STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215357	A. Building B. Wing	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lorien Nursing & Rehab Ctr - Elkridge	7615 Washington Boulevard Elkridge, MD 21075

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review, and interview with residents and staff, it was determined that the facility failed to answer call bells timely to attend to the needs of dependent residents. This was evident for 1 (Resident #19) on the Second Floor Nursing Unit. The findings include: During an interview conducted with Resident #19 on 9/10/2024 at 8:40AM, the Surveyor was informed that over the weekend the resident used the call bell to get assistance to the bathroom and it took a long time for the staff to answer the call bell and provide assistance. The resident continued, stating that he/she has to wait and wait for long periods of time for the staff to assist him/her with his/her needs. The resident communicated that it is hard to wait when you have to go. On 9/17/2024 at 11:21AM, a review of Resident #19's electronic medical record revealed that the resident has impairment on one side and was dependent on staff for toileting and transferring needs. On 9/17/2024 at 12:14PM, the Surveyor requested call light response time log for Resident #19 for the dates 9/5/2024-9/11/2024, as well as the Call Light policy for the facility. On 9/17/2024 at 12:55PM, the Surveyor and Director of Nursing (DON) #2 reviewed the call light response log, [NAME]-CARE Report, and confirmed that on 9/8/2024 at 7:47AM the call light was on for 28 minutes and at 9:37AM the call light was on for 55 minutes and 51 seconds. Review of the Call Light Policy revealed that employees are not to walk by call lights and ignore them; call lights are not to be turned off until the need of the resident has been met and if the staff is unable to meet the resident's need, the staff would leave the light on and notify an appropriate staff member. The policy is to be signed and dated by facility staff. Review of the Routine Resident Checks policy revealed that timely observation of all residents will be provided. According to procedure 3.) Resident call bells will be answered in a timely manner, not to exceed 20 minutes. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/2024 at 11:02AM, the Surveyor conducted an interview with Second Floor Supervisor #33. The Surveyor was informed that the call light should be answered within 20 minutes and that it should not be turned off until the resident's need has been met. The Surveyor and Second Floor Supervisor #33 reviewed Resident #19's [NAME]-Care Report which showed on 9/8/2024 at 7:47AM the call light was on for 28 minutes and at 9:37AM the call light was on for 55 minutes and 51 seconds. The Surveyor stated that the resident complained that he/she had to wait for a long period of time before he/she could go to the bathroom. Second Floor Supervisor #33 was unable to explain why the resident waited so long for assistance and stated she would look into the situation. On 9/23/2024 at 11:36AM, Second Floor Supervisor #33 informed the Surveyor that she was unable to determine the reason the call light was unanswered for so long and that the expectation is for staff to answer call lights timely, within 20 minutes, and to turn the call light off once the residents need has been met. Second Floor Supervisor #33 provided the Surveyor with a copy of an educational Inservice regarding Call light Expectations which was reviewed and signed by facility staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interview, it was determined that the facility failed to inform the Resident ' s Responsible Party (RP) of the need to alter treatment. This was found evident of 1 (Resident #70) of 3 residents reviewed for notifications. The findings include: On [DATE] at 11:32 AM, the surveyor reviewed Resident #70's medical record. The review revealed that Resident #70 was admitted to the facility in early 2023 from another facility. On further review, an admission note written on [DATE] by Resident #70's Physician and the facility's Medical Director (MD) #3, wrote Resident #70 had a history of ischemic CerebroVascular Accident (CVA), (condition where blood flow to the brain is blocked) with left-sided hemiparesis (one sided paralysis), and wrote Patient requires total care and is unable to participate in any medical decision making. Resident #70's Responsible Party was identified in the profile page as Resident's granddaughter. The surveyor reviewed a progress note written on [DATE] by Licensed Practical Nurse (LPN) #28. The note was written at 5:52 PM. The note stated that around 10:00 AM, Resident #70 was noted to have a lot of perspiration (sweating) and an assessment was done. Resident #70 was noted to have a distended (swollen or bloated) abdomen along with hypoactive bowel sound (indicating slower digestion). The note further stated that the physician Staff #3 was notified at 10:30 AM and an abdominal x-ray was ordered. The note stated the Residents RP was notified at 3:30 PM and that the call was delayed due to pending abdominal x-ray results. Next the surveyor reviewed the discharge summary written by Staff #3. The note described that in the morning the nurse was concerned because Resident #70 became diaphoretic (sweating). Staff #3 stated the nurse reported the abdomen was mildly distended. An x-ray was ordered, and tube feeding placed on hold. Staff #3 wrote Resident #70 had coffee-ground emesis later that afternoon and according to staff had chest congestion that required suctioning. Following these events Resident #70 was pronounced at 3:10 PM. On [DATE] at 7:02 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated that if a physician is contacted and there is a change in the plan of care the RP should be notified of those changes. She further stated that the nurse will update the physician and then call the RP to update them on the plan of care changes. She further stated the timing of notification depends on the situation. The DON agreed that LPN #28 documented there was a delay in notification. The family was not notified of the morning events until after Resident #70 was deceased .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49148 Based on review of Facility Reported Incidents (FRIs) and interviews with staff, it was determined that the facility failed to maintain documentation that a FRI was thoroughly investigated. This was evident for 1 (Resident #12) out of 13 residents investigated for FRIs during the annual survey. The findings include: On 9/10/2024 at 1:35PM, during an interview conducted with Resident #12, the Surveyor was informed that the resident reported a missing credit card months ago. On 9/16/2024 at 1:30PM, the Surveyor reviewed the resident's Personal Property Policy, section Our Responsibilities #1.) We must investigate any damage to or loss of the resident's personal property. On 9/16/2024 at 1:45PM, the Surveyor reviewed the facility's investigative file for Resident #12. Inside the file was a 39-555F Initial Report Form submitted to the Office of Health Care Quality on 2/09/2024 at 1:50PM and a 39-556F Follow-up Investigation Report Form submitted to the Office of Health Care Quality 2/13/2024 at 11:00PM. The Surveyor asked the Director of Nursing (DON) #2 if that file contained the complete investigation into the FRI for Resident #12. DON #2 informed the Surveyor that she would look into it. Further review of Resident #12's investigative file revealed no documentation of interviews with facility staff, interviews with other residents, or evidence provided by the bank regarding fraudulent use of the resident's credit card. On 9/18/2024 at 1:45PM, DON #2 confirmed the file provided to the Surveyor was the only investigative file for the FRI concerning Resident #12. No other documentation was provided.

