STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215360	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Baptist Aged Home	2801 Rayner Avenue Baltimore, MD 21216

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on medical record review and interviews it was determined that the facility staff failed to provide residents with showers and get residents out of bed. This deficient practice was evidenced in 2 (#1 & #22) of 2 residents assessed for choices during the recertification survey. The findings include: On 05/28/25 at 9:28 AM during observation rounds the surveyor asked Resident #22 how often he/she gets out of bed (OOB). Resident #22 verbalized they don't get OOB although they would like to. The surveyor observed a Gerry chair in the shared bedroom. Resident #22 verbalized the chair was used for their roommate. On 05/29/25 at 1:27 PM a review of Resident #1 and Resident #22 electronic health records (EMR) to verify if the residents had a shower; there was no documentation to verify whether the residents had a shower. A review of the shower list revealed Resident #1 was scheduled to have a complete bed bath (CBB) on Monday and Friday during the 3 PM - 11 PM shift. Resident #22 was scheduled to have a CBB on Monday and Friday during 11 PM - 7 AM shift. On 05/29/25 at 2:06 PM the surveyor asked Geriatric Nursing Assistant (GNA) #17 to show the surveyor in the electronic medical record (EMR) PointClickCare (PCC) documentation to verify Resident #22 had a shower. There was no place in the EMR for GNA #17 to document whether the resident had a shower. The surveyor asked GNA #17 if there is another place to document that a resident had a shower. GNA #17 verbalized, no. On 05/29/25 at 2:11 PM the surveyor made the Director of Nursing (DON) aware that Resident #22 had not had a shower since being admitted to the facility in October 2023 and there was no documentation to verify that Resident #1 or Resident #22 had a shower. Also, the surveyor observed both residents were in bed the past two days. The surveyor and DON went to Resident #22's room and the resident verified they had not had a shower since being admitted and they do not get OOB.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on medical record review and interviews, it was determined that the facility staff failed to provide a copy of the Notice of Medicare Non-Coverage to a resident's representative prior to being discharged from the facility. The deficient practice was evidenced in 1 (#4) of 1 resident record reviewed for NOMNC compliance during the recertification survey. The findings include: On 05/29/25 at 1:36 PM the surveyor received the list of residents who were discharged from the facility within the past 6 months. Three residents transitioned, five residents remained in the facility, and one resident went to an assisted living facility (ALF). On 05/29/25 at 2:32 PM during an interview with Social Worker #4 and the Administrator, the surveyor asked, Did Resident #4's responsible party (RP) receive a Notice of Medicare Non-Coverage prior to the resident's discharge? The surveyor received a copy of Resident #4 Notice of Medicare Non-Coverage dated 05/16/25. The resident representative's signature was not on the form; a note was typed on the form indicating that Resident #4's responsible party (RP) was notified via telephone on 05/16/25. The resident was discharged on 05/23/25. The Masters of Social Work (MSW) staff provided an envelope addressed to the RP. Social Worker #4 was unable to verify when the letter was mailed or if the RP received the letter. Social Worker #4 verbalized the facility had not received a signed copy from the RP.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with facility staff, it was determined the facility failed to ensure that the resident receiving psychotropic medications were necessary and justified when staff failed to complete behavioral and mood monitoring documentation for the conditions that the psychotropic medications were prescribed for. This was evident for 1 (Resident # 6) of 4 residents reviewed for unnecessary psychotropic medications. The findings include: Psychotropic medications, also known as psychiatric or psychoactive medications, are drugs that affect the mind, emotions and behavior. They are primarily used to treat mental health disorders, and can be divided into several categories, including