STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215341	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Nsg & Rehab Ctr Belair	1909 Emorton Road Bel Air, MD 21015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 47200 Based on observation, interview, and record review it was determined the facility failed to ensure Resident #68 had access to their call bell to call for staff assistance. This was evident for 1 out of 4 residents reviewed for environment. The findings include: During surveyor's initial tour of the facility on 5/28/24 at 10:28AM, Resident #68 was observed to be laying in bed with their call bell on the floor out of reach behind their bed. On 5/28/24 at 10:29AM the surveyor requested a dual observation with Licensed Practical Nurse (LPN) #35 who observed and upon interview, they confirmed the location of the call bell. The surveyor observed LPN #35 pick the call bell off of the floor and give it to Resident #68 and clipped the call bell cord to their bed. On 6/10/24 at 12:35PM the surveyor conducted review of the medical record for Resident #68 which revealed the following information included in the care plan interventions dated 3/5/24: keep call bell in reach and encourage me to use it for assistance and have commonly used articles within reach.

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

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

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F 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** 47200 Based on observation, interview and record review it was determined the facility failed to 1) ensure a second certification of incapacity was obtained, 2) ensure that residents were provided information regarding advanced directives, and 3) obtain Advanced Directives from residents/resident's family. This was evident for 3 (Residents #54, #90, and #112) out of 7 residents reviewed for advanced directives during the recertification survey. The findings include: An advanced directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under the State law (whether statutory or as recognized by the State courts) relating to the provision of health care when the individual is incapacitated. 1) On [DATE] at 9:57AM the surveyor observed the Maryland Order for Life Sustaining Treatment (MOLST) form in the paper chart of Resident #90 and noted that under the certification section, it was marked as the resident or authorized decision maker having declined to discuss or unable to make a decision about treatments, and the form was signed by Physician #41 and dated [DATE]. On [DATE] at 9:59AM the surveyor observed the advanced directive document dated [DATE] for Resident #90 located in their paper chart stating the advanced directive was for in the event they became incapable of making an informed decision, and further detailed that the determination of incapacity would be made by the attending and a second physician or licensed clinical psychologist after a personal examination of them, and was to be certified in writing. On [DATE] at 9:59AM the surveyor additionally observed only one certification of incapacity in the resident's medical record dated [DATE]. Upon further surveyor observation of the resident's paper chart, a facility health care decision maker form was completed which documented that as of [DATE], the health care decision maker named in the resident's advanced directive was already in place. On [DATE] at 10:05AM the surveyor conducted an interview with Unit Manager #9 who observed documentation in the medical record with the surveyor and confirmed that upon the resident's admission to the facility, the following information was documented by Physician #41: (Resident #90) came with a MOLST done by him/her, I tried to dicuss MOLST with (Resident #90) but he/she had little understanding, (Resident #90) will be full code by default until decision maker clarified. On [DATE] at 10:07AM the surveyor further inquired to Unit Manager #9 regarding a decision maker being in place for the resident without a second certification of incapacity present. At this time, they communicated to the surveyor that it was their job to ensure two certifications of incapacity were completed and confirmed with the surveyor that only one certification of incapacity was present, and informed the surveyor they would need to call a supervisor regarding the inquiry. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:29AM the surveyor conducted an interview with the Director of Social Work #21 who reported to the surveyor that they typically consulted with relatives of the resident for decision making regarding the resident. At this time, they confirmed with the surveyor that a second certification of incapacity should be present in the medical record. On [DATE] at 12:07PM after surveyor intervention, the Director of Social Work #21 provided the surveyor with a copy of a second certification of incapacity completed on and dated [DATE] and informed the surveyor that although regular audits were performed, I missed the chart. 48168 2) On [DATE] at 9:48 AM a review of Resident #54's electronic medical record revealed no evidence that the resident had an advance directive or that one had been offered to the resident. On [DATE] at 10:19 AM a review of Resident #54's paper chart revealed a Maryland Order for Life Sustaining Treatment (MOLST) dated [DATE] which indicated No CPR, Option B and indicated that this decision was per the resident's advance directives. However, there was no advance directive document found in the paper chart. On [DATE] at 11:39 AM in an interview with the social services designee (Staff #10), she stated that advance directive information should be in each resident's paper chart and may also be scanned into the electronic record. She further stated that the facility process was to offer advance directive information to all new admissions and document any discussion with residents in the progress notes section of the electronic record. Additionally, all residents were seen every quarter for assessments, perhaps sooner if the resident had a change in condition. At each of these assessments a review of the advance directives should take place and the review should be documented in the resident's medical record. On [DATE] at 11:51 AM a follow up interview with Staff #10 was conducted. When asked if Resident #54 had made or been offered to make an advance directive, Staff #10 said she was not sure and would look for that documentation. On [DATE] at 3:38 PM the Nursing Home Administrator (NHA) provided the surveyor a copy of documentation written by Staff #10 and dated [DATE] at 15:02 that stated SWA has discussed formulating an advance directive with resident in the past. She has previously declined. SWA approached the resident today and now [the resident] is in agreement to formulate a directive. SWA to assist with directive today. Since the documentation was written the day of the surveyor interview, the surveyor asked to speak to Staff #10 again. On [DATE] at 3:51 PM an interview with Staff #10 and the Director of Social Work (SW#21) was conducted. A review of Resident #54's record was conducted again with both Staff #10 and SW #21, and they both confirmed that there was no previous documentation of any discussion with the resident regarding advance directives, the resident did not have any advance directive, and the resident had been at the facility for two years. They both confirmed that there was no evidence that the resident had previously been asked for or provided information about advance directives. 50458 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) A review of Resident #112's medical record on [DATE] at 12:39 PM revealed that the resident was admitted to the facility on [DATE]. There was no copy of his/her advance directive. Further review of Resident #112's Admission Assessment Notes, written by a social worker on [DATE], showed that the social worker documented that the resident had an Advanced Directive, ask [family member]. During an interview with a social worker (Staff #21) on [DATE] at 3:51 PM, Staff #21 stated that if a resident had an advance directive, she would ask who the facility could contact to bring a copy to file in the medical record. On [DATE] at approximately 9 AM, the surveyor requested that the Director of Nursing (DON) submit copies of documentation regarding Resident #112's advance directive. On [DATE] at 10:39 AM, the DON brought a copy of Resident #112's Advance Directive. She stated that the facility's social worker had contacted resident #112's family member to get a copy of the advance directive upon admission (about a month ago). The DON confirmed that the advance directive was submitted from Resident #112's family member on [DATE] after the surveyor asked about the social worker follow up.

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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. 42507 Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative (RP) in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 1 (#86) of 6 residents reviewed for hospitalization during a recertification survey. The findings include: In an initial interview with Resident # 86 on 5/28/2024 at 11:14 AM, the resident stated that s/he was sent to the hospital over a week ago for low blood level. When asked if s/he was notified in writing the reason for the transfer, Resident #86 state s/he was told verbally about the reason for the transfer but was not given anything in writing. On 5/30/2024 at 11:45 AM, a review of nurses' progress notes revealed the following documentation dated 4/30/2024 at 23:37 (11:37 PM): Note Text: Resident admitted to UCMC (Upper Chesapeake Medical Center) per [staff name] for symptomatic anemia and GI bleed. Change in condition documentation (SBAR) dated 4/30/2024 at 17:09 (5:09 PM) revealed Resident #86 was transferred to the hospital. However, there was no documentation and/or evidence in the record indicating that the facility staff notified the resident/resident's representative (RP) in writing of the reason for the transfer to the hospital. On 5/30/2024 at 12:05 PM, surveyor requested from the Nursing Home Administrator (NHA) to see written notification for the reason of transfer to the hospital given to Resident #86 and/or their RP and a copy of the bed hold policy given to the resident or their RP. On 5/31/2024 at 10:31 AM, in an interview with the Director of Nursing (DON) and NHA, DON confirmed that she could not find any documentation that Resident #86 and/or their RP was given any written notification of the reason for transfer to the hospital on 4/30/2024. However, DON stated that the reason for transfer was documented on the change in condition form (SBAR) including that family/RP was notified. On 6/4/2024 at 8:30 AM, an interview was completed with Licensed Practical Nurse (LPN #14) who has worked full time in the facility for over a year. Regarding transferring residents out to the hospital, LPN #14 stated that she has never given a resident/RP anything in writing regarding reason for transfer out. LPN #14 further stated that the reason was written in transfer sheet placed in packet sent to the hospital. LPN #14 added that the residents and/or their families were told verbally why the residents were transferred to the hospital. On 6/4/24 at 8:54 AM, an interview was completed with Unit Manager (UM #1). UM #1 confirmed that she has never given residents/their RPs in writing the reason for transfer to the hospital. She stated that the resident and/RP were told verbally the reason why the resident was transferred (in person if RP was in the facility and/or phone call if not in facility).

