STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 18819 Based on observation and staff interview, it was determined that the facility staff failed to treat each resident in a dignified manner by 1) not knocking on the resident's door before entering, 2) standing over a resident while feeding the resident, 3) not changing a resident's wet clothing before proceeding with assisting the resident with his/her meal, 4) serving the breakfast meal on disposable paper when the facility had glass plateware available, and 5) pulling a resident backward down the hallway. This was evident for 6 (Resident #44, #6, #1, #65, #24, #19) of 54 residents reviewed during the annual survey. The findings include: 1) During an observation of Resident #44 on 09/11/22 at 8:30 AM, the surveyor observed Geriatric Nursing Assistant (GNA) #12 failing to knock on the residents door before entering Resident #44's room. 2) During an observation of Resident #6 on 09/11/22 at 8:35 AM, the surveyor observed GNA #12 failing to knock on the resident's door before entering Resident #6's room. 3) During an observation of Resident #1 on 09/21/22 at 1:10 PM, the surveyor observed GNA #57 bring Resident #1 his/her lunch meal tray and set the tray down on the table in front of Resident #1. GNA #57 stepped away to continue to pass out other residents' meal trays and that is when Resident #1 grabbed the cup of iced tea off the lunch meal tray and spilled the cup of iced tea all down the front of his/her clothing. GNA #67 was observed assisting Resident #1 with attempting to dry off Resident #1's clothing with a towel. Moments later, GNA #57 returned to Resident #1 who was seated in his/her Geri chair at the 200 hall dining area which was located at the nurses' station. GNA #57 was observed proceeding to feed Resident #1 while standing next to Resident #1. In an interview with GNA #57 on 09/21/22 at 1:16 PM, GNA #57 stated that Resident #1 was still wet from spilling his/her iced tea on himself/herself and that he/she was going to change Resident #1's wet clothing when he/she takes Resident #1 back to his/her room to put him/her to bed. 4) During an observation of Resident #6 on 09/28/22 at 11:23 AM, the surveyor observed GNA #72 pulling Resident #6 backward from his/her room, while seated in his/her wheelchair, to the 200 hall dining area near the nurses' station. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) During the observation and interview with Resident #65 on 09/11/22 at 8:56 AM, Resident #65 complained to the surveyor about eating on disposable paper plates. Resident #65 stated that this was the first time this had happened since being admitted to the facility. In an interview with the facility assistant kitchen manager (staff #58) on 09/11/22 at 12:25 PM, the facility kitchen manager stated that there was not enough kitchen staff available to prepare the breakfast meal this morning and that is why I decided to serve the residents in the facility on paper and plastic plates. The assistant kitchen manager stated that the lunch meal would be served on regular plate ware for lunch. 43096 6) During an observation of the Wye Oak unit on 9/15/22 at 10:59 AM, two surveyors observed GNA #23 pulling Resident #24's Geri chair backward with one hand in the activity area of the unit. The surveyor interviewed GNA #23 right after the observation. GNA #23 said, since the Geri chair's wheel is not going straight forward, I pushed the chair backward. GNA #23 also stated that she has been using the chair and pushing it backwards and never asked for it to be repaired. This concern was reviewed with the Interim Director of Nursing (DON) on 9/28/22 at 1:15 PM. The Interim DON confirmed that she never received a report regarding the geri chair, and stated that she would provide education to staff. 44484 7) On 9/12/22 at 8:33 AM observation was made of the breakfast cart arriving to the Mill Landing nursing unit. GNA #12 was observed carrying a breakfast tray to Resident #19's room. GNA #12 failed to knock on the resident's door before entering the room. On 9/12/22 at 8:37 AM, upon exit of Resident #19's room, GNA #12 was asked if she realized that she failed to knock on the resident's door prior to entering. GNA #12 stated, I didn't notice. On 9/12/22 at 8:41 AM Resident #19 was asked if the GNA who brought breakfast knocked on the door before entering. Resident #19 stated, No. When asked how often it happened that the staff failed to knock on the door the resident replied sometimes. The Director of Nursing was made aware on 9/27/22 of the concerns prior to survey exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on a complaint, review of medical records, and staff interview, it was determined that facility staff failed to notify a resident's representative and physician when, 1) a resident developed a Stage II pressure wound, 2) a critical lab value was reported by the lab, 3) a resident was observed having a choking episode, 4) a resident had an unplanned weight loss, 5) a resident had a medication change, and 6) a resident was sent to the hospital emergently. This was evident for 7 (Resident #55, #6, #141, #34, #62, #450, #29) of 54 residents reviewed during the annual survey. The