antidepressants, antipsychotics, antianxiety, and hypnotics. On 05/29/25 at 08:36 AM, a record review was conducted. Resident # 6 was admitted to the facility on [DATE]. He/She had the diagnosis of Paranoid Schizophrenia; Major depressive disorder; anxiety disorder unspecified; Dementia with behavioral disturbance. Upon further review, he/she was taking psychotropic medications such as, Quetipine fumarate 200 mg tablet 1 tablet by mouth twice a day together with Quetipine fumarate 50 mg tablet 1 tablet by mouth twice a day to equal 250 mg tablet. There was no indication for the Quetipine in the Physician order. Additionally, he/she was taking Valproic acid 250 mg/5 ml solution given 10 ml by mouth twice daily for Schizophrenia. He/She was also given Trazodone 50 mg tablet 1 tablet by mouth at bedtime for Insomnia and Lorazepam 1 mg tablet 1 tablet by mouth twice daily for anxiety. Further review of the medical record was done; it was found that there was no behavior and mood monitoring documentation in his/her record. Additionally, the care plan for Resident # 6 was reviewed, Resident # 6 had a history of exhibiting behavioral outburst such as persistent yelling and screaming at others. He/She has the potential to be verbally aggressive. One of the interventions was to monitor behavior every shift, document the behavior and attempted intervention. On 05/29/25 at 09:58 AM, an interview with the Director of Nursing (DON) was conducted. This surveyor asked if they were doing the behavior monitoring for any resident who was taking psychotropic medications? The DON responded yes, we do it on paper. It was in front of the medication administration binder on top of the medication cart. The DON instructed staff # 10 (Registered Nurse) to pull it from the binder. Staff # 10 were not able to find the behavior monitoring flowsheet and instead provided the Treatment Administration Record for the month of May 2025. This surveyor asked Staff # 10 if they had the behavior monitoring record and she had no response. In addition, the DON was asked for medication regimen review process, the DON stated that the pharmacy consultant comes once a month to conduct the medication review and upon completion of the review, a report will be provided to her. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/02/25 at 10:26 AM, a record review was done for the medication regimen review. It was found that on March 26, 2025, Staff # 15 (Pharmacy Consultant) reported as follows: Resident # 6 has received Trazodone 50 mg at bedtime since 12/22/2023 for Insomnia. A recommendation to attempt a gradual dose reduction (GDR) of Trazodone 25 mg at bedtime. The psychiatry provider visited Resident # 6 on 3/26/2025 and 4/30/2025 respectively and there was no documentation that this recommendation was addressed. On 6/2/2025 at 11:45 AM, The findings were shared to the DON. No comment was noted.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interviews it was determined that the facility staff failed to notify a resident's representative in writing of the reason why the resident was transferred to the hospital and failed to provide a copy of the bed-hold policy to the resident representative. This deficient practice was evidenced in 1 (#17) of 2 resident records reviewed for transfer/discharge practices during the recertification survey. The findings include: On 05/28/25 at 2:01 PM a review of Resident #17 electronic medical record (EMR) revealed the resident was hospitalized in February and April 2025. The surveyor was unable to find documentation in the EMR indicating why the resident was hospitalized . On 05/29/25 at 9:15 AM the surveyor along with the Director of Nursing (DON) reviewed Resident #17's paper medical record located at the nurse's station. The transfer summaries dated 2/26/25 and 04/27/25 indicated the resident's family/responsible party was notified by telephone of the hospitalizations. There was no documentation to verify that Resident #17's responsible party was notified in writing of the hospital transfers. On 05/29/25 at 1:22 PM during an interview with Social Worker #4 the surveyor asked did they send a copy of the Bed-Hold Policy to Resident #17's responsible party when the resident was hospitalized on [DATE] and 04/27/25. Social Worker #4 verbalized the facility only provides a copy of the Bed-Hold Policy upon admission.