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

44440

Based on review of medical records, facility investigative file, and interviews it was determined that the facility failed to adequately assess and assist a dependent resident during Activity of Daily Living (ADL) care, which led to a resident's fall from bed causing actual harm to Resident #70. This was evident for 1 of 4 (#70) residents reviewed for accidents.

The findings include:

On 9/17/24 at 11:32 AM, the surveyor reviewed Resident #70 ' s medical record. The review revealed that Resident #70 was admitted to the facility in early 2023 from another facility.

On further review, an admission note written on 3/24/23 by Resident #70 ' s Physician and the facility ' s Medical Director (MD) #3, documented Resident #70 had left-sided hemiparesis (one sided paralysis), and the Patient requires total care and is unable to participate in any medical decision making.

On 9/18/24 at 7:10 AM, the surveyor reviewed Resident #70 ' s Activities of Daily Living care plan. The interventions for bed mobility were initiated on 4/10/23 for resident #70. The intervention stated, I require 1-2 staff participation in bed mobility. On 7/28/23 the care plan was revised and stated, I require 2 staff participation in bed mobility.

On review of Resident 70's Minimum Data Set (MDS) assessment, completed on 6/30/23 both functional status and functional abilities were assessed for Resident #70. Bed mobility in the functional status assessment coded Resident #70 as needing extensive assist on self performance (resident involved in activity, staff providing weight-bearing support) and needing Two + person physical assist as the most support staff needed to provide cares. In the functional abilities assessment for rolling left and right in bed, Resident #70 was coded dependent (helper does all the effort. The resident does none of the effort to complete the activity. Or, the assistance of 2 or more helper is required for the resident to complete the activity).

