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

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 44440 Based on record review, and interviews, it was determined that the facility failed to provide a Resident's Representative/guardian the right to be involved in the initial care planning process. This was found evident in 1 (Resident #162) of 5 residents reviewed for rights. The finding include: On 9/12/24 at 6:36 AM, the surveyor reviewed Resident #162's medical record. The review revealed that Resident #162 was admitted to the facility in early September of 2024 with a past medical history that includes, but is not limited to, schizophrenia, epilepsy (brain disorder that causes seizures), and edema (swelling). The surveyor reviewed Resident #162's baseline care plan. The care plan designated that the Resident was his/her own representative. At the end of the baseline care plan there is a place for a written summary and a place for a signature where the care plan could be acknowledged as reviewed with the Resident or/or the Resident's Representative or Responsible Party (RP). No summary was written and no signatures were documented in either of the two designated signature lines. The Social Work Director Staff #10 and Nurse supervisor Staff #4 both signed and dated the document on 9/6/24. On further review of Residents #162's medical record, a discharge summary was noted from the hospital stay prior to admission to the facility. A capacity and advanced care planning notation indicated that Resident #162's capacity to make own care decisions was updated on 8/30/24 at 11:07 PM. No copy of this record was in the medical record. On 9/13/24 at 9:10 AM, the surveyor conducted and interview with the Staff #10 and the Nursing Home Administrator (NHA). During the interview Staff #10 stated on admission she conducts a social service assessment and conducts a Brief Interview for Mental Status (BIMS) screen. The surveyor asked how the facility determines if the Resident can be his/her own representative. Staff #10 stated that the medical doctor completes a certification of capacity, and the staff can speak with family and, if appropriate, ask for guardianship or healthcare power of attorney papers. She further stated they can look through hospital records. The surveyor asked Staff #10 While completing the social work assessment was she aware that resident #162 had a guardian. Staff #10 stated that she had spoke Resident #10's guardian and asked the guardian to bring in the paper work. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor interviewed the NHA on 9/13/24 at 9:24 AM and during the interview the NHA stated that Admissions should be aware if a resident has a guardianship filed and that nursing also should have been aware of the situation. The surveyor reviewed the concern that because the assessment of the responsible party was incorrect the facility failed to evolve Residents #162's guardian in the initial baseline care planning.

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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 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. 44440 Based on record review, and interview, it was determined that the facility failed to offer to help formulate or obtain a Resident ' s Advanced Directive. This was found to be evident in 2 (Resident #54, & #162) of 16 Residents reviewed for Advanced Directives during an annual survey. The finding include: Advance directives are legal documents that provide instructions for medical care and only go into effect if you cannot communicate your own wishes. The two most common advance directives for health care are the living will and the durable power of attorney for health care. 1a) On 9/11/14 at 12:25 PM, the surveyor reviewed Resident #54 ' s medical record. The review revealed that Resident #54 was admitted to the facility in late August of 2024. On further review the surveyor noted that a social worker assessment was completed on 8/22/24. In the section labeled Advanced Directives no box was checked to indicate if the Resident had an advanced directive or if the Resident did not if he/she would like to formulate one. On 9/13/24 at 9:10 AM, the surveyor interviewed the Social Director Staff #10. During the interview Staff #10 stated that once a Resident is admitted to the facility she completes a social service assessment. She further stated in that assessment she asks the Resident if they have advanced directive and if so to bring in the document. If they don ' t have one I ask if they would like to formulate one. The surveyor reviewed Resident #54 ' s advanced directive documentation. The social worker agreed there was no indication if Resident #54 had advanced directives and that the Resident was not offered to formulate one if he/she did not have one. 1b) On 9/12/24 at 6:36 AM, the surveyor reviewed Resident # 162 ' s medical record. The review revealed that Resident #162 was admitted to the facility in early September of 2024. On further review the surveyor noted that a social worker assessment was completed on 9/6/24. In the section labeled Advanced Directives no box was checked to indicate if the Resident had an advanced directive or if the Resident did not would he/she like to formulate one. On 9/13/24 at 9:10 AM, the surveyor interviewed the Social Director Staff #10. During the interview Staff #10 stated that once a Resident is admitted to the facility she completes a social service assessment. She further stated in that assessment she asks the Resident if they have advanced directive and if so to bring in the document. If they don ' t have one I ask if they would like to formulate one. The surveyor reviewed Resident #162's advanced directive documentation with Staff #10. The social worker agreed there was no indication if Resident #162 had advanced directives.