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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 Based on resident record review and staff interview it was determined that the facility failed to complete a Minimum Data Set (MDS) assessment within 14 days of a significant change of the resident's physical or mental condition. This was evident for 1 (Resident #20) of 1 resident reviewed for Hospice during an annual survey. The findings include: The Minimum Data Set (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. A significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both. On 5/29/25 at 12:16 PM a record review revealed that Resident #20 was admitted to hospice services on 5/9/25. However, the MDS significant change assessment was started on 5/19/25 and remained incomplete as of 5/30/25. On 5/30/25 at 12:37 PM a phone interview was conducted with the MDS Coordinator, and he confirmed that the resident was admitted to hospice on 5/9/2025. The MDS Coordinator also acknowledged that the significant change assessment for Resident # 20 was still in process as of 5/30/25. The Coordinator agreed that a MDS assessment should be updated within 14 days of a significant change, and the electronic records were not updated in a timely manner. The Nursing Home Administrator, Director of Nursing, Social Worker, Chief Financial Officer and other pertinent staff were made aware of these findings during the exit conference on 6/2/25. Cross Reference F640

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interviews it was determined that the facility staff failed to complete and transmit a Minimum Data Set assessment within the required 14-day timeframe. This deficient practice was evidenced in 1 (#1) of 2 resident MDS assessments reviewed for timely completion during the recertification survey. The findings include: On 05/30/25 at 12:27 PM a review of Resident #1 quarterly MDS assessment revealed the assessment review date (ARD) was 04/05/25 and the assessment was signed on 04/25/25 which was outside of the 14-day window to complete and transmit the assessment. On 05/30/25 at 12:47 PM during a telephone interview with the MDS Coordinator the surveyor asked why Resident #1 MDS assessment was completed outside of the required 14-day timeframe. The MDS Coordinator verbalized that the assessment was not completed within the required timeframe because the staff who needed to complete Section E & Section Q did not complete their assessments in a timely manner. After the facility staff completed their portion of the assessment, the assessment was submitted. The surveyor asked, were the Director of Nursing or Administrator made aware he/she was having difficulty with the staff completing Section E & Section Q in a timely manner. The MDS Coordinator verbalized, no.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical record review and interview it was determined that the facility staff failed to complete a narcotic count when a registered nurse assumed control over the nursing assignment. The deficient practice occurred during the recertification survey. The findings are: On 05/29/25 at 8:40 AM a review of the Controlled Drug Count Verification form revealed on 05/18/25 7AM - 3 PM shift a nurse signed the form as the incoming nurse. The outgoing nurse's signature 3PM - 11PM was different from the incoming nurse's signature. On 05/19/25 3PM-11PM shift the incoming nurse's signature and the outgoing 11PM- 7 AM shift was different. The surveyor could not verify if the narcotic count was completed by the nursing staff if another nurse completed the shift other than the incoming nurse. On 05/29/25 at 9 AM during an interview with the Director of Nursing the surveyor reported concerns about the nurse's completing the narcotic count as a nursing professional standard of practice. When the surveyor asked was the narcotic count completed when the nurse assumed control of the nursing assignment on 05/28/25 during 7 AM - 3 PM shift, the DON could not verify the narcotic count was completed.

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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** Based on clinical record review and observation it was determined that the facility staff failed to ensure the use of a hand splint as stated in the care plan. This was true for 1 (Resident # 9) out of 29 residents reviewed during the annual survey. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 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. On 5/29/2025 at 2:17 PM, A record review was conducted. Resident # 9 was admitted to the facility on [DATE]. He/She had hemiplegia affecting the left non dominant side and left-hand contracture. On 5/30/2025 at 11:38 AM, a review of Resident # 9's medical record was conducted, there was no documentation of any rehabilitation screening or evaluation. Minimum Data Set (MDS) quarterly assessment with the reference date of 4/7/2025 Section GG0115 was coded to have a limitation with the range of motion of the upper and lower extremity, one sided. On 05/30/25 at 11:52 AM, Resident # 9 was observed in his wheelchair with the contracture of his left hand. On 6/2/2025 at 8:49 AM, Review of the medical record revealed that Resident #9 was seen by Occupational Therapy from 4/1/2024 until 8/21/2024 and was treated for improvement of his/her activities of daily living and safety to decrease the risk for falls. There was no further occupational therapy screen or evaluation documentation found after 8/2024. Further review found to have no treatment or intervention for the contracture of his/her left hand in the Treatment Administration Record (TAR).The care plan for Resident # 9 revealed Resident has an alteration in musculoskeletal status of the left hand related to contracture one of the interventions was stated as: Staff to assist the resident with the application of supportive devices splints and check for skin checks every shift and as recommended. This was initiated on 12/14/2016 and was revised on 10/21/2024. On 06/02/25 at 09:18 AM, the surveyor observed Resident # 9 in his room and showed his/her left hand and stated I cannot completely open my hand. There was no splint, or any devices observed on his left hand. On 06/02/25 at 10:59 AM, all the findings were shared with the Director of Nursing.