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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. 42507 Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative in writing of the bed-hold policy upon transfer of a resident to an acute care facility. This was evident for 2 (#86, #104) of 6 residents reviewed for hospitalization during a recertification survey. The findings include: The bed-hold policy describes the facility's policy of holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization . 1) In an initial interview with Resident # 86 on 5/28/2024 at 11:14 AM, the resident stated that s/he was sent to the hospital over a week ago for low blood level. When asked if s/he was notified in writing the reason for the transfer, Resident #86 stated s/he was told verbally about the reason for the transfer but was not given anything in writing. Resident #86 added that s/he knew they were holding their bed but did not know for how long. On 5/30/2024 at 11:45 AM, a review of nurses' progress notes revealed the following documentation dated 4/30/2024 at 23:37 (11:37 PM): Note Text: Resident admitted to UCMC (Upper Chesapeake Medical Center) per [staff name] for symptomatic anemia and GI bleed. Change in condition documentation (SBAR) dated 4/30/2024 at 17:09 (5:09 PM) revealed Resident #86 was transferred to the hospital and the resident's representative (RP) notified of the transfer. However, there was no written documentation that the resident/responsible party was notified in writing of the bed-hold policy. Bed hold was not checked off as provided. On 5/30/2024 at 12:05 PM, in an interview with the Director of Nursing (DON), she stated that bed hold notification was given by the transferring nurse when a resident was transferred out to the hospital. The surveyor requested bed hold and written transfer notification given to Resident #86 and/or their RP when the resident was transferred out on 4/30/2024 including the facility's bed hold policy. On 5/30/2024 at 12:50 PM, in a follow up interview with the DON, she gave the surveyor copies of the facility's bed hold policy. However, DON stated that they were still looking for the bed hold notification that was provided to Resident #86 when s/he was transferred to the hospital on 4/30/2024. On 5/31/2024 at 10:31 AM, in an interview with the DON and Nursing Home Administrator (NHA), DON confirmed that she could not find any documentation that Resident #86 and/or their RP was given a copy of the bed hold notification and/or any written notification of the reason for transfer to the hospital. However, DON stated that the reason for transfer was documented on the change in condition form (SBAR) including that family/RP was notified. DON added that bed hold notification was supposed to be included in the change in condition form, but facility staff failed to complete that part of the form. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/2024 at 8:30 AM, an interview was completed with Licensed Practical Nurse (LPN #14) who has worked full time in the facility for over a year. Regarding bed hold, LPN #14 confirmed that the facility's bed hold policy was included in the transfer packet when a resident was sent out to the hospital. However, LPN #14 stated that she has never given any written bed hold policy notification to a resident and/or their representative upon transfer to the hospital. She further stated, It's my understanding that residents' and their families are aware of the bed hold policy. On 6/4/24 at 8:54 AM, an interview was completed with Unit Manager (UM #1). Regarding bed hold notification, UM #1 stated that she has never given residents/their RPs a copy of the bed hold notification upon transfer to the hospital. UM #1 confirmed that the 3-day bed hold policy was given in the envelope to the hospital upon transfer but not to the resident and/or their RP. When asked to show a copy of the written bed hold policy provided for Resident #86 when they were sent out to the hospital on 4/30/2024, UM #1 was unable to do so. 49409 2) On 05/28/24 at 10:44 AM, an interview with resident #104 and the resident's family member/responsible party (R.P) revealed that the resident fell at the facility and was sent to the hospital on 05/08/2024. R.P. was present at the facility during the resident's transfer and confirmed that the facility did not offer a bed hold policy to the resident or R.P. On 5/29/2024 at 01:43 PM, the surveyor's record review revealed that the resident (#104) had been at the facility for the past two months for short-term rehabilitation. The resident was transferred to the hospital on 05/08/24 and was admitted . However, there was no evidence that the resident or resident's representative received a bed hold policy. Documentation from 05/08/24 at 8:50 PM, regarding the change in condition, by staff #42 revealed that Bed hold policy: Not given to resident or family. The package was given to EMTs. On 06/04/24 at 08:27 AM, an Interview with staff #43 revealed that the staff prepares the required documentation package, including the bed hold policy, and gives it to the paramedic (a person trained to give emergency medical care to people who are ill or injured outside the hospital) during resident emergency transfers. Staff #43 also confirmed that he/she does not communicate with residents or family, stating that maybe nursing supervisors communicate regarding the bed hold policy. On 06/04/24 at 01:13 PM, the surveyor reviewed the lack of communication with the resident or family member regarding the bed hold policy with the Director of Nursing (DON) and the Nursing home administrator (NHA). The surveyor's review also included resident #104 not receiving a bed hold policy from the facility at the time of transfer to the hospital. DON stated that the Director of admissions usually calls families, but was not able to provide documentation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on observation, medical record review, and interview it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#70) of 42 residents reviewed during a recertification survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. On 6/3/2024 at 11:45 AM, a review of Resident #70's clinical records revealed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to adjustment disorder with mixed anxiety and depressed mood, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. On 6/3/2024 at 12:16 PM, review of physician orders revealed the following active orders originally written on 3/21/2024: Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth in the morning for Depression. On 6/3/2024 at 12:34 PM, review of the Medication Administration Record (MAR) for March, April, and May 2024 revealed the resident was getting Sertraline HCl Tablet 25 mg 1 tablet by mouth in the morning for Depression, start date 3/21/2024. On 6/3/2024 at 2:17 PM, review of Resident #70's quarterly MDS with an assessment reference date (ARD) of 4/20/2024 was completed. Section I (Active Diagnoses) did not capture adjustment disorder with mixed anxiety and depressed mood and/or Depression under psychiatric/mood disorder (subsection 15800). However, Section N (Medications) captured use of Antidepressant on both the quarterly MDS of 4/20/2024 and Discharge Return Anticipated MDS dated [DATE]. Review of progress notes revealed the following Nursing Narrative Note written on 3/21/2024 at 9:30 AM: Resident saw [Name] CRNP on 3-19-24 from Counterpoint Health Services, recommendation to start Sertraline 25mg po daily for depression, secondary to increase tearfulness and signs and symptoms of depression, Recommendation to start Sertraline 25mg po daily approved by [name of medical director]. On 6/3/2024 at 2:35 PM, a review of psychiatry note dated 3/19/2024 at 21:23 (9:23 PM) revealed the following documentation: under chief complaint/nature of presenting problem: Follow up assessment for depressed mood/grief (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under Assessment/Plan/Orders/Recommendations: [Resident's name] presented as sad and tearful today. Add sertraline 25 mg po q day. Under diagnosis, assessment . adjustment disorder with mixed anxiety and depressed mood. On 6/4/2024 at 8:30 AM, surveyor reviewed Resident #70's active orders with Licensed Practical Nurse (LPN #14) who confirmed that the resident was receiving an antidepressant Sertraline HCl Oral Tablet 25 MG daily in the morning for depression. When asked if Resident #70 had depression, LPN #14 immediately navigated to the medical diagnosis tab in PCC (electronic record) and confirmed that depression was not indicated in the medical diagnoses tab. LPN #14 further stated that she could review Psych notes for their recommendations/indication regarding the antidepressant medication. On 6/4/2024 at 9:08 AM, an interview was completed with the Unit Manager (UM #1). Regarding Resident #70's active diagnoses, UM #1 verified that Depression was not included under the medical diagnosis tab in PCC, however, adjustment disorder with mixed anxiety and depressed mood was indicated. UM #1 stated she could look under psych notes for diagnosis of depression. UM #1 reviewed and noted that Psych notes dated 3/19/2024 had recommendations to start resident on the above antidepressant and diagnosis of adjustment disorder with mixed anxiety and depressed mood. UM #1 further reviewed notes dated 3/21/2024 that she had written regarding starting the resident on the above antidepressant. She also reviewed physician orders for Sertraline 25 mg with indication Depression, and reviewed MDS sections I and N for both the quarterly on 4/20/2024 and Discharge on 5/28/2024 with the surveyor. UM #1 verified and confirmed that the diagnoses of adjustment disorder with mixed anxiety and depressed mood and/or depression were not captured on both 4/20/2024 and 5/28/2024. UM #1 stated it's a learning process. On 6/4/2024 at 9:58 AM, in an interview with the MDS Coordinator (Staff #11), surveyor reviewed Section I of Resident #70's quarterly MDS with ARD of 4/20/2024 and MDS of 5/28/2024. Staff #11 verified and confirmed that Resident #70's MDS assessment was inaccurate. She stated that usually the MDS coordinator would code the diagnosis and the expectation was to go back 60 days to look for active diagnoses and make sure the diagnoses were still active in the 7 days ARD look back period. Staff #11 added it was an oversight on their part. On 6/5/2024 at 10:55 AM, in a follow up interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA), surveyor reviewed Resident #70's Section I of the quarterly MDS with ARD of 4/20/2024 and Discharge MDS of 5/28/2024. DON stated she was not aware that the resident's diagnosis of depression and/or adjustment disorder with anxiety and depressed mood was not captured on the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on observation, medical record review, and staff interview, it was determined that the facility staff failed to develop and initiate comprehensive person-centered care plans for residents residing in the facility. This was evident for 4 (# 70, #46, #54, #90) of 42 residents reviewed during a recertification survey. 