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on medical record review, and interview with and staff, it was determined that the facility failed to accurately assess and complete a Significant Change in Status Minimum Data Set (MDS) assessment within 14 days of the resident's enrollment into a hospice program. This was evident for 1 (Resident #50) out of 1 resident investigated for hospice during the annual survey. The findings include: The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A Significant Change in Status MDS is required when a resident enrolls in a hospice program. Hospice is specialized care that provides physical comfort and emotional, social, and spiritual support for people with an anticipated life expectancy of 6 months or less. The hospice team includes doctors, nurses, social workers, and health aides who provide care that focuses on symptom management and quality of life. On 9/12/1024 at 12:30PM, during a review of Resident #50's paper medical record, the Surveyor discovered that the resident was admitted to a hospice program on 6/7/2024. Further review of the resident's electronic medical record revealed a physician order to admit to hospice on 6/7/2024. On 9/12/2024 at 1:00PM, the Surveyor reviewed the Significant Change in Status MDS with the assessment reference date of 6/17/2024, initiated by MDS Coordinator #5. The enrollment into a hospice program was not addressed in the assessment. On 9/12/2024 at 1:55PM, during an interview conducted with MDS Coordinator #5, the Surveyor was informed that a Significant Change in Status MDS is required when a resident is enrolled in a hospice program and should be completed within 14 days after the determination has been made. MDS Coordinator #5 confirmed that Resident #50 was enrolled into a hospice program on 6/7/2024 and a Significant Change in Status MDS should have been triggered. The Surveyor and MDS Coordinator #5 reviewed the Significant Change in Status MDS dated [DATE] and confirmed that hospice was not coded in the assessment.

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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** 47758 Based on observation, medical record review, and staff interview, it was determined that the facility staff failed to code the resident's status accurately on the Minimum Data Set (MDS) assessment. This was found to be evident for 2 (#7, #41) out of 42 residents reviewed during the annual survey. The findings include: The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. 1a) During a MDS record review on 9/12/2024 at 08:34 AM, the surveyor noted that Resident #7's current Annual MDS dated [DATE], Section L0200 B. No natural teeth or tooth fragment(s) (edentulous) was answered No. However, Resident #7 was observed to be edentulous during screening. During an interview on 9/12/24 at 09:56 AM, the MDS Coordinator was asked if Resident # 7's coding was correct for Section L0200 B. He replied, it's wrong, it should be coded as edentulous. He further stated, It's an error, I will fix it. On 9/12/24 at 11:54 AM, the MDS Coordinator notified the surveyor that the MDS had been corrected. The surveyor verified that a significant correction was submitted on 9/12/24 and Resident #7's coding for Section L0200 B was now answered Yes for No natural teeth or tooth fragment(s) (edentulous). The Director of Nursing was interviewed on 9/23/24 at 07:06 AM. She stated she was aware of the MDS findings during the survey. 44440 1b) On 9/12/24 at 10:16 AM, the surveyor reviewed Resident #41 ' s medical record. The review revealed that Resident #41 was readmitted to the facility in of late August of 2024 after a hospital stay and had a past medical history, including but not limited to, sepsis (body ' s overreaction to an infection) due to Methicillin Resistant Staphylococcus Aureus (MRSA), urinary tract infections, and obstructive uropathy (obstruction of urinary tract). The surveyor next reviewed the Admission assessment dated [DATE] for Resident #41. In the Urinary Management section the question Foley Present was checked yes. It further described the reason as obstructive uropathy. The surveyor noted that Resident #41 has a care plan for alteration in bladder elimination as evidenced by the presence of an indwelling foley catheter. This care plan was created on 6/7/24 and revised on 8/22/24. On 9/12/24 at 10:05 AM, the surveyor reviewed Resident #41 ' s orders. No order were present for Resident #41 ' s foley catheter. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On further review the Minimum Data Set (MDS) assessment dated [DATE], section H (Bladder and Bowel), had no documentation for indwelling foley catheter. Resident #41 was coded to always have urinary incontinence. On 9/12/24 at 1:03 PM, the survey interviewed the MDS Coordinator #5. During the interview the surveyor asked Staff #5 what is reviewed before coding the MDS assessment. Staff #5 stated he often looks at physician orders and the nursing assessments but also can also make visual assessments as well. After reviewing Resident #41s Bladder and Bowel assessment, Staff #5 confirmed he missed that Resident #41 had a foley on admission and may have just reviewed the orders when coding section H. He further stated he would correct the assessment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 44440 Based on record review, and interviews, it was determined that the facility failed to include and review all initial healthcare information and goals in the baseline care plan. This was found evident of 1 (resident #49) of 3 residents reviewed for care planning. The finding include: On 9/10/24 at 8:24 AM, the surveyor conducted and interview with Resident #49. During the interview Resident #41 reported that he/she had not had a care plan meeting yet. On 9/12/21 at 7:01 AM, the surveyor reviewed Resident #49 ' s medical record. The record revealed that in early July of 2024 Resident #41 was admitted to the facility with a past medical history that included but not limited to, disorientation, protein-calorie malnutrition and diabetes. On further review the surveyor reviewed Resident #49 ' s admission assessment completed on 7/9/24. The assessment indicated that Resident #49 was alert and oriented to his/herself and not to place or time. The surveyor reviewed the baseline care plan completed by Social Worker Assistant Staff #36 on 7/10/24 and the Nurse Supervisor Staff #4 on 7/11/24. The physician order section of the baseline care plan stated, see current Medication Administration Record (MAR) and Treatment Administration Record (TAR) orders. The next line stated see current therapy orders followed by see dietary orders. No explanation to what the orders were or how to see them. Review of the dietary section had no documentation of the current diet the resident would be receiving or dietary goals, interventions, preferences, or risks. In the therapy section functional goals were left blank as well as therapy services that would be offered. In the plan of care section a note was written that stated the Interdisciplinary team met with resident to introduce themselves and explain each of their roles in the resident ' s care. The next section of the care plan had a place for the resident or the representative to sign and date. This section was blank as well. On 9/13/24 at 9:10 AM, the surveyor conducted an interview with Social Work Director #10 and Nursing Home Administrator (NHA). During the interview Staff#10 stated she was responsible for a section of the baseline care plan and the other disciplines were responsible for filling out their section. The surveyor reviewed the concerns that several disciplines did not write out the initial goals or the cares to be furnished while in the facility in the baseline care plan. The surveyor also reviewed the concern that there was no way to know if Resident #49 was advised of all the plans and services that would be rendered or the goals set.

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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. 49148 Based on record review, and interview with staff, it was determined that the facility failed to facilitate timely care plan meetings after a resident's quarterly assessment to allow the resident and resident representative to participate in the care planning process. This was evident for 1 (Resident #38) of 3 residents investigated for care planning during the annual survey. The findings include: Interdisciplinary team (IDT) is a team of medical professionals that provide specific patient centered care to the residents within a facility. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. On 9/16/2024 at 9:06 AM a review of Resident # 38's electronic medical record revealed care plan meetings were held on 4/20/2023, 12/15/2023, 7/16/2024, and 8/27/2024. Additional review revealed a Quarterly MDS assessment on 7/18/2023, an Annual MDS assessment on 8/12/2023, a Quarterly MDS assessment on 9/15/2023, 3/14/2024, and 6/14/2024. There was no documentation of care plan meetings following those MDS assessments. On 9/16/2024 at 12:05PM, the Surveyor conducted an interview with Social Services Director #10. During the interview, the Surveyor was informed that care plan meetings are held every 90 days (quarterly), usually after a MDS assessment, or as requested by the family or resident representative. On 9/18/2024 at 8:02AM, Social Services Director #10 and the Surveyor reviewed Resident #38's care plan meetings from 4/20/2023 through 8/27/2024. Social Services Director confirmed that Resident #38 should have had quarterly care plan meetings. The Surveyor requested documentation of timely care plan meetings for Resident #38. Social Services Director #10 said she would look for that documentation. She stated that soon after she started her employment at the facility, on 3/25/2024, she completed an audit of care plan meetings. The audit identified multiple residents who were missing care plan meetings, and she made sure to get them all caught up. As of 9/18/2024 at 2:18PM, no documentation of timely care plan meetings for Resident #38 had been provided.