STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215365	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hagerstown	14014 Marsh Pike Hagerstown, MD 21742

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, it was determined that the facility failed to ensure that the most recent facility survey was readily accessible to residents, family members, and legal representatives of residents. This was evident for 1 Survey binder out of 1 survey binder reviewed during a survey. The findings include: On the morning of 5/8/25, an observation of the facility's entrance hallway revealed a binder titled Complete Care Hagerstown Survey Results. Further observation of the Binder failed to reveal the most recent Federal survey results. During a brief interview, the front desk receptionist (Staff #12) reported that she was unaware that the survey results were missing and would notify the manager. On 5/14/25 at 10:10 AM, during an interview with Staff #12, she confirmed that she did notify the administrator regarding the missing survey results. On 5/14/25 at 10:12 AM, the Regional Nurse Consultant Staff #2 confirmed that the Binder located in the entrance hallway titled Complete Care Hagerstown Survey Results did not contain the most recent federal survey results. On 5/14/25 at 10:18 AM, the above observation was shared with the Director of Nursing (DON). During the interview, she confirmed that the federal tags needed to be in the folder. On 5/14/25 at 11:18 AM, during a brief interview, Staff #2 confirmed that the front desk was the only location in the facility where the survey results were kept.

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interviews, it was determined that the facility failed to provide information to a resident to formulate an advanced directive. This was evident for 1 (Resident #4) of 4 residents reviewed for advanced directives. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they can no longer make decisions for themselves because of illness or incapacity. Resident #4 was admitted into the facility in early 2022. A quick look into the resident's medical record indicated that the resident was cognitively intact and was certified to understand and make medical decisions. Further review of the medical record failed to reveal an advanced directive. A subsequent review of Resident #4's medical record on 5/12/25 at 3:36 PM revealed a document titled Social Services Assessment and Documentation. The document stated that the resident was responsible for self and made his/her own decision. The following questions, whether additional conversation regarding advanced care planning was provided, opportunities to complete advanced directives offered, and advanced directive materials, including state form, were all answered No. The Social Services Director (Staff #12) was interviewed on 5/13/25 at 10:09 AM. During the interview, Staff #12 reported her process with advanced directives. She reported that it was initially discussed on admission with residents who were deemed capable and periodically reviewed during care plan meetings. She also reported that discussions about advanced directives were documented under Social Services Assessment and Documentation or in the care plan meeting progress notes. Staff #12 was asked if Resident #4 had an advanced directive. If not, was there documentation to indicate that information was provided to formulate one? After a quick review of the resident's medical record, she reported that the resident did not have one in place. She indicated that she would continue to review the resident's medical record and report back to the surveyor. On 5/13/25 at 12:15 PM, Staff #12 reported that Resident #4 did not have durable power of attorney for healthcare and was responsible for himself/herself. Staff #12 also reported that she did not find documentation that indicated that information was provided or opportunities were provided to complete an advanced directive. The concern was discussed with Staff #12 that there was no credible evidence to indicate that information to formulate an advanced directive was provided to a deemed capable resident. Staff #12 verbalized understanding and acknowledged the concern.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 2) A review of Resident #56's medical record on 5/9/25 revealed that the Resident received all nutrition via tube feedings since admission. A review of the Medical Nutrition Therapy Assessment, written by a Registered Dietician (RD Staff #4) with an effective date of 3/29/25, revealed the Resident's weight on that date was 122.7 lbs., the Resident met the criteria for severe malnutrition as evidenced by a BMI (body mass index) of less than 20 and the presence of moderate clavicle wasting. The documented goal was a weight gain of 2-4 lbs. per month towards 130 lbs. The recommended tube feeding would provide 1809 kcal per day. Further review of the medical record failed to reveal additional weights for March 2025. A review of the Medication Administration Record (MAR) revealed that nursing staff had documented with a check mark that weights were obtained every day from April 1 through April 7 and then on Monday, April 14th and 21st. However, a review of the weights and vitals section of the electronic health record revealed documentation of only four weights in April, on the 3rd, 10th, 17th, and 23rd. No other documentation was found in the medical record to indicate weight values were obtained on other dates in April 2025. On 4/3/25, the Resident's weight was 118.8 lbs. On 4/10/25 at 9:46 AM, the Resident's weight was documented as 113 lbs. This weight represents a more than 5 lb. loss in one week and a more than 9.7 lb. loss in less than 2 weeks. This 9.7 lb. represents a 7.9 % loss of body weight in less than 2 weeks. A review of the facility's Weight Assessment and Intervention Policy, with a Date Reviewed/Revised of 3/30/23, revealed Significant Weight Changes were defined as more than 5% within 30 days, more than 7.5 % within 90 days, and more than 10% within six months. This policy also stated that the Physician and Responsible Party of the Resident should be notified of significant weight change. The Director of Nursing (DON) was interviewed on 5/9/25 at 11:43 AM regarding the weight process in the facility. The DON reported they obtained a weight within 24 hours of admission and a re-weight in 48 hours, then weekly times four weeks. She reported that weights were usually done Monday or Tuesday, giving them Wednesday and Thursday for re-weights and that the nurses needed to supervise re-weights. Reweights were obtained the next day if the Resident had an off weight. The DON clarified an off weight as greater than 5%. The surveyor then informed the DON that no reweight was found following the 4/10/25 weight, which indicated a significant weight loss. A review of a nursing progress note, with an effective date of 4/10/25 at 12:12 PM, revealed documentation that the Resident's weight was 118.8 lbs. This note included documentation that the 118.8 lbs weight was from 4/3/25. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the nursing progress notes, dated 4/11/25 at 3:59 AM and 4/12/25 at 3:37 AM, also included documentation of the 4/3/25 weight of 118.8 lbs. Documentation of the 4/10/25 weight of 113 lbs. was not found in a nursing progress note prior to a note on 4/15/25. On 4/17/25, the Resident's weight was 113.6 lbs. Further review of the medical record revealed a note completed by the registered dietician (#4) with an effective date of 4/20/25 that included a plan .to increase TF rate to address weight loss. This note also included documentation that the responsible party and the nurse practitioner were aware of the weight change. The new tube feeding orders were implemented starting on 4/21/25. Further review of the medical record failed to reveal documentation to indicate the physician/nurse practitioner, the registered dietician, the Resident, or the Resident's responsible party were made aware of the significant weight loss prior to 4/20/25, more than a week after it was initially identified. On 4/23/25, the Resident's weight was 111.2 lbs. On 5/2/25, the Resident's weight was 114.6 lbs. On 5/09/25 at 11:48 AM, the surveyor informed the DON that no documentation was found to indicate the physician/nurse practitioner, or the registered dietician was made aware of the weight loss until the RD assessment on 4/20/25. The surveyor also reviewed the concern with the DON that the nursing progress notes for 4/11 and 4/12 referenced 118 weight and that the 113 weight was not documented in the nursing progress note until 4/15/25. On 5/13/25 at 10:47 AM, when asked how they were notified of weight loss, RD (Staff #20) reported that the electronic health record system would trigger for 5% x 30 days. On 5/13/25 at 11:02 AM, when asked about notification of weight loss, RD (Staff #4) reported weight triggers are in weights and vitals [section of the electronic health record] and that RD #20 usually keeps daily track and the nurse's letting us know. She went on to report that notification was usually within a few days. If the weight seemed a little out of the norm, they would request a re-weight, and the re-weight would usually be within the next few days. The surveyor reviewed the concern that it was ten days before there was documentation to indicate the weight loss was reported to the RD. As of the time of survey exit on 5/14/25 at 1:15 PM, no additional documentation was provided to indicate the physician/nurse practitioner, or the responsible party was notified of the significant weight loss prior to 4/20/25. Based on record review and staff interviews, it was determined that the facility failed to notify attending physician, Residents' representative, and registered dietitian in a timely manner when there were documented changes in residents' condition. This was evident for one out of three complaints reviewed during the recertification survey and one (#56) out of three Residents reviewed for tube feeding. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings include: 1) A review of complaint # MD00214514 on 5/14/25 at 8:22 AM contained an allegation that Resident #74's representative was not immediately made aware of a fall after the resident's admission to the facility. A review of Resident #74's record showed that s/he was admitted to the facility in November 2024 with diagnoses including post-right hip surgery. Continued review included a change in condition evaluation form completed for Resident #74 on 11/26/24. The form recorded that Resident #74 had a fall on 11/21/24. However, Resident #74's attending provider and representative were not notified of the change in condition until 11/26/24. Further review also found another change in condition evaluation form completed on 11/24/24 that indicated that Resident #74 had increased discomfort to right hip and change of bruise color/size at the surgical incision area on 11/22/24. However, Resident #74's attending provider and representative were not notified of the resident's change in condition until 11/24/24. In an interview on 5/13/25 at 8:01 AM, the director of nursing said that any change in a resident's condition should be reported immediately to the resident's attending provider and the representative. However, reviews completed earlier on showed that Resident #74's fall on 11/21/24 and increased discomfort to right hip and change of bruise color/size at the surgical incision area on 11/22/24 were reported two days and five days later to the Resident's attending provider and representative.