Review of a progress note written by Licensed Practical Nurse (LPN) #29 on 7/15/23 revealed that a staff Geriatric Nursing Assistant (GNA) was performing afternoon care and while attempting to roll Resident #70 onto his/her side Resident #70 ' s legs slid out of bed and Resident #70 ' s upper torso remained in bed. The note further stated that no injuries were noted and that Resident #70 was currently prescribed a blood thinner that reduces blood clots and would be monitored.

Additionally, on 7/17/23 LPN #29 wrote a skin/wound note that described two skin locations. First site was the lateral (outer) side of the left breast that noted a large discolored bruise and the second site was the left upper arm just below the shoulder that noted a yellow/blue faded discoloration.

The surveyor reviewed a progress note written on 7/19/23 by MD #3 that stated, Due to evidence of pain and possible fracture, ordered patient to be transferred to ER for evaluation.

(continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On further review of MD #3's progress notes a note written on 7/28/23 summarized the history of present illness for Resident #70. The summary stated that after Resident #70 fell from his/her bed and developed bruising. The resident was transferred to the emergency room for evaluation. An x-ray showed a mildly impacted humeral (upper arm bone) neck fracture with recommendations for sling and nonoperative management. It further states Cat Scan (CT) showed a left pectoral (chest) muscular hematoma (a collection of blood that pools outside the blood vessel). Resident #70 was found to be anemic (low red blood cells) and required a transfusion of 2 units of packed red blood cells. The surveyor reviewed the paper medical record for Resident #70. During the review a GNA care plan communication form dated 4/14/23 was reviewed. The form was filled out by GNA #30. The question on the form was, How much help does the resident need with ADL's? Total was written for bed mobility, transfers, toileting, dressing upper and lower body, personal hygiene and bathing. On 9/18/24 at 11:54 AM, the surveyor interviewed GNA #30. During the interview GNA #30 stated that total meant that the resident would be dependent for staff to do everything and would require a 2 person assist with ADL cares including bed mobility. GNA #30 further stated she remembered Resident #70 and stated he/she required assist of 2 staff for all ADL cares. On 9/18/24 at 12:02 PM, the surveyor interviewed LPN #7. During the interview LPN #7 stated she was involved in care planning development for Residents. She stated that she was the supervisor the day that Resident #70's bruises were noticed. She further stated that residents who are dependent on care similar to Resident #70 would be care planned for 2 person assist with ADL cares. Review of the facility ' s investigation report related to Resident #70's fall from bed while receiving ADL care revealed a statement from the Nursing Assistant in Training (NAT) #26 that stated, while she performed incontinence care Resident 70's legs slipped out of bed. She further stated Resident #70's upper body remained in bed and that she got the nurse and other staff to help the resident back to bed. Further in the investigation file training completed on 7/17/23 by NAT #26 was found. The training was titled, Safe Resident Lifting and Transfers. Safe resident lifting was described as 1. The use of proper body mechanisms; 2. enlisting the assistance of additional staff 3. the use of appropriate mechanical lifting devices to lift, transfer, and reposition resident. Adequate personal and/or assistive devices are to be used as indicated. The education described that totally dependent/extensive assistance needed residents require mechanical lift devices for transfers. It also described protocol for lifts from the floor. Lastly, repositioning was addressed. The education stated, All repositioning in bed will be performed by at least two staff. If resident requires more than two staff members, a mechanical lift should be used. On 9/18/24 at 12:19 PM the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor asked the DON why Resident #70 would have assistance of 1-2 for ADL cares when he/she was dependent for care. The DON stated she was not DON at the time of the incident but perhaps it was in reference to some of the ADL care that could be done by one person such as placing a pillow. The DON confirmed that the care plan was adjusted after the fall that indicated the resident required two people to provide all ADL care.