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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. Based on record review and interview it was determined that the facility staff failed to consistently provide Activities to residents who were unable to participate in communal Activities. This deficient practice was evidenced in 2 (#1 & #22) of 2 resident records reviewed for staff providing Activities to bedbound residents during the recertification survey. The findings include: On 05/28/25 at 9:25 AM while speaking with Resident #22 the surveyor asked does someone come to the room and do Activities with him/her. Resident #22 verbalized a lady used to come to their room and do Activities with him/her, but the lady no longer works there, and it stopped. On 05/29/25 at 2:24 PM during a review of Resident #1 Activities Log revealed the last documented activity session was on 05/01/25. A review of Resident #22's Activities Log revealed the last documented Activity session was 04/28/25. During an interview with Activities Director #6 he/she was unable to verbalize why the resident's were not receiving Activities regularly.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interviews and record review it was determined that the facility failed to have an Registered Nurse (RN) on duty 24 hours a day for 7 consecutive days. The findings include: The PBJ Staffing Data Report listed that on Saturday, 10/05/2024, Saturday, 11/02/2024, Sunday, 12/01/2024, Saturday, 12/07/2024, Saturday, 12/14 /2024, Saturday, 12/21/2024, and Wednesday, 12/25/2024 there weren't any RNs on duty for the full 24 hours. The facility provided 2 weekends of scheduling (5/24-5/25/2025) and (5/31-6/1/2025) and consistently on Saturdays and Sundays there weren't any RNs on duty for the entire day. During an interview with the Administrator on 05/29/25 at 10:22 AM , she was asked about the dates targeted in the PBJ report. She stated that there was not an RN on duty on those dates. The Administrator stated that the facility was unable to find RN staff for weekends and holidays either from staff or agency. For the 2 week staffing schedule that was provided, there weren't any RNs working on the weekends (weekends of 5/24-5/25 and 5/31-6/1).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, it was determined that the facility failed to: 1.) properly label medications and dated once opened, and 2). Remove expired medications from the medication cart. This was evident for 2 of 2 medication carts reviewed during the annual survey. The findings include: 1.) On 5/30/2025 at 08:58 AM, a medication observation was conducted in the presence of staff # 8 (Certified Medication Aide) and revealed for medication cart 1 to have 2 eye drops, Dorzamide and Latanoprost eye drops for Resident # 8 both opened without a date they were opened. Resident # 20 had Dorzamide eye drops and found to be not dated. Upon further observation, medication cart 2 was noted to have 2 bottles of Nystatin powder for Resident # 14 with no date when both bottles were opened. It was also found to have 2 tubes of Duoderm Hydroactive gel without any label and not dated. Staff # 8 acknowledged the findings. Upon further medication storage observation, a canister of blood glucose strip was found in medication cart 2 without the date when it was opened. This was acknowledged by Staff # 13 (Registered Nurse) and immediately disposed of the blood glucose strips. 2.) Further medication observation was conducted. In medication cart 2 revealed for Resident # 21, had a tube of Nystatin cream that expired on 7/16/2024. It was immediately taken by Staff # 12 to be discarded. On 6/2/2025 at 10:35 AM, all findings were shared to the Director of Nursing.