findings include: 1) A pressure ulcer, also known as pressure sore, or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full-thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full-thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full-thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). Review of Resident #55's medical record revealed a Nurse Practitioner Wound Consultant note, dated 08/23/22 at 11:15 AM, that indicated Resident #55 was now observed with a Stage II pressure ulcer on the sacrum. The pressure ulcer measured 3.33 cm x 2.68 cm x 8.92 cm. The depth was noted to be 0.10 cm. No odor was noted. The edges were attached. The Nurse Practitioner Wound Consultant indicated the wound was present prior to admission to the facility. Treatment for the pressure wound included: a dressing change to the wound three times a day, a wedge/foam cushion for offloading, and a wheelchair cushion, pressure reduction, and turning precautions were discussed with the staff at the time of the visit, recommended heel protection and pressure reduction to bony prominences, and the staff was educated on all aspects of care. The Nurse Practitioner Wound Consultant requested to keep the wound site covered and avoid contamination with feces at all times. No documentation was found in the medical record that indicated Resident #55's responsible party was notified at this time. In an interview with Resident #55's responsible party on 09/23/22 at 4:44 PM, Resident #55's responsible party stated that he/she has only been contacted by the nursing staff for a couple of falls and nothing regarding a pressure wound. Resident #55's responsible party also stated that there has not been a care plan meeting since admission and that the last phone call he/she received from the nursing staff was yesterday, 09/22/22, for a fall. The staff told me Resident #55 had a fall and was okay. Cross-reference F 686 2) In an interview with the facility-contracted laboratory administrator (staff member #86) on 09/22/22 at 12:58 PM, the laboratory administrator stated that on 09/09/22, Resident #55 was identified with a glucose of 44 mg/dl. The lab administrator stated that a glucose result of 44 mg/dl was a critical lab value. The lab director indicated the lab staff documented an attempt to call Resident #55's nurse 3 times (7:49 PM, 8:04 PM, 8:14 PM) on 09/09/22 without success. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #55's medical record on 09/26/22 failed to reveal lab results being placed in Resident #55's medical record or electronic medical record. A review of Resident #55's medical and electronic record failed to reveal that Resident #55's responsible party or physician were made aware of the critical glucose result of 44 mg/dl on 09/09/22. Cross-reference F 775 3) A review of Resident #6's medical record on 09/14/22 at 10:20 AM, revealed in a nursing progress note dated 09/11/22 at 11:51 PM that a GNA staff member reported to the nurse that Resident #6 was gagging while swallowing and then started spitting the food. The 09/11/22 at 11:51 PM progress note did not indicate what meal this episode occurred on. There was no documentation that Resident #6's physician or the responsible party was made aware of this episode. Further review of Resident #6's medical record revealed a nutritional assessment note dated 06/17/22 at 1:06 PM that indicated Resident #6 was at an increased risk for aspiration due to his/her diagnosis of a history of a stroke with dysphagia. A review of Resident #6's care plans revealed that Resident #6 was at risk for altered nutrition/hydration and weight change related to dysphagia. Goal #2 on the care plan indicated Resident #6 will have no choking episodes through the review date. This goal was initiated on 08/05/20 and revised on 01/13/22. The fourth nursing intervention for Resident #6's care plan was to alert Resident #6's physician and the facility dietician of significant changes. In an interview with the facility speech language pathologist (SLP-staff member #66), on 09/14/22 at 10:35 AM, the SLP stated that he/she had not been notified of Resident #6's choking episode on 09/11/22 and confirmed that Resident #6 was not receiving SLP services at that time. The facility SLP stated that nursing was responsible for notifying therapy services for any type of acute issue. The facility SLP also stated and confirmed Resident #6 was on the least restrictive diet possible, with regular textured foods with mechanical ground meat. The facility SLP was aware that Resident #6 had a history of needing artificial nutrition and hydration and that Resident #6 did have the feeding tube removed. These findings were shared with the facility Administrator and Interim Director of Nurses (DON) at the exit conference on 09/28/22 at 6:00 PM. 15701 4) A review of Resident #141's medical record related to nutritional concerns was conducted on 9/20/22 at 2:15 PM. A nutritional assessment was completed on 9/8/22 by the dialysis dietitian. The dietitian documented a weight of 200 pounds (Lbs.) that was taken on 9/6/22. The nutritional summary revealed, Resident is at nutrition risk related to inadequate oral intake with elevated nutritional needs for wound healing and likely inadequate nutrient intake. A review of the vital signs weight section of the electronic health record revealed a second weight was documented on 9/19/22 at 10:03 PM as 160.8 Lbs. by a nurse (staff #47). The electronic health record automatically documented a weight comparison noting a 19.6 % significant weight loss of 39.2 Lbs. Further review of the medical record did not reveal any type of physician or dietician notification. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Weight Monitoring policy dated 9/28/20 with a Reviewed/Revised date of 2/11/21 revealed Weight Analysis: The newly recorded weight should be compared to the previous recorded weight and it further defined significant weight change percentages. All weights are to be entered into the Point Click Care (PCC), under the weights and vital signs portal. Unit Managers and/or ADON to validate prior to PCC entry, with a further indication of physician, dietician, and resident's responsible party notifications of weight gain/loss trends need to be documented by a licensed nurse in the clinical record. Multiple care area concerns were shared with the Interim DON on 9/22/22 at 4:29 PM including the documentation of a 39 Lbs. weight loss without further documentation or physician notification. On 9/26/22 at 12:51 PM the Interim DON had a follow up discussion with the surveyor, and she involved Staff #47 in the post discussion. Staff #47 indicated that she entered a post dialysis weight and apologized for not recognizing Resident #141's significant weight loss and therefore she did not notify a physician. 31145 5) On 9/21/22 at 9:53 AM a review of Resident #34's medical record revealed the resident weighed 156.6 lbs. (pounds) on 6/21/22 and 145 lbs. on 7/13/22, which was a 7.4% weight loss in 1 month. There was no weight obtained in August 2022. Review of a nutritional assessment dated [DATE] documented, Patient has significant weight loss of 7.4% within 1 month with weight history 6/21/2022 156.6#, 7/13/2022 145# BMI 22 (normal). RD (Registered Dietician) does not believe recent weight is accurate. RD requested reweight but this has not been obtained. Further review of Resident #34's medical record failed to produce documentation that the physician or the responsible party were notified of the weight loss. On 9/21/22 at 11:16 AM an interview was conducted with Physician #77 who stated, I was not notified of the weight loss. I would have expected to be notified. Since July many nurses have quit their positions. Notifying me and making sure vitals are done and orders are carried out is what we rely on. It is not feasible to check weights myself. We rely on staff. It is an issue as I rely on staff. On 9/21/22 at 1:06 PM an interview was conducted with Dietician #25 who stated she had just started at the facility and was in the process of seeing all residents. Dietician #25 stated she saw the resident yesterday and put Resident #34 on weekly weights. On 9/21/22 at 1:43 PM a discussion was conducted with the Medical Director who stated, the physician should have been notified. 6) On 9/12/22 at 10:59 AM an interview was conducted with Resident #62's responsible party (RP). During the interview the RP was asked if she was notified by the facility of changes in Resident #62's care. Resident #62's RP stated she was not notified of a change in medication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/19/22 at 10:08 AM a review of Resident #62's medical record revealed the resident was admitted with a diagnosis of dementia. The resident was previously hospitalized for aggressive behavior and behavioral disturbances and was started on anti-psychotic medication. The resident was admitted to the facility's dementia unit for care. On 9/19/22 at 10:08 AM a review of Resident #62's medical record revealed the antipsychotic medication Seroquel was changed from 75 mg. twice per day to 100 mg. twice per day on 8/3/22 and the antidepressant medication Zoloft 25 mg. was initiated on 8/18/22. There was no documentation that the RP was notified at that time. 7) On 8/4/22 at 7:30 AM a review of the medical record for Resident #450 revealed the resident was admitted to the facility in the beginning of December 2021 from an acute care hospital with diagnoses that included, but were not limited to, type 2 diabetes mellitus, non-pressure chronic ulcer of the right lower leg, sepsis and endometrial cancer. Review of Resident #450's December 2021 physician's orders revealed the order for the diabetes medication Jardiance 25 mg. to be taken every day. Review of Resident #450's Medication Administration Record (MAR) for December 2021 documented the Jardiance was not available to be administered on 12/19, 12/20, 12/21 and 12/22/21. Review of Resident #450's MAR for January 2022 documented the Jardiance was not available to be administered on 1/5, 1/6, 1/7, 1/8, and 1/9/22. There was no documentation that the physician was notified of the delay in the administration of the medication. Review of a 1/4/22 physician's visit documented the plan was to start Resident #450 back on his/her home dose of Ozempic. (Ozempic is an injection medication used to help control high blood sugar for people with