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and resident and staff interviews, it was determined that the facility failed to exercise reasonable care for the protection of the Resident's property from loss or theft. This was evident for one (Resident #18) reviewed during the recertification survey. The findings include: In an interview on 5/8/25 at 10:13 AM, Resident #18 reported that my body wash and shampoo were stolen. Money has gone missing- $12.00. My big concern is that my lock has been broken right now for about a month or two. I've told the nurses many times- they don't do anything. On 5/8/25 at 10:38 AM, the surveyor observed the opened bedside cabinet drawer. A bank envelope, with presumably money in it, was readily visible. Resident #18's hearing aid was observed on the bottom of the drawer. Resident #18 closed the drawer and could not lock it. On 5/12/25 at 8:59 AM, the surveyor observed that the top drawer of the bedside cabinet drawer was ajar. The Resident was not in his/her room. A staff member stated, [S/he's] in the shower. On 5/12/25 at 2:36 PM, the Director of Nursing (DON) was made aware of Resident #18's broken bedside cabinet drawer lock. The DON acknowledged that Resident #18 could not file a grievance without staff assistance and that a broken bedside cabinet drawer lock failed to protect Resident #18's property. On 5/12/25 at 3:01 PM, the maintenance assistant (Staff #31) was observed replacing the broken lock in Resident #18's room. Staff #31 acknowledged that the lock was broken and needed to be replaced. Staff #31 reported that a key would be provided to Resident #18, and the maintenance department would keep a spare. On 5/13/25 at 3:30 PM, Resident #18 was observed wearing a key on a necklace. The Resident stated, It's a key to my lock.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and resident and staff interviews, it was determined that the facility failed to identify a Grievance Official in the facility's grievance policy, ensure that the policy in place processed grievances, and make prompt efforts to resolve a Resident's grievance. This was evident in one grievance investigation reviewed during the recertification survey. The findings include: On 5/9/25 at 12:59 PM, in an interview with a Registered Nurse (RN #25) and Certified Nursing Assistant (CNA #26) regarding how residents got hearing aids, Resident #24 stated, My hearing aids are missing. The surveyor asked staff, How will you help Resident #24? CNA #26 stated, I would tell the unit manager. RN #25 verbally acknowledged Resident #24's complaint. On 5/12/25 at 8:48 AM, a record review of the Grievance policy revealed a blank space for the Grievance Official's name and contact information. It also showed that the Grievance Official was responsible for overseeing the process, receiving and tracking grievances through to conclusion, leading investigations by the facility, and issuing written grievance decisions to Residents. On 5/12/25 at 2:44 PM, in an interview, the Director of Nursing (DON) stated that completed grievance forms were given to the Social Services Department (SSD). Each nurses' station had grievance forms. Any staff could help residents complete the form. The form had to be signed off by the Nursing Home Administrator (NHA) within 5 days to be considered resolved. And the SSD was to follow up in morning stand-up meetings. On 5/12/25 at 3:06 PM, a grievance form was observed and inserted into an acrylic frame on the nurse's station counter. In an interview, Licensed Practical Nurse (LPN #28) stated, there's usually a stack. The surveyor observed no stack. On 5/12/25 at 3:10 PM, in an interview, the Social Services Director (Staff #12) and Social Services Manager (Staff #27) reported that residents had access to grievance forms and could submit them anonymously to the SSD, who handed the forms to the unit manager. The unit manager was expected to investigate and document what they did to resolve the grievance, which was discussed in the morning clinical meetings. Both staff members acknowledged that they didn't know how the grievances got resolved on the unit for the resident. On 5/12/25 at 3:41 PM, a record review of the grievance log revealed that Resident #24 initiated a grievance on 1/13/25 related to missing hearing aids. On 1/17/25, the record showed concern resolved and signed by the NHA. On 5/13/25 at 9:16 AM, while the surveyor reviewed records at the [NAME] unit nurse's station, Resident #24 approached the surveyor and reported, I'm still missing my hearing aids. On 5/13/25 at 10:04 AM, the surveyor observed Resident #24 in a wheelchair in the hall without hearing aids. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 10:19 AM, in an interview, RN #25 was asked, What is your process when a resident complains about missing hearing aids? RN #25 replied, I tell my unit manager and usually write a nursing note. The surveyor asked, Would you complete a grievance form? RN #25 replied, I don't think I would. I didn't know about the grievance process. On 5/13/25 at 10:20 AM, the surveyor informed RN #25 that Resident #24 complained that her/his hearing aids were still missing. On 5/14/25 at 8:39 AM, in an interview, Staff #27 reported that SSD had not received a grievance form on behalf of Resident #24. On 5/14/25 at 8:48 AM, RN #5, [NAME] Unit Manager, acknowledged that she had not received a grievance form on behalf of Resident #24 and reported that one should have been initiated according to the grievance process. In an interview on 5/14/25 at 9:12 AM, the NHA identified himself as the facility's Grievance Official and described his responsibility as overseeing the process. The NHA acknowledged that he was unaware of Resident #24's grievance filed in January 2025. He agreed that the grievance process failed Resident #24.

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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. Based on record review and interviews, it was determined that the facility failed to ensure residents were free from unnecessary psychotropic medication, as evidenced by the lack of documentation for non-pharmacological interventions (NPIs) and adequate indication for its use. This was evident for 1 (#35) of 5 residents reviewed for unnecessary medications. The findings include: Resident #35 was admitted into the facility in late 2020. A review of the resident's medical record indicated that the resident was on a combination of psychotropic medications, including Ativan (Lorazepam), given on an as-needed basis. Lorazepam (Brand name- Ativan) is used to treat anxiety disorders. It is also used for short-term relief of the symptoms of anxiety or anxiety caused by depression. Lorazepam is a benzodiazepine that works in the brain to relieve symptoms of anxiety. Benzodiazepines are central nervous system (CNS) depressants, which are medicines that slow down brain activity and can cause a range of effects, including relaxation, drowsiness, and even unconsciousness. On 5/9/25 at 8:47 AM, a review of Resident #35's medical record, including the electronic Medication Administration Record (eMAR) for April 2025, revealed that Ativan was administered 16 times. Out of the 16 times that the Ativan was administered, concerns were identified that include: a) There was no documentation to indicate that NPIs were administered and/or attempted prior to the administration of the medication. (administered on 4/3/25- 2:10 AM, 7:25 PM; 4/4/25- 3:20 PM; 4/5/25- 1:05 PM; 4/6/25- 2:58 PM; 4/7/25- 12:07 PM; 4/8/25- 7:44 AM; 4/13/25- 3 AM, 8:32 AM; 4/17/25- 12:15 PM; 4/20/25- 6:03 PM; 4/25/25- 9 AM; 4/27/25- 11 AM; 4/28/25- 5 PM; and 4/29/25- 10:34 AM) b) There was no documentation that the resident had behaviors to support adequate indication for its use. (administered on 4/3/25- 2:10 AM, 7:25 PM and 4/13/25- 3 AM, 8:32 AM) The Nurse Manager (Staff #5) for the unit where Resident #35 resided was interviewed on 5/9/25 at 12:49 PM. During the interview, she reported her expectations from nursing staff on giving psychotropic medications on an as-needed basis. The expectations included documenting the behavior/s and NPIs' efforts before administering the medication. Staff #5 further reported that there were several ways to document. She indicated an actual order for NPIs on the eMAR, the medication order, where the nurse could add comments, progress notes, or the Task documentation for behavior monitoring & intervention. On 5/9/25 at 1:39 PM, the above findings were discussed with the Director of Nursing (DON). The DON stated, They (referring to the nursing staff) should be documenting more than that, and indicated that she would review Resident #35's medical record to look for further evidence. On 5/12/25 at 10:09 AM, the DON did not provide any further documentation to indicate NPIs were attempted, and behavior/s were documented prior to administering the psychotropic medication on the identified dates. The DON verbalized understanding and acknowledged the concern.

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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. Based on record review and interviews, it was determined that the facility failed to provide written transfer notice and written bed hold policy to a Resident's representative upon transfer to an acute care facility. This was evident for 1 (#274) of 5 residents reviewed for hospitalization. The findings include: A review of Resident #274's medical record on 5/8/25 at 11:50 AM, showed that the resident was admitted to the facility in February 2025. And per an MDS assessment (Minimum Data Set assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident) dated 2/11/25, Resident #274 had a moderate cognitive impairment. A continued review found that Resident #274 was transferred to an acute care facility on 4/28/25. However, the review lacked documentation that the resident's representative was notified in writing of the facility's bed hold policy and the resident's transfer to an acute care facility along with the reason for the transfer. In an interview on 5/9/25 at 9:05 AM, staff #29, a licensed practical nurse, said she was unsure what the facility's process was for ensuring a Resident's representative was notified in writing of the facility's bed hold policy and transfer notice. During an interview on 5/9/25 at 1:02 PM, the director of nursing reported that the facility's receptionist mailed a packet that included bed hold policy and transfer notice to residents' representative upon transfer to acute facilities. An interview on 5/9/25 at 1:09 PM, with staff #21, a receptionist, showed a lack of documentation that the facility's bed hold policy and transfer notice were mailed to Resident #274's representative upon transfer to an acute care facility on 4/28/25.