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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. Based on observations, interviews, and record review, it was determined that the facility failed to: 1) maintain proper labeling, dating, and expiration practices for food items, and 2) did not consistently meet the manufacturer-recommended range of Quaternary Ammonium Compounds (QACs) for dish sanitization. This was found to be evident during the initial kitchen visit of the annual recertification survey. The findings include: 1) During a Kitchen tour on 5/28/25 at 8:17 AM, Staff #8 was unable to identify the correct expiration date on a box of hot sauce, noting conflicting and possibly expired dates. Cereal dispensers (Raisin Bran, [NAME] Krispies, Frosted Flakes) were all labeled 2/14/25. Staff #8 was unsure if this was the date the cereal was put in the dispenser or the expiration date. Expired spices were found Poultry Seasoning (exp. 9/27/2019) and Allspice (exp. 8/10/2023). On 5/28/25 at 8:35 AM, Staff #7 and Staff #8 could not consistently identify or date items in the Unit 2 freezer due to lack of labeling. Conflicting dates were given for chicken and ground beef, and Staff #7 acknowledged the need for proper labeling of frozen goods received. An unlabeled container of potato salad in Unit 1 refrigerator was shown to Staff #8 and was discarded by Staff #8 due to uncertainty about its expiration. On 5/28/25 at 8:53 AM, two unlabeled zip lock bags of spreadable butter were found in the Unit 4 freezer without an expiration date. Staff #7 acknowledged the need to label all received food items with a received date and an expiration date going forward. Quaternary ammonium compounds (QACs) are a large class of chemicals used as antimicrobials for cleaning and disinfecting food processing equipment, food contact surfaces and utensils. Bartavation is the brand of QAC that the facility used. According to Bartovation Quaternary Ammonium (QAC, Multi-Quat) Sanitizer Test Paper strips, the target range for effective sanitization of dishes is 200-400 ppm (parts per million). 2) On 5/29/25 at 10:04 AM, Staff #9 and Staff #8 were shown the May 2025 temperature/sanitizer log. Staff #9 was unsure of the correct QAC concentration range. The May 2025 temperature/sanitizer log showed readings of 100, which Staff #9 and Staff #8 did not recognize as being outside of the proper range. Staff #7 was informed that 100 ppm was too low and needed to be between 200-400 ppm for proper sanitization. Staff #7 verbalized understanding of the correct range.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, clinical record review and observation, it was determined that the facility failed to provide an Occupational Therapy evaluation for 1 (Resident # 9) out of 29 residents reviewed during the annual survey. The findings include: The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 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. On 5/28/2025 at 09:39 AM, an initial interview was conducted, Resident # 9 stated, I don't have any therapy. On 5/29/2025 at 2:17 PM, a record review was conducted. Resident # 9 was admitted to the facility on [DATE]. He/She had hemiplegia affecting the left non dominant side and left-hand contracture. On 5/30/2025 at 11:38 AM, a review of Resident # 9's medical record was conducted, there was no documentation of any rehabilitation screening or evaluation. Minimum Data Set (MDS) quarterly assessment with the reference date of 4/7/2025 Section GG0115 was coded to have a limitation with the range of motion of the upper and lower extremity, one sided. On 05/30/25 at 11:52 AM, Resident # 9 was observed in his wheelchair with the contracture of his left hand. On 6/2/2025 at 8:49 AM, Review of the medical record revealed that Resident #9 was seen by Occupational Therapy from 4/1/2024 until 8/21/2024 and was treated for improvement of his/her activities of daily living and safety to decrease the risk for falls. There was no further occupational therapy screen or evaluation documentation found after 8/2024. Further review found to have no treatment or intervention for the contracture of his/her left hand in the Treatment Administration Record (TAR). The care plan for Resident # 9 revealed Resident has an alteration in musculoskeletal status of the left hand related to contracture one of the interventions was stated as: Staff to assist the resident with the application of supportive devices splints and check for skin checks every shift and as recommended. This was initiated on 12/14/2016 and was revised on 10/21/2024. On 06/02/25 at 09:18 AM, The surveyor observed Resident # 9 in his room and showed his/her left hand and stated I cannot completely open my hand. There was no splint, or any devices observed on his left hand. On 06/02/25 at 10:59 AM, all the findings were shared with the Director of Nursing.