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. Minimum Data Set (MDS) is a standardized assessment tool that is used to evaluate the health status and functional capabilities of residents, and to help nursing home staff identify health issues. 1) On 6/3/2024 at 11:45 AM, a review of Resident #70's clinical records revealed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to adjustment disorder with mixed Anxiety and Depressed Mood, Unspecified Dementia, unspecified severity, without Behavioral disturbance, Psychotic Disturbance, Mood disturbance, and Anxiety. During a review of Resident #70's medical record conducted on 6/3/2024 at 12:16 PM, surveyor noted active physician orders for: Sertraline HCl Oral Tablet 25 MG (Sertraline HCl) Give 1 tablet by mouth in the morning for Depression. On 6/3/2024 at 12:34 PM, review of the Medication Administration Record (MAR) for March, April, and May 2024 revealed staff documentation that Resident #70 was getting Sertraline HCl Tablet 25 mg 1 tablet by mouth in the morning for Depression, start date 3/21/2024. On 6/3/2024 at 2:30 PM, a review of Resident #70's care plan was completed: The Care plan did not address the diagnoses of depression and/or adjustment disorder with mixed anxiety and depressed mood. Furthermore, the plan of care did not mention that the resident was on a psychotropic (antidepressant) medication (sertraline 25 mg daily) as indicated in the physician's order and MAR. The facility staff failed to develop a comprehensive care plan for use of an antidepressant medication with measurable goals and nursing interventions/evaluations. On 6/4/2024 at 8:30 AM, surveyor reviewed Resident #70's active orders with Licensed Practical Nurse (LPN #14) who confirmed that the resident was receiving an antidepressant Sertraline HCl Oral Tablet 25 MG daily in the morning for depression. Regarding Care plans, LPN #14 stated that s/he has never updated/revised any resident's care plan. LPN #14 verified and confirmed that Resident #70's care plan did not address the use of antidepressant medication and/or depression. However, LPN #14 stated that she only referred to the care plan when she needed more information about a resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor reviewed Resident #70's care plan with the Unit Manager (UM #1) during an interview on 6/4/2024 at 9:08 AM. UM #1 confirmed that there was no focus, goal, or interventions on the care plan for the use of antidepressant medication and/or indication for use of the medication. UM #1 stated s/he was going to revise the resident's care plan right away to address the use of antidepressant medication. On 6/5/2024 at 10:55 AM, in a follow up interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA), surveyor reviewed the above findings with them. DON stated that the Unit Manager (UM #1) had informed them about the care plan not capturing Resident #70's diagnosis and use of antidepressant medication. 50502 2) On 05/29/24 at 09:08 AM, Resident #46 was observed having difficulty hearing the surveyor while being interviewed. He/she was also observed not wearing hearing aids on both ears. No hearing aids were seen within the resident's reach or elsewhere in the room. On 05/29/24 at 09:08 AM, Resident #46 stated that his/her hearing aids were in the room somewhere but that he/she was not sure where they were. He/she expressed that he/she likes wearing hearing aids because it helps him/her hear better. He/she added that he/she feels discouraged not hearing conversations and keeps on saying huh? He/she stated, I would like them to be accessible. He/she indicated that staff do not help him/her access the hearing aids and that he/she hasn't worn hearing aids for several weeks. On 05/30/24 at 01:01 PM, a record review of Resident #46's paper chart revealed a completed and signed belonging list dated 5/5/24, the resident's date of admission. The belonging list reflected that hearing aids 1 and 2 were present on admission. On 05/31/24 at 11:19 AM, the surveyor reviewed the hearing aid policy revised on 10/2022. The policy indicated the following: - Assess resident's knowledge of operating the hearing aid. - Assist resident to adjust control to desired level. Required if physically disabled. - Place the hearing aid in appropriate container when not in use, and store in a safe place. - Document in resident's clinical record, response to use of hearing aid, adjustment and include all pertinent observations. If resident refuses to have nursing staff lock up hearing aid at night, order must be obtained to keep it at bedside. On 05/31/24 at 11:19 AM, the surveyor reviewed the Minimum Data Set (MDS) with an assessment reference date of 5/10/24 for section B. The section was coded with ability to hear with the use of hearing aid or other hearing appliance. Also, the nursing admission assessment dated [DATE] reflected that Resident #46's hearing was not adequate and hearing aids were present on admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/31/24 at 12:17 PM, the surveyor interviewed the Minimum Data Set (MDS) nurse (Staff #11). He/she stated that Resident #46 has a hearing aid care plan dated 5/31/24 but incomplete, he/she added that there were no interventions yet. He/she further stated that even if Resident #46's assessment did not trigger the communication care area, he/she confirmed that care planning should have been completed. On 06/03/24 at 12:03 PM, the surveyor received the paper copy of the hard of hearing and hearing aid care plan from the DON. The care plan was initiated on 5/31/24, which was more than 14 days from the date of admission and after surveyors had begun their investigation. 48168 3) A nephrostomy tube is a thin, flexible catheter that drains urine from the kidney into a bag outside the body. On 5/29/24 at 9:36 AM a review of Resident #54's medical record revealed that the resident had been hospitalized in April 2024 for a urinary tract infection and kidney stones that obstructed the normal passage of urine. A nephrostomy tube was placed while the resident was at the hospital and was in place when the resident returned to the facility. On 5/31/24 at 12:54 PM a review of Resident #54's care plan revealed a problem for Risk for impairment to skin integrity related to surgical procedure (left flank nephrostomy tube) with the initiation date of 4/06/24. The associated goal for this problem was nephrostomy wound will have no complications through the review period. The following interventions were listed, all dated 4/06/24: -Check for incontinence every 2 hours and as needed. Use barrier cream with incontinence care to prevent skin breakdown. -Daily skin inspection. Notify the nurse of any changes to skin integrity. -Dietary consult for nutritional monitoring and evaluation of supplements for wound healing. -Enhanced Barrier Precautions-nephrostomy tube -Use caution with transfers The care plan lacked any care instructions for the nephrostomy wound site, care of the nephrostomy tube, or care of the urine collection bag. On 6/05/24 at 8:50 AM an interview with the Director of Nursing (DON) was conducted. Resident #54's care plan was reviewed with the DON, and she confirmed that the resident's care plan did not include care instructions for the resident's nephrostomy tube, site, and urine collection bag. 47200 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 5/28/24 upon surveyor's initial tour at approximately 10:20AM the surveyor observed Resident #90 in bed with a piece of paper posted on the wall behind their bed which indicated observation of left hip precautions and that the resident required a pink wedge pillow when in bed. At this time, no wedge pillow was observed to be in place for the resident. On 5/28/24 at 2:55PM the surveyor conducted a second observation of Resident #90 who was observed to be in bed with the wedge pillow in place. On 6/4/24 at 2:30PM the surveyor reviewed the medical orders for Resident #90 which revealed active medical orders for the following care beginning on 5/1/24: Anterior hip precautions- do not step backwards with surgical leg, no hip extension, do not allow surgical leg to externally rotate (turn outwards), do not cross your legs, use a pillow between legs when rolling to observe anterior hip precautions for left hip, kindly use the abduction pillow in bed at nighttime, every shift for post surgical precautions, Weight bearing as tolerated on left lower extremity with use of walker every shift, Apply ice pack to left hip for 20 min., may repeat TID (three times a day) indication for use; post surgical pain every 8 hours as needed for post surgical pain. On 6/4/24 at 3:35PM the surveyor reviewed the care plan for Resident #90 which revealed the care plan did not reflect interventions necessary to care for the resident who was admitted to the facility after their left hip fracture with surgical repair. On 6/5/24 at 9:20AM the surveyor conducted an interview with Licensed Practical Nurse (LPN) Unit Manager #1 and LPN Nursing Supervisor #40 who both confirmed with the surveyor that the care plan did not include anterior hip precautions and other post surgical care for the left hip fracture, but should be included. At this time, the surveyor shared their concern and requested a copy of the current care plan. On 6/5/24 the surveyor was provided with a copy of a care plan, that after surveyor intervention, had been revised to reflect post surgical care of the left hip dated 6/5/24. On 6/5/24 at 9:53AM the surveyor reviewed the post surgical and orthopedic discharge instructions which included the following post operative care instructions: postoperative sequential compression devices on both legs whenever on bed or chair more than 30 minutes, weight bearing as tolerated status, follow anterior hip precautions, use of the abduction pillow when in bed, avoid active hip abduction exercises for 6 weeks to protect the abductor repair, limit hip extension to neutral, avoid figure 4 position, limit external rotation to to 20 degrees, instructions for care of the surgical site, and ice the surgical site as frequently as possible for 20 minute periods, among other recommendations. Further review of the care plan revealed that after revisions were made on 6/5/24, the interventions still did not comprehensively reflect all of the resident's care interventions.