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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. Based on medical record review and interview, it was determined that the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the residents' medication usage. This was evident for one (Resident #31) out of one resident reviewed for Resident Assessment. The findings include: The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. On 5/9/25, a review of Resident #31's medical record revealed a Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 3/8/25, documented that the resident had received insulin injections on 7 out of the 7 days of the assessment period. Insulin is a medication used to treat diabetes. Further review of the medical record failed to reveal documentation that the resident had a diagnosis of diabetes, failed to reveal current or past orders for insulin, and failed to reveal documentation to indicate the resident had received any injections during the look-back assessment period. On 5/9/25 at 3:05, when asked where she obtained information for Section N Medications, the MDS nurse (Staff #9) reported she reviewed the MAR (Medication Administration Record). The surveyor reviewed with the MDS nurse that Section N indicated seven days of insulin injections and asked the MDS nurse to show supporting documentation of this assessment. After looking at the electronic health record, the MDS nurse acknowledged the error and stated: I will do a modification right now. On 5/13/25 at 11:55 AM, a review of the modified MDS revealed documentation that no injections of any type were received by the resident during the 7-day look-back period. On 5/14/25 at 11:25 AM, the surveyor reviewed with the Director of Nursing the concern regarding MDS inaccuracy related to injections and insulin usage.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interview, it was determined that the facility failed to ensure a required Level II Preadmission Screening and Resident Review (PASARR) evaluation was completed for 1 (#68) of 3 Residents reviewed for PASARR compliance during the recertification survey. The findings include: The PASARR is a federally mandated process designed to ensure that individuals with serious mental illness (SMI), intellectual disability (ID), or related conditions are not inappropriately placed in Medicaid-certified nursing facilities (NFs) for long-term care. The PASARR process helps determine whether a person 1.) Has a diagnosis of SMI, ID, or a related condition; 2.) Requires the level of services provided by a nursing facility; 3.) Needs specialized services for their condition. The PASARR is divided into two levels: Level I Screening is a preliminary screening conducted prior to admission to identify individuals who may have SMI, ID, or a related condition. Level II Evaluation is conducted by the State Mental Health or Developmental Disabilities Administration to determine whether the individual requires nursing facility services and/or specialized services. On 5/9/25 at 9:48 AM, a record review of Resident #68's PASARR documentation revealed that the resident's PASARR Level I did not indicate that the resident triggered for a Level II evaluation or had been granted a 30-day short-term admission exemption. There was no evidence of further screening or exemption coordination prior to admission. Further record review revealed the resident was care planned for interventions related to agitation, schizoaffective disorder, and developmental delay. On 5/9/25 at 10:21 AM, during an interview, the facility's social worker (Staff #12) presented the two PASARR Level I forms, from preadmission and post-admission, which confirmed that the resident had not been evaluated for an exemption from Level II review. The post-admission PASARR contained documentation that stated, Level II required for ID. Please proceed with Level II clearance. During the interview, Staff #12 confirmed the deficiency. On 5/9/2025 at 4:09 PM, the facility's administrator was made aware of the deficiency, and no additional evidence was provided by the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and observations, it was determined that the facility failed to develop and implement comprehensive resident-centered care plans for residents. This was evident for 2 (#7, #276) of 32 residents reviewed during the recertification survey. The findings include: 1) A review of Resident #7's medical record on 5/12/25 revealed that the Resident had resided at the facility for several years, had significant cognitive impairment and had limited physical mobility. A review of the 2/19/25 Minimum Data Set (MDS) assessment, Section F Preferences for Routine & Activities, revealed it was very important to the Resident to listen to music s/he likes, to be around animals such as pets, to do things with groups of people, and to go outside and get fresh air when the weather is good. The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. A review of Resident #7's medical record on 5/12/25 at 9:47 AM revealed a care plan addressing activities that had a focus of: [name of Resident] is dependent on staff, etc., for meeting emotional, intellectual, physical, and social needs r/t Cognitive deficits, physical limitations. The stated goal was that the Resident would attend/participate in group, 1:1, and/or independent leisure activities of choice 3-5 times weekly by the next review date. This care plan was initiated several years ago and had a revision date of 3/17/25. The interventions included: -All staff to converse with Resident while providing care. -Establish and record the Resident's prior level of activity involvement and interests by talking with the Resident, caregivers, and family on admission and as necessary. -Invite the Resident to scheduled activities such as music and socials. -Provide the Resident with materials for individual activities as desired. The Resident likes the following independent activities: (SPECIFY) No documentation was found in the care plan to indicate what independent activities the Resident liked to do. No documentation was found in the care plan regarding pet visits or going outside despite the MDS assessment that these things were very important to the Resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at approximately 1:00 PM, an interview with the Activity Director (Staff #30) revealed that he had been the activity director at the facility for several years. In regard to Resident #7, the Activity Director reported that the Resident liked to listen to music, attended activities with entertainers, and liked hot chocolate. The surveyor reviewed the concern that the care plan was not individualized. After looking at the current care plan, the Activity Director confirmed he did not specify activities that the Resident liked in this care plan. Further review of Resident #7's medical record on 5/12/25 revealed that the Resident has a history of pressure ulcers and a care plan addressing reoccurring pressure ulcers. This care plan was initiated several years ago. One of the interventions, with a revision date of 4/4/23, included: Bariatric low air loss mattress with perimeter on bed at all times; Check every shift for placement and function. A review of the March and April 2025 Treatment Administration Records (TAR) revealed that a corresponding order was in place from 11/18/24 until discontinued on 4/27/25. The nursing staff documented every shift that the mattress was checked for placement and function until 4/23/25. Further review of the physician order and the TAR on 5/12/25 failed to reveal a current order regarding the bariatric mattress or documentation to support that nursing staff were checking for placement or function every shift as indicated in the care plan. On 5/13/25 at 10:04 AM, the surveyor observed that the air mattress on the Resident's bed was set at 350 lbs. The nurse (Staff #34) confirmed the mattress was set at 350. When asked if this setting was correct, Nurse #34 responded: [name of Central Supply Staff #35] sets up the mattresses. On 5/13/25 at 11:38 AM, the Director of Nursing (DON) was interviewed about air mattresses. The DON confirmed Resident #7 had a bariatric air mattress and that the weight setting would be at 220 lbs. The surveyor then reviewed the concern that no current order was found for the air mattress, and no documentation indicated that it was being checked each shift as indicated in the care plan. Surveyor also reviewed Nurse #34's response when asked if the setting was correct. The DON reported that it should be signed off by the nurses and indicated she would look for the orders. At 12:25 PM, the DON reported there was an order, but it was not re-ordered when the Resident was re-admitted . On 5/14/25, further review of the medical record revealed an order dated 5/13/25 that stated: Resident has a bariatric air mattress. Check placement every shift. This order did not include checking for function as previously ordered or indicated in the care plan. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff utilize care plans to provide resident-centered care that includes support, services, and resources to address a resident's needs. 2a) A record review showed that Resident #276 had resided in the facility since March 2025. The review also contained an activity care plan for Resident #276 initiated on 3/29/25. The care plan recorded a goal that stated, [Resident #276] will attend/participate in group, one-on-one and/or independent, leisure activities of choice 3-5 times weekly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interventions recorded on the care plan stated All staff converse with Resident while providing care, Establish and record the Resident's prior level of activity involvement and interests by talking with the Resident, caregivers, and family on admission and as necessary, Invite the Resident to scheduled activities such as music, Provide the Resident with materials for individual activities as desired. The Resident likes the following independent activities: watch TV. A continued review of an MDS assessment dated [DATE] for Resident #276 showed that the Resident had a hearing impairment. The MDS also indicated that the activity preferences significant to Resident #276 included going outside to get fresh air when the weather was good and participating in religious services or practices. However, an earlier review of Resident #276's care plan failed to show that the Resident's personal activity preferences of going outside to get fresh air when the weather was good and participating in religious services or practices were addressed in the care plan. In an interview on 5/9/25 at 10:10 AM, staff #30, the activities director, reported that the activity care plan was individualized based on the data collected during the completion of the MDS assessment. Staff #30 confirmed that Resident #276's care plan did not address his/her preferences for activity and stated it would be corrected. 2b) In an observation of Resident #276 on 5/8/25 at 1:21 PM, s/he was lying in bed and had swelling in both legs. A record review included a nursing admission assessment dated [DATE] for Resident #276, that recorded that the Resident was admitted to the facility with pitting edema [a type of swelling characterized by the presence of indentations (pits) in the skin when pressure is applied] to bilateral legs. Continued review of an attending provider's notes dated 5/2/25 showed that Resident #276 continued to have edema in both legs. However, the review failed to show that the Resident's edema was addressed in his/her care plan. In an interview on 5/9/25 at 9:56 AM, staff #29, a licensed practical nurse, reported that Resident #276 always had edema in both legs since admission to the facility. During an interview on 5/14/25 at 10:20 AM, the director of nursing reported that Resident #276's edema in both legs should have been addressed in his/her care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to provide a Resident with the amount of assistance needed during meals. This was evident for 1 out of 3 complaints reviewed during the recertification survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. The information collected drives resident care planning decisions. A review of complaint # MD00214514 contained an allegation that Resident #74 did not receive assistance from staff with his/her meals. A review of Resident #74's medical record contained an MDS assessment dated [DATE] that showed that Resident #74 had severely impaired cognition and required set up or clean up assistance from the facility's staff with his/her meals. A continued review was completed of geriatric nurse aides' (GNAs) ADL (activity of daily living) documentation of assistance provided to Resident #74 during meals from November 20 to January 31, 2025. The review lacked documentation for helping Resident #74 with his/her meals for 4 shifts in November, 9 shifts in December, and 8 shifts in January. In an interview with the director of nursing on 5/13/25 at 2:26 PM, she confirmed the lack of documentation and stated understanding of concerns.