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49148 Based on observation, record review, and interview with resident and staff, it was determined that the facility failed to evaluate and provide documentation that activities occurred that meet the needs of each resident. This was evident for 2 (Resident #38 & #54) of 2 residents investigated for activities during the annual survey. The findings include: 1a) During a tour of the second-floor nursing unit on 9/10/2024 at 8:26AM, the Surveyor observed Resident #38 in bed, with the head of the bed raised, watching TV. In the resident's room, Surveyor noted a June activity calendar posted on the far-right wall and a July activity calendar posted on the wall across from the front of the bed. There was no daily activity sheet observed. The Surveyor asked the resident about daily activities the facility provided for the residents. Resident #38 was unable to tell the Surveyor about the activities at the facility. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. On 9/12/2024 at 1:45PM, a review of Resident #38's electronic medical record revealed an Annual MDS assessment on 8/12/2024 which stated that the resident was dependent on staff for activities of daily living care, transfers with a Hoyer lift, and wheeling a manual wheelchair. The resident indicated that it was very important to choose what clothes to wear, to have snacks between meals, to listen to music, and important to keep up with the news, do favorite activities, and do things with a group of people. A care plan is used to summarize a person's health conditions, specific care needs, and current treatments. It outlines what needs to be done to plan, assess, and manage care needs. This helps to evaluate the effectiveness of the resident's care. During further review of Resident #38's electronic medical record, the Surveyor discovered a current activity care plan with a focus: I am dependent on staff for activities, socialization, cognitive stimulation related to impaired mobility and physical limitations; a goal: I will participate in preferred group activities as tolerated and desired; and staff interventions: Post the Activities calendar in my room each month, I need assistance with escorting me to/from activities, and Invite me to activities based on my known interests and activities I may enjoy. I enjoy playing Bingo, Church services, socials that feature food, and being around my peers. I also enjoy my weekly facetime calls with my daughter who lives out of town. Additional review failed to reveal documentation of Resident #38's participation in activities at the facility. On 9/17/2024 at 7:34AM, the Surveyor reviewed a care plan update note written by Activities Director #37. The note indicated that the recreation staff would continue to provide one to one sensory programs PRN (as needed), and the staff will continue to provide sensory stimulation to enhance responses to external stimuli and maintain quality of life. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2024 at 8:31AM, during an interview conducted with Activity Director #37, the Surveyor was informed that Resident #38 likes to participate in bingo, trivia, family visits, watching TV in his/her room, and watching TV in the day/dining room on the second floor. Activity staff also provides the resident with 1 on 1 visits where they sit and talk with the resident or complete an activity of choice. If the resident does not want to come out of the room or sometimes the staff is unable to get the resident to the activity room, channel 2 on the TV plays soft jazz music with a moving screen and movies. The activity staff document the residents' participation in daily activities in Point of Care (POC). On 9/17/2024 at 8:41AM, Activity Director #37 reviewed the POC with the Surveyor and confirmed that there was no documentation, from the activity staff, of Resident #38's daily activity participation for the month of July 2024, August 2024, and up to the current date in September 2024. Activity Director #37 informed the Surveyor that her team was short staffed at this time and she has not been able to review and/or complete the resident's POC documentation. The Surveyor requested a copy of any documentation that could show Resident #38's participation in activities for July 2024, August 2024, and September 2024. On 9/17/2024 at 9:50AM, a review of Resident #38's POC documentation provided, failed to reveal that the resident was offered daily activities, participated in daily activities, or refused daily activities for any reason. The Surveyor expressed the concerns with Activity Director #37 and the Director of Nursing (DON) #2. 