type 2 diabetes). Will be started back on Megestrol for appetite stiumlant given history of cancer as recommended by oncologist. (Megestrol is similar to a natural substance made by the body called progesterone. It treats breast cancer and endometrial cancer by affecting female hormones involved in cancer growth). The physician also wrote to continue the Jardiance treatment. Continued review of Resident #450's MAR for January 2022 documented the Megestrol was not available on 1/5, 1/6, 1/7, 1/8, 1/9, and 1/10/22. The Ozempic, which was only to be given on Fridays, was not available on 1/7, 1/14, 1/21 and 1/28/22. The medication Semglee 80 units every day was not available on 1/15/22, and not signed off on 1/21/22 and 1/29/22. Semglee is a prescription long-acting man-made-insulin used to control high blood sugar in adults and children with type 1 diabetes and in adults with type 2 diabetes. The notations were either pending delivery or on order. There was no documentation that the physician was notified of the delay in the administration of the medication. A 2/10/22 physician's note documented, fingersticks has been fluctuant, reaching mid 200s. [He/she] is on high-dose Lantus 80 units. Also, [he/she] is on Ozempic. Continue the same. The resident had not received the Ozempic and the physician was unaware. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Discussed with the Interim DON on 9/28/22 at 12:15 PM and again on 9/28/22 at 5:00 PM along with the Medical Director. The Medical Director stated, nursing was educated for the physician notification and it had improved. Not sure about the training for the agency staff. Both the Interim DON and Medical Director were informed of the findings. 43096 8) A medical record review of Resident #29 was conducted on 9/22/22 at 1:20 PM. A progress note, a part of the medical record, written by Registered Nurse (RN) #79 on 9/21/22 at 6: 44 AM, stated, Resident was yelling out loud. Resident was found to be sweating profusely. Resident blood sugar checked at was 48. Resident given glucose, Blood sugar went up to 64. Resident continued to yell out. Resident wanted to go the hospital. Resident assessed by supervisor. Resident sent to ER for evaluation. An interview was conducted with RN #79 via phone on 9/22/22 at 3:11 PM. RN #79 stated that she assumed the supervisor called 911, the physician, and family members. Further review of the medical record did not reveal documentation that the physician ws notified of Resident #79's health status. On 9/23/22 at 10:23 AM, the NHA was interviewed and revealed that there was no credible evidence that the physician was notified of the resident's status. The concern was shared with the Interim DON on 9/28/22 at 1:30 PM.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on complaint MD00173347 allegation, medical record review, and staff interview, it was determined that the facility failed to provide notice to residents informing them that Medicare may deny payments for procedures or treatments and that residents may be personally responsible for full payment. This was identified for 1 (#105) of 1 resident reviewed that remained in the facility after the termination of Medicare part A skilled services. The findings include: Notification to residents regarding the end of their Medicare coverage is required to be minimally 48 hours prior to the scheduled effective date that coverage will end, therefore, affording them an opportunity to appeal the decision or to prepare for discharge. In addition, CMS is very specific in the form that is required to be used for the notification of the non-coverage of Medicare services. The SNFABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage) provides information to residents/beneficiaries that services may no longer be covered by Medicare and addresses the resident's liability for payment should they wish to continue receiving the skilled services. The NOMNC (Notice of Medicare Non-coverage) informs the beneficiary of his or her right to file an appeal of the decision and the right to an expedited review of Medicare non-coverage of services. Resident #105's closed medical record was reviewed on 9/26/22 in relation to complaint intake MD00173347. Resident #105 was admitted to the facility on [DATE], on the 98th day of the Medicare admission the resident's payment coverage was changed to private pay. A review of the closed medical record did not reveal documentation of the resident and/or the resident's responsible party receiving notification of the change in payor source. The Nursing Home Administrator was interviewed on 9/27/22 at 1:13 PM. She was informed of the required documentation that was not found in the medical record. When asked she revealed that the social worker is responsible for providing notification to a resident and/or a resident representative when the facility determined that a resident no longer qualifies for Medicare part A skilled services. An interview with the social worker (staff #3) at 2:30 PM on 9/27/22 revealed that she was not the social worker at the facility in August 2021. She was asked to review any files that may include documentation of the facility providing written notification of the change in payor source. A follow-up interview with the nursing home administrator on 9/28/22 at 9:30 AM revealed, the facility staff did not find the required documentation related to Resident #105's change in payor source.