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	215360	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maryland Baptist Aged Home	2801 Rayner Avenue Baltimore, MD 21216

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interviews it was determined that the facility assessment did not accurately reflect the services provided by the facility. This deficient practice was discovered during the recertification survey. The findings include: On 05/30/25 at 4:30 PM the surveyor reviewed the facility assessment provided by the Director of Nursing. A review of the assessment revealed it was documented the facility had an average of 10 resident admissions during the weekday. The assessment failed to include they have the capacity to admit residents who had infectious diseases such as COVID-19, MRSA, and/or Clostridium Difficile. The portion of the assessment regarding caring for residents with conditions not listed was incomplete. The assessment indicated that the facility is equipped to care for residents with a tracheostomy, although there are no current residents within the facility. Showers were not listed for assistance provided for activities of daily living. On 06/02/25 at 11:21 AM during an interview with the Director of Nursing and Administrator the surveyor reported the concerns about the inaccuracy of the Facility Assessment. The Director of Nursing verbalized it's been a while since they had a skills lab for the nurses. There are no competencies to verify the staff have been trained to care for residents with a tracheostomy or gastrostomy tube. The Administrator verbalized the area of the assessment that indicated the facility had an average of 10 admissions during the week was an error.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility's governing body and/or executive leadership failed to ensure the Quality Assurance Performance Improvement (QAPI) program identified & prioritized problems that reflected the organizational process, functions, and services provided to residents based on performance indicator data, resident and staff input, and other information. This deficient practice was discovered during the recertification survey. The findings include: On [DATE] at 10:26 AM after reviewing the Quality Assurance Performance Improvement plan the surveyor interviewed the Director of Nursing (DON). The surveyor informed DON that the QAPI plan was ineffective because it lacked a systematic approach that identified problems, tracked, investigated, and analyzed data. When the surveyor asked the DON, was there oversight of the QAPI processes by a governing body and the DON verbalized, No. On [DATE] at 10:45 AM the Administrator verbalized Chief Financial Officer #14 provided oversight of the QAPI process. When the surveyor asked has CFO #14 attended any of the QAPI meetings and provided input to determine if the QAPI process was effective. The surveyor's question was not answered. On [DATE] at 12:23 PM during a telephone interview with CFO #14 the surveyor asked do they provide oversight of the QAPI process. CFO #14 verbalized the Administrator, and the Director of Nursing keeps them abreast with what was going on with the QAPI process and they try to attend some of the morning calls. The surveyor asked what was discussed during the most recent QAPI meeting. CFO #14 verbalized they discussed a couple of resident passings, and they always discuss staffing; he/she is part of the governing body. They just went to the facility to see how the survey was going, but did not review the QAPI book. The surveyor asked CFO #14 were they aware some of the nursing staff were not certified in cardiopulmonary resuscitation (CPR) as a provider, which was identified by the QAPI committee. CFO #14 verbalized, No.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility staff failed to have an effective system in place to identify, report, track, investigate, and analyze information relating to adverse events that occur within the facility. This deficient practice was discovered during the recertification survey. The findings include: On [DATE] at 10:26 AM after reviewing the Quality Assurance Performance Improvement (QAPI) plan the surveyor interviewed the Director of Nursing (DON). The surveyor informed the DON that the QAPI plan was ineffective because it lacked a systematic approach that identify problems, track, investigate, and analyze data. The DON verbalized the team meets monthly, and they were instructed to do review problems in the areas that needed to be approved. Their major concern was staffing. At first they were not using agency but started to meet the needs of the residents. The surveyor asked for documentation to show how they were monitoring that the building was properly staff. There was no data available to review and there were no notes to verify that they were monitoring the staffing issues. On [DATE] at 10:45 AM part of the QAPI plan indicated all the nursing staff were not cardiopulmonary resuscitation (CPR) certified. The surveyor asked to review the documentation when the issue was discovered, how they are monitoring the problem, what the team did to rectify the issue, and all else data. The requested data was not in the QAPI book for review.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interviews it was determined that the facility staff failed to include the Infection Preventionist in the Quality Assurance Performance Improvement (QAPI) meetings. This deficient practice was discovered during the recertification survey. The findings are: On 05/30/25 at 2:42 PM the surveyor reviewed the sign-in sheets for QAPI meetings held on 01/31/25, 02/19/25, 03/19/25 and the Infection Preventionist's name or signature was not included on any of the sign-in sheets. On 05/30/25 at 2:56 PM during a telephone interview with Infection Preventionist #3 the surveyor asked did he/she attend any QAPI meetings. IP #3 verbalized they did not attend the QAPI meetings in person but was present via telephone. IP #3 was made aware that their name was not included as attending the meetings in person or by telephone. The surveyor asked when the last time he/she participated in a meeting. IP #3 was not able to provide the information requested. On 05/30/25 at 3:13 PM the Director of Nursing was made aware the Infection Preventionist is required to attend QAPI meetings; and verbalized understanding.