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on the resident and staff interviews and medical record review, it was determined that the facility failed to revise care plans after a resident sustained an injury after a fall. This was evident for one resident (Resident #95) out of 42 residents reviewed for care plan timing and revision. The findings include: Resident #65 has been at the facility for a month to get short-term rehab for a respiratory infection. On 05/29/24 at 11:07 AM, an Interview with a resident (#95) revealed that the resident sustained Fracture after a fall in the facility on 05/16/24. The resident was sent to the Hospital and returned to the facility on [DATE]. On 06/06/24 at 10:05 AM Record review revealed that the risk for falls care plan was Initiated on 05/02/2024 with the goal will have no falls through the review period. The resident sustained injury after a fall on 05/16/24, and after returning from the Hospital, the resident's care plan goals and interventions were not revised until 06/05/2024 to provide appropriate care after injury. On 06/04/24 at 08:27 AM, an Interview with Nursing Staff #43 revealed that she/he works mostly during night shifts. She/he gets the status of the residents at the beginning of the shift from outgoing staff and sometimes from progress notes. She/he will not initiate or update any care plans; she/he stated that supervisors may do the care plans. On 06/04/24 at 08:33 AM, an Interview with staff #47 revealed that she/he works the day shift, gets the report from outgoing staff, and reads the notes from medical records. She/he does not initiate or update care plans. On 06/04/24 at 01:13 PM Interview with the Director of Nursing (DON) & Nursing home administrator (NHA) reviewed the care plan-related issues for resident # 95. The DON stated that fall risk was assessed during the admission. If the resident is at risk for falls, appropriate interventions are implemented. If any additional changes occur, the team makes recommendations and documents. The team, including the medical Director, reviews falls weekly at a risk management meeting. IDT also trends the falls and comes up with interventions. The team also discusses fall management at QA meetings each Month. DON also stated that most of the management team is new. The DON also reviewed the Care plan process. Between unit managers, the Assistant Director of Nursing manager (ADON), the Nursing Supervisor, DON, and the Minimum Data set (MDS) coordinator, do care plan follow-ups and updates. ADON compiles and ensures that all the plans and recommendations are implemented and compiles data for the risk meeting.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50502 Based on observation, interview and record review, it was determined that the facility failed to have a resident's hearing aids accessible to the resident. This was evident for 1(Resident #46) of 1 resident reviewed for management of their hearing aids. The findings include: Minimum Data Set (MDS) is a standardized assessment tool that is used to evaluate the health status and functional capabilities of residents, and to help nursing home staff identify health issues. On 05/29/24 at 09:08 AM, Resident #46 was observed having difficulty hearing the surveyor while being interviewed. He/she was also observed not wearing hearing aids on both ears. No hearing aids were seen within the resident's reach or elsewhere in the room. On 05/29/24 at 09:08 AM, Resident #46 stated that his/her hearing aids were in the room somewhere but that he/she was not sure where they were. He/she expressed that he/she likes wearing hearing aids because it helps him/her hear better. He/she added that he/she feels discouraged not hearing conversations and keeps on saying huh? He/she stated, I would like them to be accessible. He/she indicated that staff do not help him/her access the hearing aids and that he/she hasn't worn hearing aids for several weeks. On 05/30/24 at 08:36 AM, a review of Resident #46's record revealed that the resident was bed-bound and unable to get out of bed independently to obtain supplies in his/her room. On 05/30/24 at 12:05 PM, a record review of Resident #46's treatment administration record (TAR) did not reveal any information about Resident #46's hearing aids such as instructions and care of the hearing aids. The resident's physician notes were also reviewed at that time and revealed a physician's progress note dated 5/14/24 that documented the resident was hard of hearing (HOH). On 05/30/24 at 01:01 PM, a record review of Resident #46's paper chart revealed a completed and signed belonging list dated 5/5/24, the resident's date of admission. The belonging list reflected that hearing aids 1 and 2 were present on admission. On 05/31/24 at 08:49 AM, the surveyor interviewed Licensed Practical Nurse (LPN)#20 who was assigned to work with Resident #46 on that day. When asked if she was aware that Resident #46 was hard of hearing (HOH), she stated no, I'm not aware. She further stated that other residents who use hearing devices keep the devices in a container in their rooms. On 05/31/24 at 09:28 AM, Resident #46 was again observed not wearing hearing aids. Hearing aids were also not noted on the bedside table. Resident #46 required the surveyor to repeat several times, indicating that Resident #46 had trouble hearing. On 05/31/24 at 11:19 AM, the surveyor reviewed the hearing aid policy revised on 10/2022. The policy indicated the following: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Assess resident's knowledge of operating the hearing aid. - Assist resident to adjust control to desired level. Required if physically disabled. - Place the hearing aid in appropriate container when not in use, and store in a safe place. - Document in resident's clinical record, response to use of hearing aid, adjustment and include all pertinent observations. If resident refuses to have nursing staff lock up hearing aid at night, order must be obtained to keep it at bedside. On 05/31/24 at 11:19 AM, the surveyor reviewed the Minimum Data Set (MDS) with an assessment reference date of 5/10/24 for section B. The section was coded with ability to hear with the use of hearing aid or other hearing appliance. Also, the nursing admission assessment dated [DATE] reflected that Resident #46's hearing was not adequate and hearing aids were present on admission. On 05/31/24 at 11:19 AM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator. The DON stated Resident #46's hearing aids were found locked in the night stand. The surveyor expressed concerns that Resident #46 can't reach the night stand independently and that the resident has expressed frustration at not hearing well. The DON acknowledged the concern and stated that she will talk to the nursing staff.

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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. 47200 Based on interview and record review it was determined the facility failed to: 1) ensure timely and necessary care was provided to a resident, including following medical orders, staff communication regarding resident needs, oversight, assessment and action by staff trained and allowed within the scope of practice for care of resident tube feeding equipment and appropriate documentation of care concerns, and 2) ensure that there were accurate physician orders for resident care. This was evident upon surveyor's review of two facility self reported incidents (MD00205639 & MD00205866) regarding Resident #3, and one resident (Resident #71) of three residents reviewed for rehabilitation services. The findings include: 1.) On 5/28/24 the surveyor began review of two facility self-reported incidents concerning the care of Resident #3. On 6/3/24 at 12:55PM the surveyor conducted a review of the medical record which revealed the following care information for Resident #3 which included the following: turn and reposition every 2 hours and as needed while in bed, turn q2hr and PRN pillows- placement- repositioning, provide incontinence care every 2 hours and as needed, use barrier cream with incontinence care as indicated, side rails- observe for injury or entrapment related to side rail use, bed mobility- requires participation of 2 to reposition and turn in bed to prevent shearing, dependent on staff, prefers to re-position with 2 people, frequent repositioning, check enteral tube for residual every shift/if 150 ml or over, hold feeding for 1 hour and re-check: if residual 100ml or over, notify MD- document in ml- every shift document amount, provide water flush 300ml x 3 during tube feed time 4pm-5am every evening and night shift, enteral feeding via g-tube every shift via feeding pump at 60ml/hr x 13hrs total volume 780ml/24hr up at 4pm/down at 5am one time a day run tube feeding until total volume infused, safe environment- reachable call light, and call light within reach. On 5/30/24 at 1:05PM upon surveyor review of the initial self reports made by the facility it was noted that the facility documented the first incident concerning Resident #3 was alleged as having occurred on 5/9/24. On 5/30/24 at 1:05PM upon surveyor review of the initial self-reports made by the facility it was noted that the facility documented the second incident concerning the resident was alleged as having occurred on the 11pm-7am shift on 5/11/24 into 5/12/24. On 5/30/24 at 1:05PM, the Director of Nursing (DON) verbally confirmed with the survey team that the facility-reported incident investigation files presented to the surveyor were the complete investigation files for both incidents. During an interview on 5/31/24 at 2:52PM the DON and Administrator confirmed with the survey team that the list of times documented in the investigation files were complete from their review of camera footage of staff entering and exiting the room of Resident #3 during the alleged timeframes of the incidents and confirmed that their investigations relied upon this review and documented information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 12:41PM the surveyor reviewed the facility's initial self report dated 5/9/24 which documented that the Social Worker made the facility's Director of Nursing and Administrator aware of an allegation involving Resident #3 on 5/9/23, having been left left lying flat in bed, uncovered without their call bell in reach for an extended period of time. The surveyor noted the incident was alleged as occurring on 5/9/24, and was not initially reported to the Office of Healthcare Quality until 5/17/24, approximately eight days later, during which time, a second alleged incident regarding Resident #3 was documented as occurring beginning on 5/11/24. Surveyor review of the facility's documented final self report for the 5/9/24 incident revealed the facility documented the outcome of the investigation was inconclusive, despite also documenting that it was determined that no staff rounded on the resident for three hours. On 6/11/24 at 1:19PM the surveyor conducted an interview with Geriatric Nursing Assistant (GNA) #27, who was assigned to the care of the resident on 5/9/24. GNA #27 reported to the surveyor that when they entered the resident's room on 5/9/24, Resident #3 was left laying on their side from after wound rounds and Resident #3 stated to them that they needed LPN #5 to do their dressing. GNA #27 further reported that on 5/9/24, Resident #3 stated the following to them in response to the incident: Wound rounds left me like this. At this time, GNA #27 confirmed with the surveyor that the resident was upset by the incident. GNA #27 confirmed they believed it had