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44440 Based on record review, and interviews, it was determined that the facility failed to provide education for application of a device after the knowledge deficit was identified. This was evident in 1 (Resident #70) of 1 resident reviewed for devices. The findings include: On 9/17/24 at 11:32 AM, the surveyor reviewed Resident #70's medical record. The review revealed that Resident #70 was admitted to the facility in early 2023 from another facility. On further review of MD #3's progress notes a note written on 7/28/23 summarizes the history of present illness for Resident #70. The summary stated that after Resident #70's fell from his/her bed and developed bruising, the resident was transferred to the emergency room for evaluation. An x-ray showed a mildly impacted humeral (upper arm bone) neck (top part of the bone) fracture with recommendations for sling and nonoperative management. It further stated a CAT Scan (CT) showed a left pectoral (chest) muscular hematoma (a collection of blood that pools outside the blood vessel). Resident #70 was found to be anemic (low red blood cells) and required a transfusion of 2 units of packed red blood cells. The surveyor reviewed the Occupational Therapy Note written on 7/27/23 that stated Resident #70 left the upper extremity sling adjusted as it appeared to be in the incorrect position. The surveyor reviewed a progress note written on 7/28/23 by Resident #70's physician and Medical Director Staff #3. The note stated that Resident #70 remains in a sling with non operative management of the left humeral fracture. It further stated that the family would like assurance that staff will be able to manage the sling. Staff #3 reports relaying concern to the Director of Nursing (DON) and the DON will speak with the rehab manager about developing an in-service. On 9/19/24 at 9:55 AM, the surveyor interviewed the DON. During the interview the DON stated she could recall that training was completed and would talk with the rehab department to find out more. On 9/19/24 at 10:12 AM, the surveyor interviewed Occupational Therapist (OT) #34. Staff #34 stated that she remembered conducting an in-service on the standard sling and educated staff on where the forearm should be placed. Staff #34 could not remember how many people were trained or who was there. She stated because Resident #70 was not on the OT's caseload; there was no note or documentation that the in-service took place in the medical record. She further stated that typically in-services training has a sign in sheet to document who attended but was unsure if a sign in sheet was utilized. On 9/23/24 at 7:05 AM, the surveyor conducted a follow-up interview with the DON. The DON stated she could not find any documentation that an in-service was completed but would follow-up with the Director of Rehabilitation. At the time of exit no documentation was provided that indicated the in-service was completed.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 44440 Based on record review, and interview, it was determined that the facility failed to obtain radiology services in a timely manner. This was found evident in 1 (Resident #70) out of 1 resident reviewed for radiology services. The finding include: On 9/17/24 at 11:32 AM, the surveyor reviewed Resident #70's medical record. The review revealed that Resident #70 was admitted to the facility in early 2023 from another facility. The surveyor next reviewed a progress note written by Licensed Practical Nurse (LPN) #29 on 7/15/23. The note described that a staff Geriatric Nursing Assistant (GNA) was performing afternoon cares and while attempting to roll Resident #70 onto his/her side Resident #70's legs slid out of bed and Resident #70's upper torso remained in bed. The surveyor reviewed Resident #70's paper medical record. The review revealed that on 7/17/23 LPN #29 communicated with a provider the observation of a bruise on Resident #70 via eMedicall with a response from the provider for labs in the morning and clarification of the previous fall. The surveyor reviewed the next eMedicall transaction and on 7/18/24 at 11:52 AM. The Nurse Supervisor Staff #35 communicated a clarification about the fall and followed up asking if the labs were needed and/or an x-ray. On 7/18/23 at 12:53 PM the message was escalated and again at 1:08 PM. On 7/18/23 at 1:22 PM, Resident #70's physician and Medical Director Staff #3 responded and orders a left rib x-ray and left humerus (upper arm bone) and shoulder x-ray. The surveyor reviewed a progress note written on 7/19/23 by MD #3 that stated, Staff has attempted to contact radiology to obtain an estimated time of arrival (ETA) but none is available. Due to evidence of pain and possible fracture, ordered patient to be transferred to the hospital's emergency room (ER) for evaluation. The surveyor reviewed Staff #35's corresponding progress note written on 7/19/23 at 4 PM, that stated Resident #70 was transported to the hospital at 3 PM. On 9/18/24 at 12:14 PM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed the x-ray was never completed at the facility. The DON stated that she obtained documentation that the x-ray order was placed 7/18/23 at 5:50 PM and was assigned to be completed on 7/19/23. She further stated the radiology company the facility used at the time is no longer the radiology company the facility uses now.