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on surveyor observation and staff interview it was determined the facility staff failed to have a process to provide housekeeping and maintenance services necessary to keep the building clean, neat, attractive and in good repair. This was evident throughout the survey and on all nursing units. Additionally, the facility failed to supply heated water between 100- and 120-degrees Fahrenheit. The findings include: On 9/28/22 at 12:48 the Environmental Services (EVS) Director (staff #19) indicated that in addition to his title as the EVS Director he assumed the role of the Maintenance Director. A tour of the environment of care was conducted on 9/28/22, in response to team discussions of prior findings during the survey. The following limited observations were collaborated with the Director of EVS and Maintenance beginning at 1:30 PM on 9/28/22. On the Homestead unit in room [ROOM NUMBER] the EVS Director was informed of the initial observations of this room occurred on 9/12/22 at 8:45 AM. A shower curtain and rod remained on the floor in the left-hand corner of the room by the window. The over the bed tray table base was rusted. The wall to the left of the window was observed with two areas of wall board missing on the ledge exposing a silver (metal) bead approximately 4 inches and 6 inches in each area. The light over the sink was not fully lit. The ceiling vent above the toilet appeared encrusted with dirt. The EVS director stated, it looks terrible. An 8-foot section of cove molding at the end of the hallway was noted to be separating from the wall exposing cavities in the brown wood behind it. Outside of room [ROOM NUMBER] the heating element appeared to be separating off the wall as it was sloped downward. The wall handrail across from the nursing station was missing the end cap. On the Chesapeake unit in room [ROOM NUMBER] the air conditioner vent was shown to have black mold like discolorations. In room [ROOM NUMBER] there was not a privacy curtain for the toilet. In 217 B a handle to the bed side drawer was broken. In room [ROOM NUMBER] the air conditioning unit in the wall did not have a filter and there was built up accumulations of lint like particles on the vents. In the unit's shower room malodors were detected upon entering the room. There was a 5-inch uncovered drainage hole in the floor of the left shower stall. Cracks were noted in the cove molding and on the floor covering close to the entrance to the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The windows to the common area by the nurse's station were observed to be dirty, with cobwebs and spider webs on the outside. The EVS Director was informed of observations made to room [ROOM NUMBER] at the initiation of the survey on 9/11/22 of a large roll of brown paper towel was noted on the floor of the resident's toilet/ bathroom. The square paper towel dispenser on the wall was empty. It was reported that the square paper towel dispenser was replaced on 9/29/22. Rooms on the Mills Landing unit that were occupied during the initiation of the survey and not utilized now were observed. In room [ROOM NUMBER] and 403 the window screens were bent and ill fitted with cobwebs and dead bugs entrapped between the screen and window. In room [ROOM NUMBER] there was a series of quarter sized bumps and/or holes in the ceiling wall board along the long wall. The plastic light cover in the fixture above the bed was noted to be dislodged. The bathroom had discoloration in the floor tiles around the parameter of the room. In room [ROOM NUMBER], the door to the bathroom had two quarter sized ill repaired filled holes but remained indented and not repainted. In room [ROOM NUMBER] the sink in the bathroom was not level as it was noted with a tilt to the right. An incomplete wall repair was noted as there was white dry jagged spackle with unsmoothed edges above the cove molding. On 9/15/22 at 4 PM Resident #2 reported having cold water from the hand sink in the room. The hot water temperatures were checked in rooms #102, 104, and 106. The hot water temperatures were tested to be less than 80 degrees Fahrenheit in all three rooms. The staff was informed of the lack of hot water. An interview was held with the nursing home administrator at 4:50 PM on 9/15/22. She revealed that the maintenance man was so busy that he failed to check the water temperatures for the day. On the morning of 9/16/22, the EVS/Maintenance Director informed the survey team that by the end of the day a new hot water heater would be installed. A review of hot water logs on 9/27/22 revealed some room locations that were not reaching the minimum hot water temp of 100 degrees Fahrenheit. room [ROOM NUMBER] was tested to be 91 degrees on 9/24/22 and room [ROOM NUMBER] was tested to be 98 degrees on 9/24/22. During the environmental tour at approximately 2:45 PM, maintenance tested the hot water in room [ROOM NUMBER] at 80 degrees and tested the hot water in room [ROOM NUMBER] at less than 80 degrees. 18819 An observation of Resident #25's room on 09/11/22 at 8:56 AM revealed a set of bed side drawers that appeared to be in disrepair/non-functioning. In an interview with Resident #25 on 09/11/22 at 8:56 AM, Resident #25 indicated that he/she had been asking the staff for awhile to fix the drawers. (continued on next page)