44440 1b) On 9/10/24 at 8:43 AM, the surveyor conducted and interview with Resident #54. During the interview Resident #54 stated that the facility has not offered activities but he/she would be interested in doing something. Resident #54 further stated that the only thing he/she has had offered was rehabilitation services. On 9/11/14 at 12:25 PM, the surveyor reviewed Resident #54 ' s medical record. The review revealed that Resident #54 was admitted to the facility in late August of 2024. On further review the surveyor reviewed the Minimum Data Set (MDS) assessment regarding preferences that was completed on 8/23/24. Resident #54 indicated that it was somewhat important to have reading materials, music, be around animals, keep up with the news, be with groups, do favorite activities, getting fresh air, and practicing in religious activities. The surveyor was unable to find any documentation that activities were offered or provided to the resident in the medical record. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/24 at 9:08 AM, the surveyor interviewed the Director of Activities Staff #37. During the interview Staff #37 stated that when a Resident is admitted she completes the MDS preferences section and also completes a Home and Lifestyle Assessment. She further stated that she provides a calendar of activities and offers puzzles and magazines as well as informs them of the movie channel. Staff #37 stated that the Residents are visited everyday. The surveyor asked if any of these interventions were documented. Staff #10 stated that at the care plan meeting she would write a progress note and that she and her staff can document interventions in the TASK section in Point Click Care (the electronic medical record). The surveyor requested the TASK documentation and the Home and Lifestyle Assessment that were competed for Resident #54. On 9/17/24 at 9:20 AM, the surveyor conducted a follow-up interview with Staff #37. The surveyor reviewed the documentation of activities for September of 2024 for Resident #54. On 9/15/24 it was documented Resident #54 was offered a beverage and that nail care was provided. No other interventions were documented for any other day in September. The surveyor asked about August ' s log. Staff #37 stated there was no documentation for that month for Resident #54 and that activities were limited due to a COVID-19 outbreak that month. The surveyor asked about the History and Lifestyle assessment for Resident #54. Staff #10 stated that no assessment was completed for Resident #54. The surveyor reviewed the concern that Resident #54 ' s history and lifestyle preferences were not assessed and there was minimal documentation to show that any of his/her preferences for activities were provided.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interview, it was determined that the facility failed to have physician orders written to assure proper care and treatments were in place for foley care. This was found evident in 1 (Resident #41) of 3 residents reviewed for urinary catheter and Urinary Tract Infection (UTI) during the survey. The finding include: On 9/12/24 at 10:16 AM, the surveyor reviewed Resident #41' s medical record. The review revealed that Resident #41 was readmitted to the facility in of late August of 2024 after a hospital stay and had a past medical history, including but not limited to, sepsis (body's overreaction to an infection) due to Methicillin Resistant Staphylococcus Aureus (MRSA), urinary tract infections, and obstructive uropathy (obstruction of urinary tract). The surveyor next reviewed the Admission assessment dated [DATE] for Resident #41. In the Urinary Management section the question is a foley (a tube that helps drain urine from the bladder) present is checked yes. It further describes the reason as obstructive uropathy. The surveyor noted that Resident #41 had a care plan for alteration in bladder elimination as evidenced by the presence of an indwelling foley catheter. This care plan was created on 6/7/24 and revised on 8/22/24. On 9/12/24 at 10:05 AM, the surveyor reviewed Resident #41's physician orders. No orders were written for Resident #41 to have a foley and no orders for foley cares or treatments. Next the surveyor reviewed the September 2024 Treatment Administration Record (TAR). No foley cares were documented for September 2024. On 9/12/24 at 11:32 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that there were no orders for Resident #41's foley. When asked if cares were documents for the foley, the DON stated care for the foley would be in the TAR but because there was no order the task never got assigned to the TAR. She further stated that Resident #41 should have had orders for the foley on admission.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44440 Based on observation, record review, and interviews, it was determined that the facility failed to ensure that a resident received services to promote healing of a pressure ulcer. This was found evident in 1 (Resident #49) out of 5 residents reviewed for pressure ulcers. The finding include: On 9/10/24 at 8:29 AM, the surveyor observed Resident #49 in bed with his/her feet on the mattress without any protective boots on and the surveyor noted green protective boots placed on a wheelchair that was located next to Resident #49's bed. On 9/12/24 at 8:25 AM, again the surveyor observed Resident #49 in bed without protective boots on and noted the green boots were up on the top of Resident #49's closet. On 9/13/24 at 9:59 AM, the surveyor observed Resident #49 in bed with his/her heels on the bed and no protective boots on. On 9/13/24 at 10:22 