all essential equipment working safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 15701

Based on observation and staff interview it was determined the facility failed to: 1) keep the kitchen walk-in freezer in safe operating condition. This was evident during the initial tour of the kitchen and during 2 subsequent visits; and 2) ensure two assistive shower chairs and one sitting chair in a resident room were in safe condition for use evident in one of one seated style shower chair and one of one adjustable shower chair and one of two sitting chairs located in room [ROOM NUMBER] on the [NAME] Wing.

The findings include:

1. On 1/8/24 at 8:41 AM an initial tour of the facility's kitchen was performed with the food service manager (staff #3). When the door was opened to the walk-in freezer it was like walking into a cloud and the visibility of items in the freezer was very difficult to see.

On 1/18/24 at 11:50 AM, the 2nd observation of the walk-in freezer was easier to see than the first day. There were small mounds of ice covering the entire ceiling of the freezer. There was a built-up ice clump (approximately the size of two curled up fists) in the middle of 1 of the 2 circular fans of the main unit. Ice was observed to be on boxes of food directly below the fan units and on boxes below the top row.

The food service manager opened the door to the freezer while the surveyor identified to her the ice clump on the fan, ice on the boxes of food and the ice bumps on the entire ceiling. She said that she would call maintenance.

On 1/29/24 at 10:34 AM a third observation of the walk-in freezer was made. The freezer was not repaired as the space was somewhat cloudy. Ice was still prevalent on the food boxes below the fan unit and the ceiling was almost entirely covered with small ice bumps.

47200

2. On 1/9/24 at 12:14PM the surveyor observed a seated bath chair located in the [NAME] Wing shower room with pink mesh type material for the chair's back support, which was detached and ripped in appearance 3/4 of the way down on one side of the chair's back.

On 1/22/24 at 10:30AM the surveyor requested Staff #8, Unit Manager 2nd Floor, Licensed Practical Nurse, to observe the shower chair condition. At this time, the surveyor conducted an interview of Staff #8, who observed the shower chair and confirmed the shower chair was used for residents. Staff #8 stated to the surveyor regarding the condition of the shower chair's back support: I think that's just the velcro. At this time, the surveyor noted and communicated to Staff #8 that there was no velcro type material present on the chair, and shared the concern regarding the compromised back support of the shower chair. Staff #8 confirmed understanding of the surveyor's concern and stated regarding the chair's backing: It is split. The surveyor observed an additional shower chair in the [NAME] Wing shower room with significant wear and fraying to the green mesh type material along where the mesh that supports body weight connects to the chair's frame. The surveyor shared the concern with Staff #8 who observed, acknowledged, and confirmed understanding of the concern.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Largo Nursing and Rehabiliation Center	600 Largo Road Glenarden, MD 20774