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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 medical record review, interviews, and observations, it was determined that the facility failed to provide an ongoing program of activities to meet the needs and preferences of residents. This was evident for 2 (#7, #276) out of 3 residents reviewed for activities. The findings include: 1) A review of Resident #7's medical record on 5/12/25 revealed that the resident has resided at the facility for several years and had significant cognitive impairment and limited physical mobility. A review of the 2/19/25 Minimum Data Set (MDS) assessment, Section F Preferences for Routine & Activities, revealed it was very important for the resident to listen to music s/he likes, to be around animals such as pets, to do things with groups of people, and to go outside and get fresh air when the weather is good. A review of the resident's care plans on 5/12/25 at 9:47 AM revealed a plan that addressed activities that had a focus of [name of resident] is dependent on staff etc. for meeting emotional, intellectual, physical and social needs r/t Cognitive deficits, physical limitations. The stated goal was that the resident would attend/participate in group, 1:1, and/or independent leisure activities of choice 3-5 times weekly by the next review date. This care plan was initiated several years ago and had a revision date of 3/17/25. The interventions included: All staff to converse with resident while providing care, establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family on admission and as necessary, Invite the resident to scheduled activities such as music and socials, Provide the resident with materials for individual activities as desired. The resident likes the following independent activities: (SPECIFY). No documentation was found in the care plan to indicate what independent activities the resident liked. No documentation was found in the care plan regarding pet visits or going outside despite the MDS assessment that these things were very important to the resident. On 5/12/25 at approximately 1:00 PM, an interview with the Activity Director (Staff #30) revealed he had been the activity director at the facility for several years. He confirmed that all the documentation related to activity participation is found in the TASKS section of the electronic health record and that he writes the care plans for activities. The Activity Director confirmed that a volunteer brought a dog for pet visits. However, she came when he was not in the facility and indicated he was not sure who she visited. Staff #30 confirmed that he did not provide a list of residents who would like pet visits to the volunteer. In regard to Resident #7, the Activity Director reported that he was aware that the resident liked to listen to music, attend activities with entertainers, and like hot chocolate. The surveyor reviewed the concern that the care plan was not individualized. After looking at the current care plan, the Activity Director confirmed he did not specify the activities that the resident liked in the care plan. The surveyor requested the activity documentation for the past 90 days for review. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 1:47 PM, the Activity Director provided the activities documentation for February 2025 through 5/12/25. A review of the documentation revealed that staff frequently documented family or friend visits as an activity. A review of the documentation for March 2025 failed to reveal documentation of activities for 23 out of the 31 days; this included no activity documented from March 1-7, 10-17, or 24-28. Of the 8 days where activities were documented, 3 of the 8 were documented as family or friend visits; 3 days had documentation of a movie, one staff visit, and one special event. A review of the documentation for April 2025 revealed documentation of activities for 12 out of the 26 days the resident was in the facility. However, 6 of these 12 days were only documented as family or friend visits. A review of the documentation for May 1-11, 2025, revealed documentation of activities on two of these eleven days. This consisted of a staff visit on 5/4 and an entertainer on 5/9. On 5/14/25 at 11:25 AM, the surveyor reviewed the concern regarding the failure to provide an ongoing program of activities in accordance with a resident's assessment with the Director of Nursing. A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff utilize care plans to provide resident-centered care that includes support, services, and resources to address a resident's needs. The Minimum Data Set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected is used in the Resident's care planning decisions. 2) In an observation on 5/8/25 at 9:16 AM, Resident #276 was observed sitting in a wheelchair in his/her room, by the bedside with his/her television turned off and no meaningful activity program going on. The Resident was asked about activities and stated, I just sit in this chair after therapy till 2 PM when I can get back to bed. The Resident continued to state that s/he did not like to turn on his/her television due to his/her hearing difficulty. In a subsequent observation on 5/9/25, Resident #276 was observed to be helped back to bed by staff. The Resident was asked what activity program she liked and responded, What is there to do here? A record review for Resident #276 showed that the Resident was admitted to the facility in March 2025 with diagnoses including Dementia. The review contained an activity care plan for Resident #276 initiated on 3/29/25. The care plan recorded a goal that stated, [Resident #276] will attend/participate in group, one-on-one and/or independent, leisure activities of choice 3-5 times weekly. A continued review of an admission MDS assessment for Resident #276, dated 4/3/25, showed that the Resident was interviewed about Preferences for Activities by staff #30, the activity director. The Activity preferences recorded revealed that it was essential for Resident #276 to go outside to get fresh air when the weather was good and participate in religious services or practices. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of activity logs for Resident #276 for March 29- May 9, 2025, was completed. The review showed four family/friend visits, one movie, two coffee/news, two staff visits, and one resident refusal. However, the review failed to show that Resident #276 was involved in activities programs 3-5 times weekly, which included going outside to get fresh air when the weather was good, and participating in religious services or practices previously documented as his/her activity preferences during the admission activity assessment. In an interview on 5/9/25 at 10:10 AM, staff #30 stated understanding of concerns and said the concerns would be corrected.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on interviews, observations, and record review, it was determined that the facility failed to assist a resident in gaining access to hearing services to maintain hearing abilities. This was evident for one resident (#18) investigated during the recertification survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool that nursing home staff use to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. On 5/8/25 at 10:45 AM in an interview, Resident #18 stated, I'm legally blind and hard of hearing- I use a hearing aid in my right ear, but it doesn't work. Resident #18 confirmed that the staff knew about the broken hearing aid and did not address her/his needs. On 5/8/25 at 11:00 AM the surveyor observed Resident #18's hearing aid in the top bedside cabinet drawer. Resident #18 retrieved, inserted the hearing aid and stated, it needs a new battery or something. On 5/9/25 at 10:25 AM Resident #18 was observed in the hallway without hearing aid. On 5/9/25 at 10:30 AM a review of a nursing progress note dated 5/1/25 revealed that Resident #18 had hearing aids. On 5/9/25 at 11:29 AM a record review of Resident #18's MDS assessment revealed that s/he had a high hearing impairment. On 5/9/25 at 12:59 PM in an interview, Registered Nurse (RN #25) acknowledged that Resident #18 had a hearing aid that did not work and stated, the hearing aid provider is supposed to follow-up. She denied receiving training/education on how to use the hearing aid. On 5/9/25 at 1:05 PM in an interview, Geriatric Nurse Assistant (GNA #26) reported that she would help Resident #18 get the hearing aid fixed by telling the unit manager. On 5/12/25 at 10:02 AM Resident #18 was observed in wheelchair, waiting in the main entrance lobby without hearing aid. Resident #18 inquired, Will you look into that for me? On 5/12/25 at 10:30 AM in an interview, Licensed Practical Nurse (LP #37) reported that she did not tell the unit manager about the resident's broken hearing aid. On 5/12/25 at 11:12 AM in an interview, the unit manager, LP #5, reported that she was not made aware that Resident #18's hearing aid was broken. On 5/13/25 at 10:30 AM in an interview, the Director of Nursing (DON) acknowledged concerns that the facility failed to assist Resident #18 in gaining access to hearing services to maintain hearing abilities

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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. Based on medical record review, interview, and observation, it was determined that the facility failed to ensure wound care orders were entered correctly into the electronic health record and failed to ensure an air mattress was kept at the correct setting. This was evident for one (#7) out of three Residents reviewed for pressure ulcers. The findings include: Review of Resident #7's medical record on 5/12/25 revealed that the Resident had resided at the facility for several years, had significant cognitive impairment, and limited physical mobility. The Resident had a history of pressure ulcers, which included a stage 4 ulcer on the left hip that was first identified several years ago. A stage 4 pressure ulcer involves full thickness skin and tissue loss with exposed or palpable muscle or bone in the ulcer. Review of the medical record revealed documentation that the wound specialist assessed the Resident once per week, documenting wound status and treatment recommendations. Review of the 3/17/25 wound NP (Staff #36) Wound Assessment Report revealed documentation of the Stage 4 left hip ulcer. The treatment orders included to cleanse with 0.25% Dakins solution, use medial grade honey and collagen particles, and use betadine on the peri wound (area surrounding the wound) area. The dressing change frequency was every other day and PRN (as needed). Review of the Treatment Administration Record (TAR) for March 2025 revealed a corresponding order for every other day dressing changes from 3/13/25 until it was discontinued on 3/24/25. Review of the 3/24/25 wound NP (Staff #36) Wound Assessment Report revealed documentation of the Stage 4 left hip ulcer. The treatment orders included cleaning with betadine, using Mupirocin ointment and calcium alginate, and skin prep for the periwound. The dressing change frequency was daily and as needed. Review of the TAR for March revealed there was an order in effect from 3/24/25 until it was discontinued on 3/26/25 to Cleanse betadine, pat dry and apply Mupirocin cream to the wound bed, apply calcium alginate, cover with border gauze every day and PRN every day shift every other day for wound care. This order failed to include the site of the wound. Review of the March and April 2025 TARs revealed the following order in effect from 3/26/25 until it was discontinued on 4/14/25: Cleanse left hip betadine, pat dry, and apply Mupirocin cream to the wound bed, apply calcium alginate, cover with border gauze every day and PRN (Apply skin prep to the peri wound) every day shift every other day for wound care. No documentation indicated that the dressing change to the left hip was completed on March 28 or 30, 2025. Review of the 3/31/25 wound NP (Staff #36) Wound Assessment Report revealed documentation of the Stage 4 left hip ulcer. The treatment orders remained the same as the note for 3/24/25, including the recommendation for daily and as needed dressing changes. No documentation indicated the dressing change to the left hip was completed on April 1, 3, 5, 7, 9, 11, or 13, 2025. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/25 at 8:00 AM, the Director of Nursing (DON) was interviewed regarding the process when the wound specialist came to the facility. She reported that a facility nurse rounded with the wound Nurse Practitioner (NP). The NP did the wound care herself, took the measurements, and completed real-time charting. The NP gives orders to the nurse, who puts the orders into the electronic health record. She also reported that the orders had to go through the attending provider and that 10 times out of 10, the attending provider agreed with the wound NP orders. On 5/13/25 at 9:43 AM, the surveyor observed nurse #34 complete the Resident's pressure ulcer dressing changes for four wounds. The nurse completed the dressing change for three wounds on the Resident's lower backside area, then turned the Resident and completed the dressing change to the Resident's left hip. On 5/13/25 at 12:57 PM, an interview with the unit nurse manager (Staff #23) reported that if the nurse who usually rounded with the wound NP were unavailable, she would go with her on the rounds. Nurse #23 confirmed that the wound NP's recommendations were reviewed by the attending provider prior to being entered into the electronic medical record. Nurse #23 reported that the wound NP sends a wound sheet by the end of the day that she will print off and do another check and that sometimes the wound NP tells her something and then orders something else. Nurse #23 confirmed there would be a paper train if there were a change between what the wound NP said and what she put into writing. On 5/13/25 at 1:09 PM, a review of the 3/24/35 Wound Report with Nurse #23 revealed that the dressing change frequency for the hip wound should have been daily and prn. The surveyor then reviewed the concern that the order had been every other day and that the report indicated it should have been changed to every day. Reviewing the MAR, the order reads every day and every other day, and the area to document was every other day. Nurse #23 stated: I think it was put in wrong, I have caught that before, wrote every day but hit every other day. 5/13/25 at 2:35 PM Reviewed with the DON the concern regarding the wound orders that were put in as every other day when the wound specialist indicated the order was to be every day. The DON reported she had been made aware and indicated she needed to find out who was on wound rounds that day. Further review of the medical record revealed a care plan addressing the reoccurring pressure ulcers. This care plan was initiated several years ago. One of the interventions, with a revision date of 4/4/23, included: Bariatric low air loss mattress with perimeter on bed at all times; Check every shift for placement and function. Review of the March and April 2025 Treatment Administration Records (TAR) revealed that a corresponding order was in place from 11/18/24 until discontinued on 4/27/25. Nursing staff were documenting every shift that the mattress was checked for placement and function until 4/23/25. Further review of the physician order and the TAR on 5/12/25 failed to reveal a current order regarding the bariatric mattress or documentation to support that nursing staff were checking for placement or function every shift as indicated in the care plan. On 5/13/25 at 10:04 AM, the surveyor observed that the air mattress on the Resident's bed was set at 350 lbs. The nurse (Staff #34) confirmed that the mattress was set at 350. When asked if this setting was correct, Nurse #34 responded: [name of Central Supply Staff #35] sets up the mattresses. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the air mattress control panel and user manual revealed an area for weight setting. The weight settings were at the following increments: 90 lbs, 150 lbs, 220 lbs, 290 lbs, 350 lbs, 420 lbs, 490 lbs, 550 lbs, 620 lbs and 660 lbs. Review of the Resident's weights from April 2024 through May 2025 revealed a range of 153 - 171 lbs. On 5/13/25 at 10:16 AM, the Central Supply Staff #35, who reported she is also a Geriatric Nursing Assistant (GNA), was interviewed in regard to the air mattresses. When asked about the settings, Staff #35 reported that: have to figure out what the person weighs, she also reported that the bariatric pumps are a little different but confirmed that they are also based on weight. Surveyor then informed Staff #35 that Resident #7's mattress was currently set at 350 lbs. Staff #35 responded: [s/he] doesn't weigh that. On 5/13/25 at 10:22 AM, observation of the air mattress control panel was done with Staff #35, who determined the lock button was on and needed to be pressed before the weight setting could be changed. Staff #35 spoke with the nurse and proceeded to adjust the level from 350 lbs to 220 lbs. On 5/13/25 at 11:38 AM, the Director of Nursing (DON) was interviewed in regard to the air mattresses. The DON reported that the physician gives an order, they are included in the care plan, central supply is contacted, and [name of Staff #35] sets it, and they shouldn't be changed unless there is a need for it. DON confirmed Resident #7's bariatric air mattress and that the weight setting would be 220 lbs. Surveyor then reviewed the concern that no current order was found for the air mattress and no documentation to indicate it was being checked each shift as indicated in the care plan. The DON reported that it should be signed off by the nurses and indicated she would look for the orders. At 12:25 PM, the DON reported she thought there was an order, but it was not re-ordered when the Resident was re-admitted . On 5/14/25, further review of the medical record revealed a new order regarding the bariatric mattress. On 5/14/25 at 8:54 AM surveyor requested from the DON the current order for the air mattress and the order from 2024 that was discontinued in April 2025. DON reported that must have been when [the Resident] went out to the hospital. Review of the 5/13/25 order provided by the DON revealed: Resident has a bariatric air mattress. Check placement every shift. This order did not include checking for function as previously ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview it was determined that the facility failed to ensure toxic chemicals were stored safely and appropriately. This was evident when toilet bowl cleaner was found in 1 ([NAME] Hall Pantry) of 4 nourishment pantries inspected during the recertification survey. The findings include: On 5/9/25 at 3:30 PM, an observation of the nourishment room refrigerators in the [NAME] Hall Pantry was conducted. The nourishment room was secured by keypad entry. A bottle of toilet bowl cleaner containing bleach was stored underneath the sink. Licensed Practical Nurse (Staff #3) and the unit manager for [NAME] Hall (Staff #5) were present during the observation and were immediately interviewed. Both staff members acknowledged that the chemical should not have been stored in that location. Staff #3 removed the bottle from the room and gave it to Staff #5. At approximately 4:00 PM on 5/9/25, the facility Administrator and the Director of Nursing were notified about the observed storage of a hazardous chemical in the nourishment area. Both said they were aware of the concern and affirmed the deficiency.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and staff interview, it was determined that the facility failed to manage a resident's pain effectively. This was evident for 1 out of 3 complaints reviewed during the recertification survey. The findings include: A review of complaint # MD00214514 contained an allegation that Resident #74 did not receive adequate pain management when needed. A review of Resident #74's medical record showed that the Resident was admitted to the facility with diagnoses including post-right hip surgery for a fracture. A continued review contained an attending provider's order that was initiated on 11/20/24 for Resident #74 for the use of NPIs (Non-pharmacological Interventions - treatments without the use of medications, for example, repositioning, hot/ice pack, massage, music) before giving a PRN (as needed) pain medication and the specific interventions used to be documented in the Resident's record. Further review showed an attending provider's order dated 11/20/24 for Resident #74 to receive an opioid medication, one tablet every 4 hours as needed for pain levels 4-10 (A pain scale/level ranges from 0 to 10; 0 means no pain, and 10 means the worst pain. It is used to assess a patient's level of pain so that better treatment can be provided). The review also included Resident #74's medication administration records (MAR) from November 20 to February 4, 2025. The MAR showed that Resident #74 received the pain medicine on: 11/22/24 for a pain level of seven, 12/2/24 for a pain level of five, 12/3/24 for a pain level of six, 12/10/24 for a pain level of eight, 12/12/24 for a pain level of nine, 12/13/24 for a pain level of eight, 12/26/24 for a pain level of five, 1/2/25 for a pain level of seven, 1/3/25 for a pain level of five, 1/24/25 for a pain level of five, 2/2/25 for a pain level of four, and 2/3/25 for a pain level of seven. However, the review failed to show a record of Resident #74's pain assessment before administering the medicine, including the specific locations, type of pain, and non-pharmacological interventions implemented before administering the pain medicine. The review also noted that after administering the pain medicine, Resident #74 continued to have pain at a level of three on 11/24/24, two on 11/27/24, three on 11/28/24, three on 12/5/24, four on 12/6/24, three on 12/15/24, two on 12/24, three on 12/26/25, and two on 1/3/25. However, the review failed to show what the staff did to manage Resident #74's pain at those levels after receiving pain medicine. In an interview on 5/13/25 at 2:13 PM, the director of nursing (DON) said her expectation of the staff was to try NPI before giving Resident #74 the pain medicine. The DON continued to state that she expected the Resident's continued pain to be managed by the staff.