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interview, it was determined that the facility failed to maintain medical records in accordance with professional standards. This was found evident in 2 (Resident #70 & #38)) of 42 Residents reviewed during the survey. The finding include: 1a) On [DATE] at 11:32 AM, the surveyor reviewed Resident #70's medical record. The review revealed that Resident #70 was admitted to the facility in early 2023 from another facility. Further review revealed an order was placed on [DATE] at 3:44 PM for Resident #70 to be placed in isolation related to COVID-19 positive sample. A progress note was written for the date of [DATE] stated that Resident #70 was positive for COVID-19 and that the Responsible Person (RP) was notified at 4 PM. The surveyor next review Resident #70 paper medical records. The review revealed a paper with results documentation from a point-of-care COVID antigen test completed at the facility for Resident #70. The document had the time the specimen was completed at 1:30 PM. The results of the test were positive. There was no date on the form on which day this test was performed. The surveyor reviewed the concern with the Director or Nursing that the documentation was incomplete. 49148 2a) Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. Do Not Intubate (DNI) is an order placed in a person's medical record by a doctor informs the medical staff that chest compressions and cardiac drugs may be used, but no breathing tube will be placed. On [DATE] at 12:22PM, during a review of Resident #38's current paper medical record, the Surveyor discovered an incomplete MOLST form. Page 1 of the MOLST form was completed, signed and dated with a code status of Do Not Intubate (DNI). Page 2 was incomplete and signed and dated. On [DATE] at 12:25PM, the Surveyor informed Second Floor Supervisor #33 that Resident #38's MOLST form was incomplete. The Second Floor Supervisor #33 was asked to provide the Surveyor with the completed MOLST form. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:55PM the Director of Nursing (DON)#2 informed the Surveyor that Second Floor Supervisor #33 was unable to locate Resident #38's completed MOLST form and will make sure to have a new MOLST form generated. DON #2 stated that both sides of the MOLST form should be filled out entirely. An interview conducted on [DATE] at 12:05PM with Social Services Director #10 revealed that the best practice is to make sure both sides of the MOLST form is completed, signed, and dated by the physician. Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped. Do Not Resuscitate (DNR) is an order placed in a person's medical record by a doctor that informs the medical staff that CPR should not be attempted. 2b) On [DATE] at 9:30AM, a review of Resident #38's electronic medical record revealed an active physician's order ordered on [DATE] at 12:26PM which stated, NO CPR OPTION A-2, DO NOT INTUBATE (DNI): Transfer to hospital for any situation requiring hospital-level care. Resident #38's MOLST form clarified that the code status was DNI A-2. During additional review of Resident #38's electronic medical record, the Surveyor discovered a care plan with a focus that stated CODE STATUS: I want my resuscitation status to be DO NOT RESUSITATE, INTUBATE (DNR A-1), initiated on [DATE], created on [DATE] by Assistant Director of Nursing (ADON) #4. On [DATE] at 1:45PM, the Surveyor conducted an interview with ADON #4 and confirmed that the resident's care plan did not reflect the correct code status and that the correct code status was DNI A-2. ADON #4 identified the concern and stated that she would update the resident's care plan immediately. On [DATE] at 2:05PM DON #2 was made aware of the concern with Resident #38's care plan code status and informed her that ADON #4 made the correction to update the resident's care plan. On [DATE] at 2:20PM, ADON #4 provided documentation to show the resident's care plan code status of DO NOT RESUSITATE, INTUBATE (DNR A-1) had been updated on [DATE] to reflect the current code status of DO NOT INTUBATE (DNI A-2).