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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. Based on observation and interviews with facility staff, it was determined that the facility failed to ensure that they had an adequate emergency water supply and were unaware of the building's water system and unable to provide a description of it, a diagram and no testing of the water had been done for legionella and/or other opportunistic waterborne pathogens. The findings include: On 05/28/25 at 10:27 AM the surveyor spoke with two housekeeping staff and the Director of Maintenance (Staff #1) regarding water testing and emergency water supply. Staff #1 said the city took care of water testing and would notify the facility if there was a problem. The surveyor informed him that the City provided the water up to the facility, but that the facility was responsible for the water system inside the building including testing for Legionella and other waterborne bacteria. He was completely unaware that the facility was responsible for testing the water and stated that they had not tested it anytime during the 2 years he had been employed in the facility. He also stated that they had not change the aerators in the residents' rooms and had not engaged a plumber to do any maintenance on the water system except for emergency breakdowns. One of the housekeeper's (Staff #2), accompanied the surveyor to check the basement area while checking the laundry and the emergency water supply. There were 11-5 gallon containers of water and 4 empty containers observed in an alcove of the basement between the laundry and a storage area. The surveyor made Staff #1 aware that the recommended emergency water supply was a gallon of water a day per resident and staff for 3 days. The facility has the capacity of 29 residents and schedule 10 staff per day for a total of 39. That would require 117 gallons to be onsite at all times. When the surveyor asked about the empty bottles, Staff #1 said the water was the emergency supply and used by the facility day to day. He stated that they had a contract with a water supplier and that last week 10 bottles were ordered but only 3 were delivered. The surveyor informed the Director of Maintenance (Staff #1), Staff #2 and the Nursing Home Administrator (NHA), that the facility's emergency water supply was significantly below the 117 gallons that they were supposed to have.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility staff failed to apply for a room waiver for rooms less than the required square footage. This deficient practice was discovered during the annual survey. The findings include: On 05/28/25 at 8:33 AM during the entrance conference with the Director of Nursing (DON) the surveyor asked did the facility have any waivers. The DON verbalized the facility had a waiver for rooms that are less than the required size. The surveyor requested a copy of the waiver. On 05/29/25 at 9:15 AM the surveyor reviewed a document received after the entrance conference. The document indicated rooms [ROOM NUMBERS] was less than the required square footage. The surveyor asked the Administrator for a copy of the waiver. The Administrator verbalized they were told not to apply for a waiver unless the survey team asked for the waiver. The surveyor made the Administrator aware the waiver should have been available prior to the survey to avoid noncompliance.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and staff interview it was determined that the facility staff failed to: 1) ensure a call device was installed in shower areas and 2) a cord used to turn on/off a call light was attached to the call system in the toilet stalls. This was evident for 2 of the 2 environmental observations during the annual survey. The findings include: On 5/28/25 at 10 AM the surveyor conducted a tour of the facility and observed the bathroom on the long hall without a call device in the shower area, and no string attached to the call device in the toilet stall. The shared bathroom on the short hall was without a call device in the shower area and two of the 3 toilet stalls were without strings attached to the call device. On 5/29/25 at 11:01 AM a subsequent tour of the facility with the Nursing Home Administrator (NHA) and Maintenance Director revealed the bathroom on the long hall without a call device in the shower area, and no string attached to the call device in the toilet stall. The shared bathroom on the short hall was without a call device in the shower area and two of the 3 toilet stalls were without strings attached to the call device. The Maintenance Director confirmed that the call device strings would be installed right away and installation of the call devices for the showers will be done as soon as approval to purchase is received from the NHA.