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review and interviews, it was determined that the facility failed to ensure that a resident with a history of trauma received the appropriate trauma-informed care. This was evident for 1 (#74) of 32 residents reviewed during the recertification survey. The findings include: A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff utilize care plans to provide resident-centered care that includes support, services, and resources to address a resident's needs. A record review contained a care plan initiated on 11/22/24 for Resident #74, which had recorded that Resident #74 had a history of past trauma related to surviving a house fire and the loss of [family] . The care plan recorded one intervention, which stated eval [evaluate] for psych consult. However, the care plan failed to address what Resident #74's triggers were for the traumatic event and how to mitigate or eliminate them to ensure the Resident was not traumatized again. During an interview on 5/13/25 at 2:42 PM, the director of nursing reported that she expected to see more interventions that staff would implement to avoid re-traumatization on Resident #74's care plan for trauma. In an interview on 5/13/25 at 3:12 PM, the social services director, staff #12, stated that if a resident had a history of trauma, then their care plan should have included specific triggers and interventions that staff would implement to lessen the Resident's chance of being traumatized again.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on pertinent document review and interview, it was determined that the facility failed to ensure that Geriatric Nursing Assistants (GNAs) received annual performance reviews. This was evident for 2 GNAs (GNA #14 and GNA #6) of 3 GNAs reviewed during the Sufficient and Competent staffing task portion of the recertification survey. The findings include: On 5/12/25 at 1:31 PM, the 2024 annual performance evaluations were requested for GNA # 13, GNA#14, and GNA #6. On 5/12/25 at 2:24 PM, the facility provided a performance evaluation for GNA Staff #13 but failed to give performance evaluations for GNA Staff #14 and GNA Staff #6. On 5/12/25 at 3:59 PM, during a brief interview with the Administrator, he confirmed that there was a lack of evidence that GNA#6 and GNA# 14 received an employee evaluation for 2024. On 5/14/25 at 8:25 AM, the above concerns were shared with the Director of Nursing. No additional information was provided before the end of the survey.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and record review, it was determined that the facility failed to establish systems to accurately reconcile controlled medications using acceptable standards of practice. During observation of the facility's narcotic books, it was observed that 1 of 4 narcotic reconciliations was inaccurately documented during the recertification survey. The findings include: Standard practice for narcotic reconciliation count is conducted at the end-of-shift with two licensed personnel, the on-coming licensed personnel, and the outgoing licensed personnel, to count all controlled medications, verifying the count accuracy and documenting their initials in the narcotic book. Reconciliation refers to a system of recordkeeping that ensures an accurate inventory of medications by accounting for controlled medications. The reconciliation process identifies the loss or potential diversion of controlled drugs to minimize the time between the actual loss or potential diversion and the time of detection and follow-up to determine the extent of the loss. On 5/9/25 at 9:35 AM, a record review of the [NAME] unit's narcotic book signature page on May 9, 2025, provided by Registered Nurse (RN #25) revealed RN #25 initials were accurately signed for the on-coming 7 AM shift and inaccurately signed for the off-going 11 PM shift. In an interview, RN #25 stated, That's how I was trained in orientation. She seemed confused about the importance of accurately documenting a narcotic shift count. On 5/9/25 at 9:50 AM, the [NAME] Unit Manager, Licensed Practical Nurse (LP #5), reviewed and confirmed early and inaccurate documentation of RN #25's initials on the narcotic sheet dated 5/9/25. A record review of the facility's policy for Controlled Substances Administration and Accountability stated, in part, Two licensed nurses account for all controlled substances and access keys at the end of each shift. On 5/12/25 at 2:26 PM, the Director of Nursing acknowledged that the facility's narcotic reconciliation practice failed to employ acceptable standards of practice.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on records review and interviews, it was determined that the facility failed to 1a) ensure pharmacy recommendations were reported to the facility in a timely manner, 1b) specify all necessary timeframes for the steps in the Medication Regimen Review (MRR) policy and 2) ensure that an attending provider documented in residents medical record that pharmacist's recommendations were reviewed and stated what if any, actions were taken to address them. This was evident for 2 (#35, #18) of 5 residents reviewed for unnecessary medications. The findings include: 1a) Resident #35 had resided in the facility since late 2020. A review of Resident #35's medical records was conducted on 5/9/24 at 12:33 PM. The review revealed that monthly medication regimen reviews (MRR) were conducted. However, the attending physician signed the MRR report with a service date of 3/5/25 on 4/3/25, and the MRR report with a service date of 4/2/25 was not found in the resident's medical record. On 5/9/25 at 1:28 PM, the Director of Nursing (DON) was interviewed regarding the facility's process with MRR. The DON reported that the pharmacist conducts MRRs monthly and sends the report in an encrypted format that only she and another Registered Nurse (RN #9) had access to. She indicated that she keeps hard copies of the MRR report in a binder. A review of the MRR reports for Resident #35 was conducted with the DON. The review revealed that the pharmacist had the same recommendation for the review conducted on 3/5/25 and 4/2/25. The DON reported that the MRR report on 3/5/25 was sent late and was signed by the attending physician a day after the 4/2/25 MRR report. 1b) A review of the facility's MRR policy was conducted on 5/12/25 at 7:41 AM. The policy was dated as reviewed/revised on 2/15/24. The review revealed the timelines and responsibilities for medication regimen review, which indicated that the pharmacist was to send written reports within 10 working days of the review. Further review of the MMR policy failed to specify a timeframe for the attending physician to respond to urgent needs. On 5/12/25 at 7:56 AM, the DON confirmed that the March 2025 MRR report was not sent to the facility until the next month's MRR was being conducted, prompting the pharmacist to have the same recommendation for the same identified irregularity. The concern was discussed with the DON that a) the MRR report was not sent in a timely manner and b) the MRR policy did not specify a timeframe for the attending physician to respond to urgent needs. The DON verbalized understanding and acknowledged the concern. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 5/9/25 at 2:59 PM, the Director of Nursing (DON) explained the MRR process as follows: Geri-scripts (a pharmacy provider) conducted MRR at least once a month for all facility residents. Their recommendations were sent to the facility via On Guard (a software that transmits pharmacy reports). Geri-scripts emailed the DON, notifying her that the recommendations were completed. The DON printed the recommendations and provided a hard copy to the in-house Nurse Practitioner (NP.) She accepted/rejected the recommendations and returned the signed recommendations to the DON. The DON sent the signed recommendations to each unit manager who entered the information into Point Click Care (PCC), an electronic health record. The front desk staff scanned the hard copy into the medical record. On 5/12/25 at 7:56 AM, a record review of three random pharmacy recommendations for Resident #18 revealed pharmacy recommendations dated 10/9/24, 2/18/25, and 5/8/25. The review lacked documentation of the actions taken or not taken by the attending provider to address the pharmacist's recommendations. On 5/12/25 at 8:06 AM, the DON acknowledged concerns as evidenced by the lack of required documentation.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on records review and interviews, it was determined that the facility failed to ensure residents were free from unnecessary medications. This was evident in 1 (Resident #35) of 5 residents reviewed for unnecessary medications. The findings include: Resident #35 was admitted into the facility in late 2020 with diagnoses that include hypertension. Hypertension, or high blood pressure, is a condition where the force of blood pushing against the artery walls is consistently too high. It's often called a silent killer because it frequently has no noticeable symptoms but can lead to serious complications like heart attack and stroke if left unmanaged. Blood pressure is expressed as two numbers: systolic (top number) and diastolic (bottom number). Blood pressure medications, also known as antihypertensives, are a cornerstone treatment for hypertension and can significantly reduce the risk of serious complications. One of the most common side effects of blood pressure medication is dizziness or lightheadedness. This can occur due to a drop in blood pressure, especially when standing up quickly (orthostatic hypotension). A review of Resident #35's medical orders on 5/9/25 at 7:36 AM, revealed a blood pressure medication to be taken every morning and at bedtime with specific instruction to hold if the systolic blood pressure was less than 120. On 5/9/25 at 8:47 AM, a review of Resident #35's electronic Medication Administration Record (eMAR) for April 2025 was conducted. The review revealed that the blood pressure medication was given even when the systolic blood pressure was less than 120 on 4/11-9am, 4/12-9pm, 4/16-9am, 4/20-9am, 4/27-9am, and 4/30-9am. The Director of Nursing (DON) was interviewed on 5/12/25 at 10:09 AM. During the interview, Resident #35's eMAR was reviewed and the DON confirmed that the blood pressure medication was given outside the parameter on the identified dates and times.