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #9. During the interview the surveyor asked LPN #9 if Resident #49 was supposed to have protective boots on while in bed. LPN # 9 confirmed that Resident #49 should have boots on while in bed and that Resident #49 currently has wounds on his/her feet. She then opened Resident #49's closet door, grabbed the boots, and applied them to Resident #49's feet. On 09/13/24 11:54 AM , the surveyor reviewed orders for Resident #49. An order was placed on 7/9/24 that stated, elevate/float heels while in bed every shift. An order was written on 8/23/24 that stated, off loading boots: apply when in bed for pressure relief every shift for pressure wounds. On 9/13/24 at 12:20 PM, the surveyor reviewed Resident 49's care plan. A care plan was initiated on 7/9/24 that stated Resident #49 is at risk for pressure ulcers. The care plan was revised on 8/26/24 to include stage 2 pressure ulcer on Resident #49's heels. The surveyor reviewed Resident #49's Treatment Administration Record (TAR) for September of 2024. No where on the TAR was the ability to document pressure relief intervention for Resident #49. On 9/13/24 at 12:24 PM, the surveyor reviewed the concern that pressure ulcer interventions were not being completed with the Director of Nursing (DON). The DON confirmed that the boots should have been applied as ordered and if the Resident refused it should have been documented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interview, it was determined that the facility failed to provide treatment for constipation and maintaining bowel continence. This was found evident of 1 (Resident #41) of 3 residents reviewed for bladder and bowel during the survey. The finding include: On 9/10/24 at 1:30 PM, the surveyor conducted an interview with Resident #41. During the interview the resident stated that he/she had been having some troubles with bowel regularity while at the facility. On 9/12/24 at 10:16 AM, the surveyor reviewed Resident #41's medical record. The review revealed that Resident #41 was readmitted to the facility in late August of 2024 after a hospital stay. The surveyor reviewed the Admission assessment dated [DATE] for Resident #41. In the Bowel Management section, the question that asks for use of laxative to move bowels was checked, yes. The surveyor reviewed the TASK Bowel Movement (BM) documentation for Resident #41. No BMs were recorded on 9/1/24, 8/7/24, 9/8/24, 9/10/24, and 9/11/24 and 9/12/24. The surveyor reviewed Resident #41's Medication Administration Record (MAR) for September 2024. The review revealed that MiraLax (a medication prescribed to treat constipation) was ordered on 8/22/24 with the instructions; Give 17 gram by mouth every 24 hours as needed for CONSTIPATION MIX WITH 4 TO 8OZ OF FLUID- BOWEL PROTOCOL. None as needed MiraLax was given as of 9/12/24 at 11:47 AM. The surveyor reviewed the facility's bowel protocol. The protocol stated; Facility's standing order protocol is no BM in >24hrs: to perform abdominal assessment every shift prior to initiated next steps and notify the provider of any abnormal findings. Step 1: (No BM is 24hrs) :Prune Juice every 24 hours as needed for bowel protocol 1. If no BM in 3 shifts give 4 oz of prune Juice on the 4th shift. Step 2: Give Miralax 17gm by mouth every 24 hours as needed for bowel protocol step 2. If if no results from prune juice each shift. On 9/16/24 at 7:44 AM, the surveyor interviewed the Director of Nursing (DON). During the interview the surveyor relayed the concern that the bowel protocol was not being followed for Resident #41 and he/she continued to have consecutive days without a bowel movement documented and Miralax was not administered per protocol.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47758 Based on interview and review of pertinent facility documentation it was determined that the facility staff failed to obtain appropriate certification for a Nurse Aide in Training (NAIT) in the required time frame. This was determined to be evident for 3 (#24, #25, and #26) of 6 NAIT's reviewed for certification. The findings include: 1a & b) On [DATE] at 11:11 AM, the surveyor conducted a review of 5 random NAIT employee files revealed that NAIT #24 was hired on [DATE]. Although this was during the pandemic waiver period, NAIT #24 was required to obtain a Geriatric Nursing Assistant (GNA) licensure by the end of the waiver period which was [DATE]. When the current Human Resources (HR) Director determined that licensure had not occurred in the appropriate time period, NAIT #24 was reassigned to the Assisted Living side of the facility on [DATE] until Licensure was obtained on [DATE]. She is currently employed as a GNA in the facility. NAIT #25 was hired on [DATE], but did not obtain licensure by [DATE]. The date of resignation was [DATE]. The HR Director provided NAIT #25's time punch documentation and confirmed that she continued to work as a NAIT from [DATE] until she resigned on [DATE]. The HR director acknowledged that this was a concern and stated that there currently is a process in place to track educational progress for all NAIT's. The Director of Nursing was interviewed on [DATE] at 07:06 AM about the concern of the NAIT's working past their 120 days. She asked if the HR Director was aware and stated additional information would be provided if available. No further information was provided prior to the end of the survey. 