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NAME OF PROVIDER OR SUPPLIER Lorien Nursing & Rehab Ctr - Elkridge		STREET ADDRESS, CITY, STATE, ZIP CODE 7615 Washington Boulevard Elkridge, MD 21075	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on observation, and interviews, it was determined that the facility failed to maintain practices to help prevent the transmission of infections. This was found evident on 3 random observations made on the survey. The findings include: 1a) On 9/12/24 at 8:28 AM, the surveyor observed that Resident #41's had a foley catheter (a tube that drains urine from the bladder to outside the body) and observed the catheter connected to a drainage bag that was laying on the ground. On 9/12/24 at 8:30 AM, the surveyor observed Resident # 41 puts on his/her call button. Geriatric Nursing Assistant (GNA) #8 answered the call and Licensed Practical Nurse (LPN) # 7 walked past the room stating she would be in shortly and would be changing the foley drainage bag. On 9/12/24 AM, LPN #7 walked into Resident #41's room. At this time the surveyor asked LPN #7 why the foley drainage bag was on the floor. LPN #7 stated that she was informed by the GNA that the clip was broken this morning. LPN #7 then changed the foley drainage bag and hung the new bag up on the bed frame. On 9/12/24 at 9:32 AM, the surveyor conducted a interview with GNA #8. During the interview GNA #8 stated that she reported that the clip on the foley drainage bag was broken and that is was unable to be hung up to the LPN #7 when she was doing vitals at approximately 7:30 AM. On 9/12/24 at 12:08 PM, the surveyor reviewed the concern with the Director of Nursing (DON) that Resident #41's foley drainage bag was laying on the floor for approximately an hour after two staff members were aware of the situation which could increase the risk for infection. 1b) On 9/12/24 at 9:15 AM, the surveyor observed Registered Nurse Staff #19 get ready to change Resident #41's Peripherally Inserted Central Catheter (PICC). (A PICC line is a long, thin tube that is inserted through a vein in your arm and passed through to the larger veins near your heart). While removing the old dressing the surveyor observed the date written on the dressing as 9/2/24. Staff #19 had some difficulty removing the dressing and was able to have the Director of Nursing (DON) assist with the dressing change. After the PICC dressing was changed the surveyor confirmed that the dressing was labeled as last changed on 9/2/24. The surveyor reviewed the Medication Administration Record (MAR) for Resident #41 and discovered that Nurse Supervisor Staff #4 documented the PICC dressing was changed on 9/9/24. The last change documented before was on 9/2/24. The order stated; Change transparent dressing weekly on Mondays and as needed for soiling or lifting of dressing. Use central line dressing change kit and sterile technique for PICC line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 9:25 AM, the surveyor conducted an interview with the DON. During the interview the surveyor discussed that the date on the dressing that was removed was not the date that was documented in the MAR. The DON stated she would find out why there was a discrepancy. On 9/12/24 at 11:36 AM, the surveyor conducted a follow-up interview with the DON. The DON stated she spoke with Staff #4 and it was reported that Staff #4 documented the PICC dressing change and then went to the room to change Resident #41's dressing, however he/she was at therapy and that Staff #4 was not able to do the task. The DON confirmed that Staff #4 should not have documented the dressing changes prior to completing the dressing change and the dressing should be changed on 9/9/24. The surveyor reviewed the employee educational in-service provided by the facility. The document states, PICC line (dressing) should be changed at least one time per week. If the dressing becomes loose, wet, or dirty the dressing must be changed more often to prevent infection. 1c) On 9/18/24 at 5:25 AM, the surveyor observed Geriatric Nursing Assistant (GNA) #27 walk out of room [ROOM NUMBER] with a solid linen bag and place the bag into the soiled linen receptacle. No gloves were observed. The surveyor next observed GNA #27 walk over to the clean linen cart and begin to move the cart away from the wall and lift the cover that was over the clean linen cart. The surveyor conducted an interview with GNA #27 and GNA #27 confirmed that he had just placed soiled linen in the receptacle. He further stated he was just moving the cart and agreed he should have hand sanitizer after holding the soiled linen bag. The surveyor next observed GNA #27 walk into the door frame of room [ROOM NUMBER]. The surveyor stopped GNA #27 and asked if he should sanitize his hands at which time he applied hand sanitizer from the door.