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, it was determined that the facility failed to 1) maintain medical products within expiration dates and in a secure location and 2) have a system to secure access to controlled medications. This was evident during the recertification survey. The findings include: 1a) On [DATE] at 1:11 PM, an observation was made with the Assistant Director of Nursing (ADON) (Staff # 3) of the emergency cart located in the first-floor dining room. Further observation of the first drawer of the emergency cart revealed approximately 10 packs of jelly lubrication. A closer examination of the lubrication Jelly packets revealed an expiration date of 2/2025. On [DATE] at 11:17 PM, during a brief interview with ADON Staff#3, she reported that the lubrication jelly was used to facilitate airway procedures. The ADON confirmed that the packets with lubrication jelly had expired and removed them. She reported that she would replace the packets with lubrication jelly within the expiration date. 1b) On [DATE] at 5:30 AM, the Observation of Longmeadow (back hall) revealed a medication cart next to the nursing station. Further observation revealed a glucometer on the cart with a glucometer strip, an alcohol pad, and four diabetic lancets. Continued observation of the medication cart failed to reveal a nurse in view of the cart. A diabetic lancet device is a small, spring-loaded device used to puncture the skin, typically on a finger, to obtain a small blood sample for testing blood glucose levels. People with diabetes commonly use it to monitor their blood sugar. On [DATE] at 5:37, the surveyor observed Nurse (Staff #15) walking up to the med cart. Staff #15 reported that the lancets should not be left unattended. On [DATE] at 7:38 AM, the concern that lancets were left unattended on the med cart was discussed with the Director of Nursing (DON). The DON confirmed that the lancets should not be left unattended in the resident hallway. 2) During observation of the facility's medication storage refrigerators, it was observed that 4 out of 4 medication refrigerators were found to have unaffixed storage compartments for controlled medications. Controlled Medications are substances that have an accepted medical use, have the potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications fall under US Drug Enforcement Agency (DEA) Schedules II-V. On [DATE] at 7:40 AM, the [NAME] unit manager, a Licensed Practical Nurse (LP #5), unlocked and opened the unit's medication refrigerator. Surveyor and LP #5 observed that the narcotic box was not affixed to the fridge internally. She acknowledged that it needed to be attached and secured. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 7:51 AM, LP #5 unlocked and opened the medication refrigerator on the Long Meadow unit. It was observed that the narcotic box was attached to the internal wire shelf. However, LP #5 was able to remove the wire shelf with the attached narcotic box. S/he stated, I will get maintenance on it. On [DATE] at 8:02 AM, LP #5 unlocked and opened the medication refrigerator on the Paramount unit. It was observed that the narcotic lock box was missing. S/he stated, I don't understand why there's not a narcotic box here. On [DATE] at 8:07 AM, LP #5 unlocked and opened the medication refrigerator in the ventilator unit, [NAME]. It was observed that the narcotic lock box was missing. LP #23, [NAME]'s unit manager, acknowledged that the lock had been broken for at least a week and that maintenance was aware of it. On [DATE] at 8:20 AM in an interview, the surveyor and LP #5 informed the Director of Nursing (DON) and the Nursing Home Administrator (NH) that the medication refrigerators on all four of the facility's units failed to have a system to secure access to controlled medications. The DON and NH acknowledged the concern. In an interview on [DATE] at 8:27 AM, the Director of Maintenance (Staff #24) stated, I don't recall receiving a repair ticket from the [NAME] unit. On [DATE] at 8:51 AM, the surveyor observed Staff #24 remove the wire shelf with the attached narcotic box from the Long Meadow medication refrigerator. On [DATE] at 10:00 AM, a review of the facility's Controlled Substance Administration and Accountability Policy revealed, in part, areas without automated dispensing system utilize a substantially-contructed storage unit with two locks.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record reviews and interviews, it was determined that the facility failed to provide routine dental services to a resident. This was evident in 1 (Resident #19) of 1 resident reviewed for dental care. The findings include: Resident #19 had been a resident of the facility since late 2019. The resident's medical record indicated that the resident was cognitively intact. An interview with Resident #19 was conducted on 5/8/25 at 9:18 AM. During the interview, the resident stated, I've never seen a dentist here. On 5/12/25 at 1:34 PM, Resident #19's medical records were reviewed. The review revealed a care plan that indicated the resident had broken teeth and likely cavities. This care plan was initiated on 1/7/21. However, there was no documentation to indicate that the residents had dental services to address these concerns. On 5/12/25 at 2:42 PM, the Director of Nursing (DON) was interviewed regarding dental services. The DON reported that Healthdrive was a program that the facility uses to enroll residents for hearing, vision, and dental services. The DON was asked if Resident #19 has had dental services and she indicated that the resident had refused dental services. The DON reported that she would review the resident's medical record for documentation regarding dental services. On 5/13/25 at 7:30 AM, the Business Office Manager (Staff #32), provided documentation that indicated the facility deducts $120 monthly from Resident #19's personal funds account, as premium for dental services. On a subsequent interview with the DON on 5/13/25 at 7:38 AM, she reported and verified that Resident #19 was enrolled in the dental program with Healthdrive. Again, she indicated that the resident had been refusing dental services. The DON was asked if there was documentation to indicate the refusal and she stated, That's what I'm looking for. Resident #19 was again interviewed on 5/13/25 at 10:55 AM if s/he had ever declined dental services offered/arranged by the facility, the resident stated, No. On 5/13/25 at 11:22 AM, the DON reported that there was no documentation to indicate that Resident #19 had refused dental services.

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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 observation and interviews, it was determined that the facility staff failed to wear beard restraint in the kitchen. This was evident in 2 of 4 observations of meal preparation in the kitchen during the recertification survey. The findings include: On 5/8/25 at 7:05 AM, an observation of the facility's kitchen was conducted. During the observation, the Dietary Aide (Staff #16) was observed as he made pancakes. He had a long beard and did not wear a beard restraint. After he made pancakes, Staff #16 proceeded to prepare resident meal trays without a beard restraint in place at 7:16 AM. On 5/8/25 at 12:37 PM, the facility's kitchen manager (Staff #18) was informed of the deficiency related to Staff #16 without beard restraint. He made no acknowledgment of the deficiency. On 5/9/25 at 2:57 PM, an interview was conducted with the Nursing Home Administrator (NH) to review the finding that Staff #16 did not wear a beard restraint during meal preparation on 05/08/25. He acknowledged the finding. On 5/12/25 at 11:34 AM, another observation was conducted of the kitchen area during lunch meal preparation. The corporate Certified Dietary Manager (CDM), Staff #17, and the facility's kitchen manager (Staff #18) were observed in the kitchen without beard restraints, and both had facial hair. Staff #17 and #18 acknowledged not wearing beard restraints, and #17 stated, You tell me if we need a beard restraint. On 5/13/25 at 2:47 PM the NH was made aware of the second observation of no beard restraint use in the kitchen by the supervisors.

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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** Based on medical record review and interviews, it was determined that the facility failed to ensure the orders for life sustaining treatment in the electronic health record matched the orders found on the Maryland Orders for Life sustaining Treatment (MOLST) form and failed to ensure the accuracy of physician orders. This was evident for one (#56) out of four residents reviewed for advance directives and one (Resident #71) of 3 system selected closed record reviews during the recertification survey. The findings include: 1) On [DATE], a review of Resident #56's medical record revealed a MOLST, dated [DATE], that included order for No CPR (cardiopulmonary resuscitation) Option A-1, Intubate: Comprehensive efforts may include intubation and artificial ventilation. This MOLST was found uploaded in the Miscellaneous Section of the electronic health record (EHR). Review of the physician orders section of the electronic health record revealed an order, dated [DATE], for DNR (Do Not Resuscitate, i.e. No CPR), DNI (Do Not Intubate). This order co-insides with Option A-2 on the MOLST form. On [DATE] at 12:15 PM the nurse (Staff #25) reported, if a resident had no pulse or respirations she would check the resident's MOLST form to determine code status. She stated the MOLST forms are found on the crash cart (cart that contains supplies needed when performing CPR). The nurse proceeded to go to the crash cart and check the resident's MOLST, confirmed the resident's DNR (No CPR) status and confirmed, yes to intubate. The nurse went on to state that if her resident was just having a change in condition she would check the code status found in the orders section of the electronic health record. When surveyor reviewed the concern with Nurse #25 that the orders found in the EHR are for DNI, the nurse asked about the date. The surveyor clarified the order was put in the EHR in April, the nurse acknowledged the MOLST was dated May and stated: they may need to update that (regarding the order in the EHR). On [DATE] at approximately 1:30 PM further review of the medical record revealed the [DATE] order for DNR/DNI was discontinued; and a new order was put in place on [DATE]. On [DATE] at 11:54 AM the DON reported that when a MOLST is changed the social worker gets the MOLST, the new MOLST is scanned in, the old one is printed and voided and kept in a book and the nurse is informed to put a new order into the electronic health record. DON indicated she was aware of the surveyor's finding from the day before and reported they had a Quality Assurance meeting about it. 2) A review of Resident #71's medical record revealed a Maryland Order for Life Sustaining Treatment (MOLST) form dated [DATE] indicated the resident should have No Cardiopulmonary Resuscitation (CPR), no intubation and no transfer to the hospital. Further review revealed a physician's order dated [DATE] that indicated Do Not Resuscitate (DNR), do not intubate, and transfer to hospital for unmanaged symptoms. This review was conducted on [DATE] at 10:21 AM. (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 10:52 AM an interview was conducted with the Director of Nursing and the Nursing Home Administrator to inform them of mismatch between Resident #71's MOLST form and the physician's resuscitation orders. They acknowledged the findings. No further evidence was provided by the end of the survey.