been several hours since the resident had been checked on last, and additionally reported, that after the incident, all parties involved were taken to the Director of Nursing's office where staff were asked if they understood the severity of the situation. Further review of the facility's complete investigation file revealed a written statement by Wound RN #28 regarding the 5/9/24 incident, which included the following: I entered first and noted location of (Resident #3's) call bell. I asked if s/he could tap it- s/he tried- unsuccessful. No documentation was found regarding any actions having been taken by Wound RN #28 in response to their initial finding that Resident #3 was unable to tap the call bell. On 6/11/24 at 1:26PM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #20, who reported the following information regarding their role with wound rounding on 5/9/24: My job was to make sure the resident was prepped for the doctor to come in and see them. The doctor, wound nurse, and I went in and turned the resident on their side. When the surveyor inquired as to if the resident was left by the team with the call bell within reach, LPN #20 replied that they did not remember. Upon surveyor inquiry as to what measures were being put into place following the incident to prevent recurrence, they reported to the surveyor that temporary dressings were now being applied after at the conclusion of wound team rounding, so that no one has to be positioned in a way they can't reach a call bell. Further review of the facility's investigation revealed a statement collected from LPN #5, dated 5/10/24 which stated the following: Regarding repositioning, I am unable to confirm that it was performed as assigned GNA stated s/he knows residents routine. Wound nurse did not notify myself or orienting nurse that wound team saw resident during wound rounds to prioritize resident's wound treatment above all other tasks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's complete investigation file for the 5/9/24 incident revealed the Administrator's documented timeline review of camera footage of when staff was in the resident's room on 5/9/24: 9:33-9:38AM: Registered Nurse- Wound Nurse #28, LPN #20, and Physician #29, go into room (LPN #20 is last one to exit room) 1:18PM-GNA goes in room 1:21PM (LPN #5) goes in room as well 1:22PM RN #20 goes in to room as well, works on getting treatments from cart with LPN #5 1:27PM RN #20 and LPN #5 exit room 1:37PM GNA exits room. Review of the camera footage timeline documentation revealed no staff present in the resident's room between the hours of 9:38AM and 1:18PM, approximately three hours and forty minutes. Further review of the facility's complete investigation file revealed written information dated 5/9/24 by LPN Unit Manager #1, stating the following information: (Resident #3) did not request to not have the GNA or nurse again. S/he just wants to be taken care of and I agree totally. LPN Unit Manager #1 further documented they believed the assigned staff required education secondary to the resident's complaint. Continued review of the complete investigation file revealed the following information documented in employee education notes and/or disciplinary action form: On 5/9/24 resident was seen by wound rounds and was left on side with no dressing to sacrum. Resident is totally dependent on staff for repositioning and care. Resident is incapable of reaching for call bell and needs to be positioned in such a way that s/he is able to utilize the call bell for assistance. On 5/9/24 during wound rounds, a nurse was covering for a regular wound round staff member, and a dependent resident was left on his/her side, with call bell not able to be reached. In addition, the dressing was not intact, leaving wound exposed. On 5/9/24 [Resident #3] was left in a flat position after wound rounds and unable to have his/her call bell in reach. [Resident #3] is at high risk for pressure ulcers and aspiration and turning and repositioning are necessary for skin integrity and to prevent aspiration. Review of the active medical order dated as beginning on 12/28/22 on the treatment administration record for the month of May 2024 revealed the following was ordered to occur: Turn and reposition every 2 hours (every shift) every shift strict t & p (turning and repositioning) Q (every) 2 hrs. Review of the facility-reported incident alleged to occur on 5/11/24 and 5/12/24 revealed documentation that a weekend supervisor was called to the resident's room on 5/12/24 around 2pm, and it was reported that Resident #3 felt like food was coming up and was scared of aspiration and unable to call for help. The documentation submitted in the initial self report to the Office of Healthcare Quality on 5/13/24 documented a concern that the Resident was left in bed from 6pm to 6:30am without access to her call bell and being left in the same position. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor review of the facility's follow-up self-report dated 5/17/24 regarding this second incident revealed the following information was documented by the facility: DON/NHA (Nursing Home Administrator) apologized on behalf of the facility that the situation occurred. DON and NHA placed the touch call pad in different locations near his/her cheek and hand and the Resident was unable to press the call bell in any position, regardless of proximity. Discussed concern for the resident not being able to use the call bell. Facility documentation for the conclusion/outcome of their investigation revealed it was deemed inconclusive, however, the facility documented the following in their conclusion: It is confirmed that the GNA did not provide care from 11p-6:30am. The nurse provided medications around 10pm and early morning medications/flush around 6:30am. The nurse did see the resident sleeping around 3-4am with no distress noted. On 5/30/24 at 2:16PM the surveyor conducted an interview with the Administrator and DON, at this time they confirmed with the survey team that based on their camera footage review of both shifts for 5/11 and 5/12/24, no one was in the room from approximately 11pm to 6:30am, and further confirmed that the documentation in the investigation file of camera footage times was for the dates of 5/11/24 and into 5/12/24. Review of the facility's complete investigation file for the 5/11/24 and 5/12/24 incident revealed the Administrator's documented timeline review of camera footage of when staff was in the resident's room on 5/11/24 into 5/12/24: 6:47-6:58PM- LPN #31 in room 8:49-9:01PM- LPN #31 in room 9:09PM- RN #28 and RN #26 open door and check in on Resident 10:40pm-10:43PM GNA #32 goes into room 6:30-6:35AM LPN #31 in room 6:38-7:00am GNA in room On 6/3/24 at 3:26PM the surveyor conducted an interview with the Administrator and DON who both verbally confirmed to the survey team that no staff was in the resident's room during the timeframe overnight in question. The DON stated to surveyors that a nurse was seen rounding, but did not go into Resident #3's room. The DON further confirmed with the surveyor that the overnight tube feed for the Resident needed to be checked on, and could not be observed appropriately from the hallway. On 6/3/24 at 10:43AM the surveyor conducted an interview with the DON who stated the following was their documentation expectation for facility staff: There should be something in the medical record that staff met with the resident and concerns were addressed. On 6/6/24 at 9:10AM the surveyor conducted an interview with the Administrator who reported there was no current process in place to ensure that documentation of resident complaints ends up in their medical records. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/24 at approximately 10:37AM the surveyor conducted an observation of Resident #3's room from the hallway prior to entering the room, and noted the resident's feed pump was unable to be visualized from the nursing unit hallway, and the resident was unable to be effectively visualized from the nursing unit hallway. After the facility concluded their final investigation on 5/17/24, and after surveyor intervention, the DON reported that disciplinary action would take place because of the rounding and checking on the infusing tube feeding that did not occur. Further surveyor review of the facility's complete investigation file revealed GNA #33 was assigned to the resident for the 11PM to 7AM shift beginning on 5/11/24 and into 5/12/24, as confirmed by the staffing schedule and their statement. The surveyor noted the following information included in GNA #33's statement sent to the DON: Upon commencing my shift, I found [Resident #33] asleep. I began my rounds at 5am, attending to him/her at approximately 6:30AM. During my care routine, I stopped his/her feeding before I attended to her personal needs, I completed my tasks by resuming her feeding and turning off the lights before departing his/her room. The surveyor noted at this time that the GNA was describing they had manipulated the Resident's tube feed pump. On 5/31/24 at 2:41PM the surveyor conducted an interview with the DON who reported the following information: The issue we had with them [GNA #33] was the 2 hour rounding not being done. When the surveyor further inquired as to the GNA performing stopping and starting of the tube feeding, the DON replied: The issue was the 2 hour rounding, I didn't catch that. The DON further reported that the issue of the tube feed not being checked on by LPN #31 was not thought of until recently, and they did not realize this issue at the time of their investigation. Further surveyor review of the investigation file revealed GNA #33 was not allowed to return to the facility beginning on 5/13/24, and the facility documented a complaint that was made regarding GNA #33 to the Maryland Board of Nursing. The following information was included in the investigation file: It was determined that the GNA (#33) was assigned 11PM-7AM but did not go into the Resident room for any care until 6:30AM. NHA notified GNA #33 that camera footage was reviewed and there was no evidence of him/her going into the room. On 6/11/24 at 12:20PM, after surveyor intervention, the Administrator informed the surveyor that a follow up complaint to the Maryland Board of Nursing, regarding GNA #33's documented actions of starting and stopping the Resident's tube feed pump were made on 6/11/24, and provided a copy. On 6/12/24 at approximately 9:03AM the surveyor shared concerns with the facility Administrator and DON, who both acknowledged understanding of the concerns. 48168 2) On 5/28/24 at 3:08 PM in an observation of Resident #71, a sign posted above the resident's bed indicated that the resident used a hand splint for their right hand. On 5/31/24 at 1:43 PM a review of Resident #71's physician orders revealed that there were no orders regarding the resident's hand splint. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 12:07 PM an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) was conducted to review splint care for Resident #71. The DON stated that the resident had used the splint since 2022. The DON was asked about the orders for the splint and documentation of the resident's use and response to use of the hand splint. The DON responded that she could not find any order for the splint or care of the splint, and because there was no order entered into the medical record the care was not entered into the Treatment Administration Record where documentation of care would be documented. She stated that there should have been an order and care documentation for the resident's splint care. She could not explain why the order and documentation was not in the resident's records.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48168 Based on observation, interview, and record review it was determined that the facility failed to ensure that residents received respiratory care consistent with professional standards of practice. This was evident for 2 (#44, #86) of 2 residents reviewed for respiratory care during the recertification survey. 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. Oxygen therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider. 1) On 5/28/24 at 10:53 AM Resident #44 was observed in bed with oxygen tubing lying next to the bed. The oxygen tubing was connected to a wall oxygen outlet and was set at 1.5 liters. The connected humidification water bottle was empty and undated, and the oxygen tubing was also undated. When asked, the resident explained that they used oxygen all of the time but must have taken the tubing off sometime during the night but was not sure. During the same observation, the surveyor asked the resident to activate the call device to test it and the resident did so. At 11:02 AM, the unit manager (Staff #1) entered the resident's room and when asked about the resident's oxygen use, she said she thought the resident used oxygen continuously, but she was not sure and also said she wanted to check the resident's oxygen levels. Staff #1 left the room and returned with a pulse oximeter device and checked the resident's oxygen level which ranged from 90%-94% on room air. Staff #1 then explained that she would get a new oxygen set up since the one in place was undated and she did not know how long it had been in use. At 11:08 AM Staff #1 returned to the resident's room with new tubing and water bottle and connected them to the wall oxygen, she placed the oxygen nasal cannula (plastic tubing that goes into the nose) on the resident, dated the water bottle and tubing, and encouraged the resident to take deep breaths. On 5/28/24 at 1:55 PM a review of Resident #44's medical records revealed that there were no physician orders for oxygen and there was no mention of oxygen use in the resident's care plan. On 5/29/24 at 2:25 PM an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) was conducted. They both said they were aware that Resident #44 had been observed to be without oxygen and that the humidification water bottle and oxygen tubing were found undated. The DON and NHA were asked to provide evidence of an active physician order for oxygen and care plan documentation for oxygen use. On 5/30/24 at 1:14 PM a review of Resident #44's care plan revealed no problem listed for oxygen use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/03/24 at 2:32 PM the DON brought copies of oxygen orders for Resident #44. The list of orders contained two active orders, one dated 5/30/24 to change oxygen equipment weekly, and an order dated 6/01/24 for oxygen at 2 liter/min[ute] continuously via N/C [nasal cannula] to maintain sats [oxygen level] above 92%. She confirmed that there was no active oxygen order in place on 5/28/24 when the resident was observed to have oxygen at bedside and then placed on the resident by Staff #1. The DON stated that she thought the oxygen order missed being re-entered when the resident returned from the hospital in March 2024. The DON also brought a copy of the resident's care plan which contained a problem for oxygen use which was dated 6/01/24. The DON confirmed that there was no problem for oxygen on the resident's care plan from 3/12/24 through 6/01/24 and that there should have been. 42507 2) On 5/28/2024 at 10:56 AM, the surveyor observed Resident #86 lying in bed. The resident was wearing a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) that was connected to a humidifier (water) bottle connected to wall oxygen set at 1LPM (liters per minute). The LPM oxygen flow rate of 1 indicates that 1 liter of oxygen should flow into the resident's nose in 1 minute. The humidifier bottle was empty and dated 5/15/2024. However, the oxygen tubing/ nasal cannula was not dated. When asked, the resident was unable to recall when the oxygen tubing was last changed but indicated that the oxygen should be set at 2L via nasal cannula. On 5/28/2024 at 11:09 AM, Licensed Practical Nurse, LPN #5 observed and confirmed that the oxygen was set at 1LPM, Oxygen tubing was not dated, and humidifier bottle empty and dated 5/15/2024. LPN#5 stated that the humidifier bottles were changed at night, but s/he was going to replace it. When asked what the ordered Oxygen setting for Resident #86 was, LPN #5 stated that s/he was going to find out if they were titrating the resident's oxygen down. Regarding labeling, LPN #5 stated that the expectation was that all oxygen tubing should be labeled with the date and time they were hung. On 5/28/2024 at 11:15 AM, LPN #5 came back to Resident #86's room and told the surveyor that the only order s/he found was for Oxygen at 2LPM via nasal cannula. LPN #5 then changed and dated the humidifier bottle and set the oxygen level to 2L via NC. During a review of Resident #86's medical record conducted on 5/30/2024 at 10:11 AM, surveyor noted an active physician order dated 5/11/2024 for: OXYGEN: Every Shift O2 @ 2L/MIN CONTINUOUS VIA N/C FOR hypoxia at bedtime every shift patient wears at hour of sleep. There was another order dated 5/12/2024 for OXYGEN EQUIPMENT: 11-7 Shift Weekly O2/NEB Equipment CHANGE O2 TUBING NASAL CANNULA/MASK WEEKLY IF IN USE every night shift every Wednesday- change and date oxygen tubing and humidifier. On 5/30/24 at 10:40 AM, review of Treatment Administration Record (TAR) for May 2024 revealed staff documentation that the Oxygen equipment was changed on 5/15/2024, 5/22/2024, and 5/29/2024. Staff on all 3 shifts from 5/11/2024 documented Oxygen was at 2L/min continuous via N/C for hypoxia at bedtime every shift patient wears at hour of sleep. However, the tubing had no date label, and the humidifier bottle was dated 5/15/2024 when surveyor did their observation on 5/28/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/2024 at 11:23 AM, a review of Resident #86's care plan reveal that a plan of care was developed for Oxygen therapy r/t hypoxia, SOB. The interventions included but were not limited to: Oxygen via nasal cannula at 2L as needed to maintain oxygen saturation greater than 92%. The goal was for the resident to have no signs or symptoms of poor oxygen absorption through the review date. However, the plan of care did not instruct that the oxygen tubing and humidifier be changed and dated once a week as indicated in the physician's order and TAR. On 5/30/2024 at 12:51 PM, in an interview with the Director of Nursing (DON), surveyor reviewed resident's orders for Oxygen, staff documentation on the TAR, oxygen care plan, and surveyor's observations on 5/28/2024. DON stated it was the responsibility of all the nurses to replace the humidifier when the bottle was empty. Regarding care plans, DON stated that the care plan was updated by the IDT (Interdisciplinary Team) members. Surveyor reviewed the resident's care plan on Oxygen therapy with the DON. DON stated that the Unit/nurse managers were responsible for initiating that care plan. Regarding the interventions not being comprehensive and resident centered, DON stated that it would be of additional benefit if the care plan was reflective of the physician orders. However, she added that nurses would refer to the residents' orders, MAR and TAR to prioritize their day before going to look at the care plan. On 5/30/24 at 2:00 PM, the surveyor reviewed facility's policy on Oxygen Administration via Nasal Cannula or Mask: Under Policy - .Oxygen Therapy will be administered in accordance with Physician's order, or in an emergent situation by patient requirement by a Respiratory Therapist or licensed Nurse. Under procedure and Maintenance - Check equipment daily. Empty remaining water in refillable humidifier when water level is low and refill with distilled water. Under Set up: .Set flow meter to designated liter flow (read center of the ball. All concerns were addressed with the DON and Nursing Home Administrator (NHA) prior and during the exit conference on 6/12/2024 at 1:10 PM.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42507 Based on medical record review and staff interview it was determined the facility staff failed to ensure that pharmacist recommendations were acted upon and documented in the resident's medical record. This was evident for 1 (#2) of 5 residents selected for Unnecessary Medications Review during a recertification/complaint survey. Findings include: Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. Resident #2's medical record was reviewed on 5/31/2024 at 11:37 AM. Resident #2 was admitted to the facility on [DATE]. Monthly medication regimen review with consultant pharmacist recommendation to physician was not readily found in Resident #2's medical record. On 6/3/2024 at 9:10 AM, in an interview with the Director of Nursing (DON), s/he stated that the pharmacist reports were in the resident's paper chart. DON was asked to provide copies of the drug regimen review and documentation that the recommendations, if any, were reviewed and/or addressed by the resident's physician for the months of January through May 2024. On 6/3/2024 at 12:45 PM, in a follow up interview with the DON, s/he stated that there were no pharmacist recommendations for February through May 2024. However, DON added that there was a pharmacist recommendation for the month of January 2024, but s/he was in the process of getting the documentation from medical records. On 6/4/2024 at 12:19 PM, the surveyor received and reviewed consultant pharmacist recommendation to physician for MRR dated 1/17/2024: This resident has been taking omeprazole 20 mg QD since 8/23/23. PPIs are potent drugs as inhibitors of gastric acid production at the parietal cell. Their inhibitory effects can last for up to 72 hours and even longer for most geriatric residents. Additionally, some studies have strongly indicated that patients taking PPIs for longer than one year are at significantly higher risks for hip fracture. All PPI drug therapy requires a documented review for continued use after 12 weeks of routine use. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed the following response was checked: This Resident's PPI therapy has been re-evaluated and is appropriate for continued use; dose reduction is contraindicated, and the benefit of use outweighs the risk. However, the form was signed on 6/3/2024 (same day surveyor requested information regarding the review from the DON). There was no indication that Resident #2's physician reviewed the above pharmacist recommendation on 1/17/2024 and signed off as accepting or declining it prior to surveyor's intervention. Further review of the progress notes did not reveal any documentation that the above pharmacy recommendation on 1/17/2024 had been addressed prior to 6/3/2024. There was no documentation by the attending physician that the identified irregularity had been reviewed and acted upon. In a follow-up interview conducted with the DON and Nursing Home Administrator (NHA) on 6/4/2024 at 12:45 PM, DON was asked if the recommendations by the pharmacist on 1/17/2024 for Resident #2 were evaluated by their attending physician. The DON confirmed that there was no documentation regarding the attending physician's evaluation addressing the medication in question for Resident #2. DON further stated that s/he (DON) had given the form to Resident #2's attending physician to sign on 6/3/2024 because they could not find any documentation that the pharmacist recommendation on the MRR dated 1/17/2024 was addressed. S/he acknowledged that it was missed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 50458 Based on interviews and record reviews, it was determined that the facility failed to monitor and document residents' needs for the use of PRN (as needed) psychotropic medication. This was evident for 1 (Resident #112) of 5 residents reviewed for unnecessary medication during the annual survey. The findings include: Clonazepam is a psychotropic medication used to treat seizures, panic disorder and anxiety. On 5/31/24 at 9:22 AM, a review of Resident #112's medical records revealed that the resident was prescribed Clonazepam routinely for panic disorder 2 times per day, at 4 PM and 8 PM, and was also prescribed a PRN dose that could be given once per day if needed for panic disorder that was not managed with the routinely scheduled doses. Further review of Resident #112's Medication Administration Record (MAR) showed that the resident received 5 PRN doses of Clonazepam in May 2024: 5/14/24 at 2:48 PM, 5/18/24 at 12:01AM, 5/19/24 at 1:56 PM, 5/21/24 at 8:36 AM, and 5/26/24 at 1:45 PM. However, there was no documentation of the resident's behavior that described the need for any of the PRN doses given. During an interview on 6/03/24 at 8:39 AM with Licensed Practical Nurse (LPN #12), she was asked how residents' were assessed for the need for PRN psychotropic medications. LPN #12 explained that if residents had mood and behavior concerns like agitation, medication would be given, and it would be documented on the MAR and on the progress notes why the medication was given. During an interview with the Director of Nursing (DON) on 6/03/24 at 12:01 PM, he/she confirmed the rationale for PRN medication should be documented in the progress notes when it was given. The surveyor shared that Resident #112's PRN Clonazepam doses did not have corresponding rationale documented in the progress notes. The DON validated the surveyors' concerns.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47200 Based on observation, interview and record review it was determined that the facility staff failed to: 1) ensure cold holding temperatures were consistently taken, ensure cold holding temperatures are maintained within appropriate ranges, ensure ice cream freezers were free from ice build up, and ensure ice cream was covered, and 2) ensure the required sanitation levels of the facility's dishwashing machine at each mealtime were monitored. This was evident during the facility's recertification survey. The findings include: 1) On 5/28/24 at 9:01AM the surveyor conducted an initial tour of the facility's kitchen. On 5/28/24 at 9:05AM the surveyor observed the walk in refrigerator and the temperature documentation which revealed there were no documented temperature readings in the AM or PM for 5/1/24 and 5/2/24, no documented temperature readings for 5/9/24 in the AM, no documented temperature readings for 5/16/24 in the AM, and no documented temperature readings for 5/24/24 in the PM. Additionally, the surveyor observed the following temperatures documented above 41F for the walk-in refrigerator: 5/7/24 AM temperature of 42F 5/8/24 AM temperature of 42F 5/10/24 AM temperature of 43F 5/13/24 AM temperature of 45F 5/14/24 AM and PM temperature of 42F 5/15/24 AM temperature of 45F 5/25/24 AM temperature of 42F 5/28/24 AM temperature of 44F On 5/28/24 at 9:09AM the surveyor conducted an interview and shared their concerns with Staff #4, Food Service Director. At this time, the Food Service Director reported their awareness of missing temperatures and temperatures documented above 41F from a recent local health inspection. On 5/28/24 at 9:16AM the surveyor observed ice build up on top of a large ice cream tub with a damaged lid that was not securely covering the container, and approximately a one inch build up of ice was present around the perimeter of the freezer chest. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/28/24 at 9:23AM the surveyor observed a second freezer chest with a top sliding glass door, with several inches of ice build up around the perimeter present. On 5/28/24 at 9:26AM the surveyor observed the temperature log for the arctic air server refrigerator and noted that on 30 occasions during the month of May 2024, the temperature was documented as exceeding 41F. On 6/10/24 at 10:26AM the surveyor reviewed the local health inspecton report dated as performed on 5/23/24 documenting the facility was out of compliance for cold holding temperatures which was corrected on site. The surveyor noted that elevated temperatures and a missing temperature continued to occur after 5/23/24. On 5/29/24 at 2:25PM the surveyor shared additional kitchen concerns with the Administrator and Director of Nursing, who acknowledged understanding of the concerns. On 6/12/24 surveyor concerns were shared again during the exit conference. 15701 2) A follow-up kitchen inspection was conducted on 6/10/24 to observe the functioning of the dish washing machine and review dishwashing monitoring logs. One dietary staff member was operating the dishwashing machine. The water temperature gauges were observed to be above the minimal wash and rinse temperatures as per the dish machines manufactures guidelines. Review of the current Dishwashing/warewashing machine temperature log revealed missing documentation as the dishwasher temperatures were not checked at each mealtime. On 6/3/24 there were only recorded hot water temperatures for breakfast. On 6/4/24 there were only recorded temperatures for dinner. On 6/6/24 there were only temperatures recorded for breakfast. There were not any temperatures recorded on 6/7/24. On 6/8/24 there were only temperatures recorded for breakfast with a rinse temperature recorded at 113 degrees Fahrenheit which was below the minimal requirement of 180 degrees. There were not any temperatures recorded for all three meals on 6/9/24. Review of the previous dishwashing log with dates between 5/10/24 to 5/27/24. Review of the document revealed only one mealtime dishwasher temperatures were documented on 5/11/24 (L), 5/12/24 (L), 5/13/24 (B), 5/16/24 (D), 5/21/24 (D), 5/22/24 (D), 5/26/24 (L), 5/27/24 (L). The following dates did not have any documented dishwashing temperatures, 5/15/24, 5/20/24, and 5/25/24. An introduction to the director of food service (staff#4) occurred at 10:32 AM with review of the current dishwashing log with her acknowledgement of missing temperature documentation for certain dates and mealtimes. She was asked to make a copy of the current and previous temperature log. She took the dishwashing temperature log and questioned the dietary worker (staff#23) and filled in a couple of temperatures before making the requested copies. Upon receipt of the dishwasher logs, the concern that staff were not routinely monitoring the dishwashing water temperatures was addressed with the food service director.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49409 Based on the surveyor's observation, interview with facility staff, and medical record review, the facility failed to 1) maintain accurate medical records on each resident in accordance with professional standards. This was evident for 3 residents (Resident # 58, #3 and #567) out of 42 residents reviewed for the accuracy of medical records. Findings include: The medical record must reflect the resident's condition and the care and services provided across all disciplines. This ensures that information is available to facilitate communication among the interdisciplinary team. 1) Resident #58 had been at the facility since 03/11/24. The surveyor observed the resident in bed on 05/28/24 at 10:09 AM, 05/29/24 at 11:20 AM and 11:34 AM, and on 06/06/24 at 01:08 PM. The resident was not able to respond verbally. On 06/06/24 at 01:37 PM, a Medical record review revealed that staff #15 documented in monthly activity progress notes on 03/21/24, 04/12/24, and 05/07/24 that the resident was provided with books/magazines on request, hallway guitar music, pets on wheels and mail delivery. Has received a puzzle book to work on in the room and enjoyed in-room activities. On 06/10/24 at 12:33 PM, a medical record review of activity task / Kardex documentation revealed the following: (Task) Creative arts offering PRN: for 22 times, (Task) Mental activity PRN; 15 times, (Task) Music and entertainment activities PRN: 13 times, (Task) Physical activities: 13 times, (Task) Social activities: 24 times, documented as the resident was not available during the month of May 2024. On 05/29/24, at 11:20 AM, an interview with Nursing Staff #44 revealed that the resident sometimes refuses showers and medication. On 05/29/24, at 11:30 am, Nursing Staff #45, a full-time day shift employee, revealed that she/he had never seen any activities offered to the resident inside the room. She/he hears the activity department making an announcement sometimes but has not seen anyone coming to the resident's room. On 06/06/24, at 01:08 PM, an Interview with Nursing staff #36 revealed that the resident refuses to get out of bed and care but has never seen activities coming to the resident's room unless the activity staff visited when the employee was on break. On 06/11/24 at 09:10 AM, an Interview with activity staff #15 stated that the staff working with residents may be able to give accurate information. Staff# 37 stated that people from a church take communion to the resident's room but he/she was unsure if the resident accepted the communion or if the family visited. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/24 at 09:55 AM, Staff #47 Stated that the resident was always sound asleep but left the daily agenda at the bedside. 