44440 1c) Facilities may utilize unlicensed personnel assigned to direct resident care duties if the staff is enrolled in a geriatric nursing assistant training program approved by the Maryland Board of Nursing and is employed by the facility on a full time basis. The nursing home may not employ an individual as a Geriatric Nursing Assistant (GNA) until the individual has successfully completed a competency evaluation approved by the Maryland Board of Nursing and a person hired as geriatric nursing assistants shall complete an approved geriatric nursing assistant training program within 120 days of employment. On [DATE] the surveyor reviewed a facility investigation report from an investigation related to a resident fall July of 2023. In the investigation Nurse in Training (NAIT) #26 wrote a statement about the fall. On [DATE] at 7:15 AM, the surveyor reviewed Nurse in Training (NAIT) #26's employee file. The review revealed that NAIT #26 was hired as a dietary aide in October of 2022. No records were on file to indicate that NAIT #26 was enrolled in a nurse- in- training program. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] the surveyor conducted an interview with the Human Resource Director Staff #32. During the interview Staff #32 stated she started as Human Resource Director in April of 2024. She described the process when an employee applies for a nurse aide in training that the corporate recruitment staff works with the employee and provides the pre employment tasks. The recruitment staff enroll the NAIT in the initial training and lets the facility know when the NAIT is ready for orientation. The recruitment team uploads the NAIT's documents and certification. We check to make sure all requirements are in the record and have meetings to discuss the employee progress. We make sure that Cardiopulmonary Resuscitation CPR certification, licensure, and background checks are completed and uploaded. Staff #32 confirmed that NAIT #26 completed her 120 hours of training on [DATE]th of 2023 and her certification of completion was uploaded to her employee file. She further stated her GNA certification was updated on [DATE]. After reviewing these dates Staff #32 confirmed that NAIT ' #26 was employed as a NAIT until February 8th of 2024 and on [DATE] and [DATE] was coded as a GNA according to NAIT #26's timesheets. Staff #32 agreed NAIT #26 did not qualify to be a NAIT for several of the months she was employed or a GNA for her last two days.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47758 Based on observations, interviews with staff, and record reviews, it was determined that the facility failed to store food, dishes and monitor temperatures in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents eating food prepared in the facility's kitchen. The findings include: During the initial kitchen tour on 9/10/24 at 07:22 AM, the surveyor observed bottles of Oregano, Italian Seasoning, and Old Bay in use on the counter that were not labeled when opened or when to discard. [NAME] #18 stated that she just opened the containers and had not dated the spices yet. Additionally, unlabeled cheese, a meat patty, a bag of meat, and an opened scrambled egg carton were identified with the Dietary Team Lead who stated that we label items as they are opened but we may have missed some. A dishwasher temperature log was found with missing entries and a stack of wet bowls were found on the storage shelf upright in a manner that did not allow for drainage. On 9/12/24 at 11:03 AM, the surveyor interviewed the Certified Dietary Manager (CDM) who stated they have fixed all the unlabeled items. She further stated she inserviced staff about the missing temperatures on the log and provided a copy of the inservice. She stated she was aware of the wet cups being stored upright and showed me that all the drying dishes were now properly stored. The surveyor observed a refrigerator on the second floor on 9/16/24 at 10:17 AM with Certified Medication Assistant (CMA) #15. There was an open pudding container with no label or date found that was discarded by CMA #15. Unlabeled, and undated resident food was also found. When asked what the process was for labeling food, Unit Secretary #15 stated whoever put the food in should label it. Registered Nurse (RN) #17 stated that whoever puts the food in is supposed to label and date all food and we throw it away if it is not labeled and dated. During a kitchen revisit on 9/17/24 at 10:33 AM with the CDM, the surveyor found a container of egg salad that was labeled to expire 9/15/24, and jars of mayonnaise and mustard with no label or date. These were removed by the CDM. On 9/23/2024 at 07:10 AM, the Director of Nursing stated that the CDM had reported the findings and improvement measures taken.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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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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)

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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.