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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** Based on observations, record review and staff interviews, it was determined that the facility failed to ensure staff use appropriate infection control practices. This was evident for 3 (#18, #51, #425) out of 32 residents reviewed during the recertification survey. The findings include: Personal Protective Equipment (PPE) refers to protective items such as masks, gowns, gloves, eye protectors, shoe covers, etc. worn to protect the body or clothing from hazards and to protect residents from cross-transmission. Enhanced Barrier Precaution (EBP) refers to an infection control practice designed to reduce the transmission of multidrug-resistant organisms (MDRO) that include donning a gown and gloves during high-contact care activities. There are certain criteria to place residents on EBP; when a resident has an infection or colonization with a MDRO or when a resident has a wound and/or when a resident has an indwelling medical device. 1) On 5/8/25 at 8:13 AM, it was observed that Residents #18 was on EBP and there was PPE stored in a clear plastic bin outside of the room. On 5/8/25 at 1:30 PM, a record review revealed that Resident #18 had Benign Prostatic Hyperplasia with urinary symptoms that required the use of an indwelling Foley catheter. A Foley catheter transports urine from the bladder to outside of the body which is collected into a catheter bag. On 5/9/25 at 3:28 PM, Certified Nurse Assistant (CAN #37) was observed transferring Resident #18 back to the bed. Transferring is considered high contact care. CAN #37 did not don gown or gloves before assisting the resident back to bed. On 5/9/25 at 3:38 PM, Licensed Practical Nurse (LP #28) was observed entering Resident #18's room without pumping-in, that is to apply alcohol-based hand rub (ABHR) designed for application to the hands to reduce the number of viable microorganisms. LP #28 stepped over the catheter bag that was on the floor and hugged and repositioned Resident #18 without donning gown or gloves. On 5/9/25 at 3:41 PM in an interview, LP #28 acknowledged that she had violated infection control practices. On 5/9/25 at 4:22 PM in an interview, the [NAME] unit manager, LP #5, acknowledged that staff had failed to use EBP in the delivery of resident care. 2) On 5/12/25 at 10:00 AM, a record review revealed that Resident #51 had a nephrostomy (an artificial opening between the kidney and the skin to allow urine to flow out of the body through a tube) and required EBP during high contact care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 10:35 AM in an interview, LP #37 reported that Resident #51 required a dressing change to the nephrostomy site. On 5/12/25 at 11:05 AM, LP #37 entered Resident #51's room without hand hygiene. She donned gloves and began to remove Resident #51's absorbent dressing. The surveyor intervened and handed a gown to LP #37. LP #37 then washed hands, donned gown and clean gloves and completed the dressing change. On 5/12/25 at 11:10 AM, LP #37 wore the dirty gown and gloves, and carried the dirty dressing into the hallway and disposed them into a receptacle. On 5/12/25 at 11:11 AM, in an interview, LP #37 acknowledged that she did not use EBP nor proper hand hygiene. On 5/12/25 at 11:15 AM the unit manager, LP # 5, acknowledged the break in infection control practice. On 5/14/25 at 9:30 AM, the Director of Nursing was made aware that staff had failed to use EBP in the delivery of resident care. 3) Resident #425 is a Type 2 Diabetic and is being treated for Methicillin-Resistant Staphylococcus Aureus (MRSA). MRSA is a contagious bacterial infection caused by a type of staphylococcus bacteria that has become resistant to certain antibiotics. MRSA can cause various infections, including skin infections, pneumonia, and bloodstream infections. On 5/9/25 at 10:00 AM, the surveyor observed Nurse #22 during medication administration as he prepared to provide Resident #425 with an injectable medication. The nurse obtained the injectable pen from the medication cart, put on gloves, and administered the medication. He then removed his gloves. However, he failed to perform hand hygiene both before putting on the gloves and after removing them. The surveyor asked Nurse #22 about the standard practice for hand hygiene. In response, the nurse quickly used hand sanitizer and stated that he hadn't had time to do it yet. When the surveyor asked if he realized he had not sanitized his hands prior to preparing the resident's medication, the nurse admitted he must have missed it and confirmed that he had not performed hand hygiene between patients or after removing his gloves. When asked if he had received education about the moments for hand hygiene, the nurse confirmed that he had received such an education in the past. On 5/13/25 at 2:48 PM, the surveyor reviewed the facility's policy and procedure titled Hand Hygiene (revision date: 3/14/23). The policy states that all staff must perform hand hygiene to prevent the spread of infection to other personnel, residents, and visitors. This requirement applies to all staff working in all areas of the facility. The policy includes a hand hygiene table, which specifies that hand hygiene should be performed before and after using gloves, between resident contacts, and prior to preparing or handling medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 8:53 AM, the surveyor spoke with the Director of Nursing and informed her that Nurse #22 had failed to perform hand hygiene during medication administration for Resident #425. The Director confirmed that the expectation is for all staff to follow the facility's Hand Hygiene policy, which states that hand hygiene must be performed prior to handling medications, between residents, and before and after using gloves.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on pertinent document review and interviews, it was determined that the facility failed to offer the current COVID-19 vaccination or document the refusal for the current COVID vaccine for their staff. This was evident for 5 out of 6 staff reviewed for Infection Control during a survey. The findings include: On 5/8/25 at 10:20 AM, the Administrator provided the employee files for 6 staff requested by the surveyor that were randomly chosen. On 5/8/25 at 2:20 PM, the Review of the employee files failed to reveal documentation that the most recent COVID vaccine was offered to the following staff: GNA (Staff #6), GNA (Staff #7), Housekeeping (Staff #8), Nurse LP (Staff # 10), and GNA (Staff # 11). Further review failed to reveal documentation that the aforementioned staff accepted or refused the COVID vaccine. On 5/12/25 at 10:10 AM the regional Nurse Consultant (Staff #2), confirmed that the facility did not have documentation that the above staff were offered the COVID vaccine. On 5/14/25 at 8:25 AM the Director of Nursing confirmed that the facility was able to obtain declinations (documentation that the staff refused the vaccine) GNA (Staff #6), GNA (Staff #7), Housekeeping (Staff #8), Nurse LP (Staff # 10), dated after intervention. The DON reported that Staff #11 no longer worked at the facility, and she was unable to provide a declination for staff # 11.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on record review, observations and facility interviews, it was determined that the facility failed to maintain safe operating condition of facility exits equipped with the WanderGuard System, potentially affecting six residents identified as elopement risk. This was evident for 1 of 2 exits alarmed with the WanderGuard System investigated during the recertification survey. The findings include: The WanderGuard System helps protect residents from elopement by ensuring resident safety with customizable door access. WanderGuard uses radio-frequency identification (RFID) technology that accurately detects wander-prone individuals by sounding alarms and automatically locking equipped exits. The facility identified six elopement risk residents (#2, #3,# 6, #18, #35, and #40.) On 5/12/25 at 10:02 AM, Resident #18 was observed in the main entrance lobby alone and unattended in a wheelchair. The top of the receptionist's head was observed as s/he was seated behind the welcome desk which was about 4 ft high from floor to countertop. On 5/13/25 at 8:41 AM, a review of Resident #18's record revealed that s/he was an elopement risk, had an order for WanderGuard and the Care Plan stated: locate WanderGuard on wheelchair as resident cannot ambulate. On 5/13/25 at 11:37 AM, a record review of the Elopements and Wandering Residents policy revealed elopement risk residents will receive adequate supervision and the Resident Alarms policy revealed supervision shall be provided. On 5/13/25 at 12:18 PM in an interview, Certified Nurse Assistant (CAN #33) acknowledged that she did not know how to assess whether the WanderGuard was working, I guess you take the wheelchair to the front door. On 5/13/25 at 2:06 PM two surveyors observed Maintenance Director (Staff #24) and Registered Nurse (RN #2) demonstrate the use of the main lobby WanderGuard system utilizing Resident #18's non-occupied wheelchair. The alarm triggered when the chair approached the main entrance, within 5-7 feet of the door, it was observed that the sliding glass doors did not close or lock down. On 5/14/25 at 10:08 AM Resident #18 was observed unattended in the main entrance lobby in her/his wheelchair. On 5/14/25 at 11:00 AM in an interview, the director of nursing (DON) verified that elopement risk residents should be supervised and that she was not aware that doors could open even when the WanderGuard System was activated. She indicated that the doors should be closed and locked when triggered by the WanderGuard System. On 5/14/25 at 11:24 AM surveyor reviewed with the DON and nursing home administrator (NH), that on 5/13/25 it was observed that the main entrance WanderGuard alarm sounded but the doors remained open, they did not lock down; A resident could have exited the building. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 11:28 AM the NH reported that the maintenance director had called WanderGuard Company this morning about concerns related to the doors not locking when triggered.