47200 2) During surveyor's record review of the medication administration audit report on 6/3/24 at 12:55PM the surveyor observed the following documentation in the medical record signed off by LPN #31 for the following care for Resident #3: On 5/12/24 at 1:58AM LPN #31 documented the following care occurred at 1:57AM: Assessment of the enteral tube for proper placement prior to each feeding, flush, or medication administration. On 5/12/24 at 1:58AM LPN #31 documented the following care occurred at 1:57AM: Check enteral tube for residual every shift/if 150ml or over, hold feeding for 1 hour and recheck: If residual 100ml or over, notify MD-document amount in ml every shift document amount. On 5/12/24 at 1:58PM LPN #31 signed off on enteral tube water flushes. On 5/12/24 at 2:02AM LPN #31 signed off on every shift monitoring of a pressure relief mattress for proper function. On 5/12/24 at 2:02AM LPN #31 signed off on an assistive device: wedge for repositioning in bed every shift and for pressure relief when in bed every shift. On 5/12/24 at 2:02AM LPN #31 signed off on elevation/floating of the Resident's heels while in bed every shift. On 5/12/24 at 2:02AM LPN #31 signed off on strict turning and repositioning of the Resident every 2 hours every shift. On 5/12/24 at 2:02AM LPN #31 signed off on skin prep wipe application to the Resident's heels every shift, assessment for change of status, barrier cream application, behavior monitoring, and aspiration precautions. Review of the facility reported incident alleged to occur on 5/11/24 and 5/12/24 revealed documentation that a weekend supervisor was called to the resident #3's room on 5/12/24 around 2pm, and it was reported that Resident #3 felt like food was coming up and was scared of aspiration and unable to call for help. The documentation submitted in the initial self report to the Office of Healthcare Quality on 5/13/24 documented a concern that the Resident was left in bed from 6pm to 6:30am without access to his/her call bell and being left in the same position. Surveyor review of the facility's follow up self report dated 5/17/24 revealed the facility's documentation for the conclusion/outcome of their investigation revealed it was deemed inconclusive, however, the facility documented the following in their conclusion: It is confirmed that the GNA did not provide care from 11p-6:30am, The nurse provided medications around 10pm and early morning medications/flush around 6:30am, The nurse did see the resident sleeping around 3-4am with no distress noted. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/30/24 at 2:16PM the surveyor conducted an interview with the Administrator and DON, at this time they confirmed with the survey team that based on their camera footage review of both shifts for 5/11 and 5/12/24, no one was in the room from approximately 11pm to 6:30am, and further confirmed that the documentation in the investigation file of camera footage times was for the dates of 5/11/24 and into 5/12/24. Review of the facility's complete investigation file for the 5/11/24 and 5/12/24 incident revealed the Administrator's documented timeline review of camera footage of when staff was in the resident's room on 5/11/24 into 5/12/24: 6:47-6:58PM- LPN #31 in room 8:49-9:01PM- LPN #31 in room 9:09PM- RN #28 and RN #26 open door and check in on Resident 10:40pm-10:43PM GNA #32 goes into room 6:30-6:35AM LPN #31 in room 6:38-7:00am GNA in room On 6/3/24 at 3:26PM the surveyor conducted an interview with the Administrator and DON who both verbally confirmed to the survey team that no staff was in the resident's room during the timeframe overnight in question. The DON stated to surveyors that a nurse was seen rounding, but did not go into Resident #3's room. The DON further confirmed with the surveyor that the overnight tube feed for the Resident needed to be checked on, and could not be observed appropriately from the hallway. On 6/3/24 at 10:43AM the surveyor conducted an interview with the DON who stated the following was their documentation expectation for facility staff: There should be something in the medical record that staff met with the resident and concerns were addressed. On 6/11/24 at approximately 10:37AM the surveyor conducted an observation of Resident #3's room from the hallway prior to entering the room, and noted the resident's feed pump was unable to be visualized from the nursing unit hallway, and the resident was unable to be effectively visualized from the nursing unit hallway. After the facility concluded their final investigation on 5/17/24, and after surveyor intervention, the DON reported that disciplinary action would take place because of the rounding and checking on the infusing tube feeding that did not occur. On 6/12/24 at approximately 8:43AM the surveyor shared their concerns with the Administrator and Director of Nursing who both acknowledged understanding of the concerns. 50458 3) On 6/04/24 at 10:10 AM, surveyors observed Licensed Practice Nurse (LPN #5's) administer eight oral medications and one subcutaneous medication to Resident #567. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 12:20 PM, surveyors requested copies of the Medication Administration Audit Report (a report which contained the actual time when a medication was given). The review revealed that the Breztri inhaler was documented as given at 10:30 AM. During an interview with LPN #5 on 6/06/24 at 10:23 AM, LPN #5 stated that he administered Resident #567's inhaler around lunch time on 6/04/24 although he documented that he gave it at 10:30 AM. The surveyor shared The Medication Administration Audit Report with LPN #5, which indicated that LPN #5 administered the Inhaler at 10:30 AM on 6/04/24. LPN #5 stated I know, I did it wrong, I charted that I gave the inhaler even before giving the meds, my bad. On 06/06/24 at 12:48 PM an interview was conducted with the Director of Nursing (DON) about medication administration and documentation. The surveyors shared the Medication Audit Report for Resident #567 with the DON on which the Bezetri inhaler was documented as given at 10:30 AM on 6/04/24 but not observed by the surveyors during medication pass observation, and LPN #5 admitted that he actually administered the medication around noon, but documented it as given before he gave it. The DON stated I do not know why LPN#5 would document before giving. The DON validated the above concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48168 Based on observation, record review, and interview it was determined the facility staff failed to 1) ensure proper hand hygiene while performing dressing changes. This was evident for 2 observed dressing changes for residents #44 and #54 conducted during the infection control facility task investigation. 2) perform handwashing before and after gloving. This was evident for one (Resident #567) of 6 residents reviewed for Infection Prevention and Control. The findings include: A pressure ulcer, also known as a pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. A nephrostomy tube is a thin, flexible catheter that is surgically inserted and drains urine from the kidney into a bag outside the body. 1)On 5/28/24 10:54 AM in an interview with Resident #44, the resident said they had a sore on their backside. On 5/30/24 at 1:14 PM a review of Resident #44's medical records revealed documentation that the resident had multiple pressure ulcers which required daily dressing changes. On 6/03/24 at 10:05 AM an observation was made of Resident #44's left heel ulcer dressing change by Licensed Practical Nurse (LPN #24). After removal of the old dressing, LPN #24 removed her dirty gloves but failed to perform hand hygiene before she donned clean gloves and applied the clean dressing to the resident's left heel ulcer. On 6/05/24 at 10:47 AM a follow up interview with LPN #24 was conducted. The dressing change steps were reviewed, and LPN #24 confirmed that she did not clean her hands after she removed her dirty gloves and before she put on clean gloves. She confirmed that she was aware that this was a deficient practice. On 6/05/24 at 11:04 AM the Director of Nursing (DON) and the Nursing Home Administrator were informed that nursing staff failed to perform hand hygiene after they removed dirty gloves and before they donned clean gloves during a dressing change procedure. The DON confirmed that this was a deficient practice. 2)On 5/29/24 at 9:36 AM a review of Resident #54's medical record revealed that the resident had a nephrostomy tube placed in April 2024. On 6/03/24 at 3:11 PM an interview with the Infection Prevention Registered Nurse (RN #2) was conducted regarding hand hygiene at the facility. RN #2 said she provided staff education on hand hygiene in multiple ways: 1) at staff orientation, 2) she sent text reminders, and 3) hand hygiene audits, which she and other staff conducted regularly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/24 at 9:15 AM Licensed Practical Nurse (LPN #14) was observed to change Resident #54's nephrostomy tube site dressing. After LPN #14 removed the soiled dressing and removed her soiled gloves she failed to perform hand hygiene before she donned clean gloves and applied the clean dressing. On 6/05/24 at 10:51 AM a follow up interview with (LPN #14) was conducted. When asked to review the dressing change procedure, LPN #14 confirmed that she did not clean her hands and she also said she did not know it was required to clean her hands between glove changes. On 6/11/24 at 11:28 AM an interview with the Infection Prevention Registered Nurse (RN #2) was conducted. She was asked to describe the dressing change procedure and she confirmed that staff hands must be cleaned after removing dirty gloves and before donning clean gloves. 50458 3) On 6/04/24 at 10:10 AM, surveyors observed Licensed Practice Nurse (LPN #5's) administer medication to Resident #567. LPN #5 administered a subcutaneous anticoagulant medication with gloved hands to Resident #567. However, LPN #5 did not perform hand sanitizing before and after the injection. During an interview with LPN #5 on 06/06/24 at 10:23 AM, LPN #5 stated that nursing staff were supposed to perform hand washing before entering the room, handwashing before and after touching each patient and before putting on clean gloves, and after taking off dirty gloves. When LPN #5 was asked about the observation on 6/04/24 that he did not wash his hands either before putting gloves on or after removing his dirty gloves when he administered Resident #567's anticoagulation injection, LPN #5 said, my fault, I did not do handwashing before and after gloving. During an interview with Infection Preventionist (Staff #2) on 6/11/24 at 11:27 AM she confirmed that hand wash (sanitizing) was required when 1) entering/exiting residents' rooms, 2) touching resident's body, 3) touching the resident room's environment, and 4) before putting on clean gloves and after taking off dirty gloves. On 6/12/24 approximately 11 am, the surveyor shared the above concern with the Director of Nursing (DON). She validated the concern.