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On 1/11/24 at 11:07AM the surveyor began to conduct an interview in room [ROOM NUMBER] and observed a sitting chair with an exposed sharp metal piece, approximately 1 inch in length x 0.5 inch wide, sticking up out of the back of the upper left corner of the chair. Upon further inspection of the chair, the chair arms were movable back and forth, by approximately 1 inch, and both chair arms lifted up easily from their pegs. On 1/11/24 at approximately 11:08AM, the surveyor conducted an interview with Resident #26 who reported the chair had been there since they came to the facility to live, and they reported regarding the chair: It was over there, I moved it over here. On 1/11/24 at 11:43AM the surveyor requested Staff #8, Unit Manager 2nd Floor, Licensed Practical Nurse, to observe the sitting chair with surveyors. The surveyor shared their concerns at this time with Staff #8, who acknowledged the concerns and stated the following: Yes, I see, this is not safe, so I will remove it and give the chair to maintenance and get the resident another chair.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. 37296 Based on surveyor interview and observation, it was determined that the facility failed to have adequate and functional mechanically operated exhaust ventilation, as necessary to control moisture and odors to ensure good air circulation to keep all parts of the facility odor free. This was evident during the initial tour of the facility. The findings include: On 5/2/2024 at 9:30 AM the Surveyors entered and began the initial tour of the facility. Immediately upon entering the second floor, a distinct ligneous malodorous smell was persistent throughout the second floor of the facility. On 5/3, 5/7 and 5/8/24, the malodorous smell was persistent to all Surveyors. On 5/7/24 at 9:23 AM, a tour with the Maintenance Director revealed that all 10 intakes located on the second-floor nursing unit were not functional. On 5/7/24 at 11:18 AM an interview with the Maintenance Director Revealed that all intakes are vented to the outside using 2.5-inch PVC pipe and the intakes are not built to use a motor. The Maintenance Director confirms the malodorous smell which he states may be coming from the carpet. An observation on 5/3, 5/7 and 5/8/24 of the secure unit on the second floor revealed no carpet on the unit but the ligneous malodorous smell was persistent throughout.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48168 Based on record review and interviews it was determined that the facility failed to provide Quality Assessment and Performance Improvement (QAPI) training to staff. This was evident during completion of the Extended Survey portion of the survey and had the potential to affect all residents, families, and visitors. The findings include: Quality Assurance and Performance Improvement (QAPI) is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem solving (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition, accessed 12/18/2020). In an interview on 1/30/24 at 3:12 PM, the facility's Nurse Educator (Staff #23) was asked about staff training records. She explained that she was new to the facility and was unable to provide any training records for 2022 for any staff. An interview with the Administrator and the Regional Director of Operations (Staff #62) was conducted on 1/31/24 at 11:17 AM. When asked for evidence of QAPI training, the Administrator initially did not answer the question. When asked again the Administrator said the facility did not have specific QAPI training, that he thought it was part of another training topic. The surveyor asked for additional evidence. No additional QAPI training evidence was provided to the survey team.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 43096 Based on documentation review and interview, it was determined the facility failed to ensure nurse aides receive the required training, including dementia care and abuse prevention, no less than 12 hours per year. This was evident for 3 Geriatric Nursing Assistants (GNAs) (#29, #40, and #42) of 3 GNA training records reviewed. The findings include: GNA's personnel files were reviewed on 1/30/24 at 9:04 AM. 1. A review of GNA #29's personnel file revealed GNA #29 was hired in July 2019. The employee file showed that GNA #29 completed online training for abuse and neglect in December 2020, May 2022, and October 2023. However, there were no required training records (abuse, neglect, and dementia care) upon hire and in the year 2021. 2. A review of GNA #40's personnel file revealed GNA #40 was hired in July 2019. The record listed GNA #40's abuse training in November 2020, November 2021, and November 2023. However, there were no records of abuse and dementia training upon hire in 2022. 3. A review of GNA #42's personnel file revealed GNA #42 was hired in October 2021. The online training transcription listed that GNA #42 completed abuse training in December 2023 and dementia training in October 2021 and December 2023. However, there was no other documentation to support GNA #42 completed abuse training upon hire and annual required training in 2022. During an interview with Staff #23 (educator) on 1/30/24 at 11:56 AM, Staff#23 stated that the facility used [name of online training program] for employees' training. The system automatically assigned employee training, and Staff #23 tracked them. The surveyor shared concerns that GNA's required training (no less than 12 hours, including dementia care and abuse training) was not presented in employees' personnel files. Staff #23 said, I started in May 2023. When I started, their training was not tracked, so I tried to catch up with the most recent training. I don't know about the training records before I started. On 1/31/24 at 8:21 AM, an interview was conducted with the Director of Nursing (DON). The DON validated the above concerns about GNAs' training.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 31982 Based on review of facility records and interview with staff it was determined the facility failed to provide a behavioral health training program for all staff which included but was not limited to providing care for residents diagnosed with mental, psychosocial, or other behavioral health condition and Individualized non-pharmacological approaches to care. This was evident for 1 (#18) of 4 residents reviewed for Behavioral-Emotional. The findings include: Facility Reported Incident MD00198994 was reviewed on 1/25/24 at 11:00 AM. The report revealed an incident on 10/28/23, witnessed by another staff member in which Staff #29 allegedly struck Resident #18 with a telephone during a physical struggle. The employee file for Staff #29 was reviewed on 1/29/24 at 12:53 PM. Staff #29 was hired on 7/30/19 as a Geriatric Nursing Assistant (GNA) and began working as a full-time receptionist at the facility in November 2021. Staff #29's record of training since hire was requested and reviewed. The record revealed she received 1/2 hour of RELIAS (an electronic training software) training on 10/24/23 related to Managing Aggressive Behaviors. There was no record that Staff #29 received any Behavioral Health training. An interview was conducted on 1/30/24 at 3:22 PM with Staff #23 the Staff Development Nurse. She was asked what specialized training was provided for the staff related to caring for residents with mental and psychosocial disorders. She indicated they received training from RELIAS -behavior health for older adults for GNA's and Nurses. She was made aware that there were residents with psychiatric disorders including schizophrenia and that the surveyor was looking for specific training for staff to be able to provide care and services to meet the needs of residents with Psychiatric problems. She was unable to describe any specialized training or provide information related to staff training for behavioral health. A copy of the RELIAS Behavioral Health for Older Adults was provided and reviewed by the surveyor on 1/31/24 at approximately 11:00 AM. The Learning Objectives stated After taking this course, you should be able to: * Identify behavioral health disorders common in older adults. *Describe tools used for behavioral health screening. And *Explain the available services to support the behavioral health functioning of older adults which outlined various treatment settings such as outpatient, hospital, and community/home settings. It did not include training for staff related to developing and implementing resident centered plans of care based on each residents individualized behavior health needs including but not limited to behavior monitoring and identification and implementation of individualized non-pharmacological interventions. There was no evidence the staff received education related to behavior management including but not limited to aggressive behavior, threatening behavior, hallucinations, or delusions. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's bed capacity was 130 and the resident census at the beginning of the survey on 1/8/24 was 127 residents. The facility's most recent Facility Assessment was provided by the Administrator and reviewed on 1/31/24 at approximately 2:00 PM. Table 1.4 summarized the most common conditions and combinations of conditions the facility may accept as admissions or that current residents may develop. The table included 17 categories including but not limited to Behavioral Health which indicated that at the time the assessment was completed 60 residents were identified for Care Planned Behavioral Health Needs. Behavior Management Program was blank. The Psychiatric/Mood Disorders section reflected 26 residents with Schizophrenia, 47 residents with Depression, 75 residents with Anxiety Disorder, 43 residents with Psychosis (hallucinations/delusions) 0 with PTSD (Post Traumatic Stress Disorder), and 28 with Bipolar Disorder. The Medication Therapy section included: Antipsychotic: 79, Antidepressant: 99, Antianxiety: 32 and Hypnotic: 3. Table 1.5 Care & Services Provided to our Residents identified all care and services the facility identified it provided based on resident needs. The table included 5 categories. Other Services included Mental Health, Behavior Management, Non-Pharm. Approaches. Cross reference F 741.