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Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of Resident #45's room on 09/11/22 at 9:10 AM, revealed that Resident #45's window was obscured by a large buildup of dirt and cobwebs. An observation of the 200 nursing unit dining area located next to the nurses' station, on 09/11/22 at 10:50 AM, revealed that the large bay window was obscured by dirt and cobwebs. 31145 On 9/11/22 at 9:13 AM observation was made of holes in the corners of the fitted bed sheet in room [ROOM NUMBER]A. The left corner hole exposed 6 inches by 6 inches of the bed mattress. On 9/11/22 at 9:20 AM observation was made of 2 ceiling tiles that had 2 circle shaped brown stains that were over the bed in room [ROOM NUMBER]B. The bottom of the over the bed tray table was rusted and the vinyl on the bilateral wheelchair armrests were cracked down the inside and outside of the armrests. On 9/12/22 at 10:31 AM observation was made of Resident #67 sitting in a wheelchair in the front dining room. The left wheelchair armrest was missing vinyl over half of the armrest and the underneath padding was exposed. The right wheelchair armrest also had cracked vinyl throughout the armrest. On 9/13/22 at 7:59 AM the vinyl on Resident #115's right wheelchair armrest was torn and the padding was exposed. On 9/13/22 at 12:25 PM employees on the Homestead nursing unit showed the surveyor the courtyard off the Homestead unit where the residents used to go outside for fresh air. The employees stated the fence was down, therefore the residents could not go outside. It was also observed that there was high grass and weeds. The employees stated, they just don't take care of the place. While on the unit there was black debris noted on the ceiling grates. On 9/14/22 at 7 AM in the Homestead nursing unit nourishment room there were 3 floor tiles missing by the refrigerator. Under the sink were dead and active bugs. The back wall under the sink appeared to be busted through to the foundation with concrete rocks as the back wall. There were plastic wrappers on the floor and under the sink along with cobwebs. Observation was made on 9/15/22 at 11:12 AM of the over the bed light in room [ROOM NUMBER]. The string from the over the bed light was not attached, therefore the resident was unable to turn the light on and off.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 18819 Based on policy review, review of facility reported incident MD00180950 and complaint MD00176593, and resident and staff interviews, it was determined that the facility failed to ensure a resident was free from misappropriation of resident property and exploitation. This was evident for 1 (Resident #113) of 13 residents reviewed for abuse, neglect and exploitation during the annual survey. The findings include: A review of the facility Abuse, Neglect and Exploitation policy, on 09/26/22, revealed that the policy was last reviewed/revised and implemented on 10/12/20 and defined Misappropriation of Resident Property as: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent, use of a resident's belongings or money without the resident's consent, Reviews of Facility Reported Incident MD00180950 and Complaint MD00176593 on 09/26/2022 revealed an allegation that Resident #113 went to retrieve his/her $2500.00 in cash, credit cards, and gift cards from the administrator on 04/29/2022 at 2:30 PM and discovered that someone had stolen Resident #113's cash, credit cards, and gift cards. A review of the facility investigation revealed that Resident #113 was admitted from the hospital on 04/19/2022. At that time, staff members documented and photocopied Resident #113's cash, credit cards, and gift cards. The staff provided Resident #113 with a photocopy of the credit cards and gift cards and a receipt for the $2547.00. The items were then secured in the facility safe. On 04/29/2022 at 5:00 PM, the facility investigation indicated that Resident #113 requested the return of his/her cash, credit cards, and gift cards. At that time, the staff were unable to locate Resident #113's $2547. 00 cash, credit cards, or gift cards. The facility administrator initiated an investigation and notified the local police. In an interview with Resident #113 on 09/26/2022 at 2:47 PM, Resident #113 stated that someone at the facility took my money. I had to cancel all my credit cards. I had gift cards that I received during Christmas, but I was unable to determine how much was on each of the gift cards. When it happened, a staff person told me that the police would want to speak with me, but no police officer ever interviewed me. I kept my receipt the staff gave me when I was admitted from the hospital. The facility did reimburse me with a check for the amount of cash only. In an interview with the former facility administrator that was working at the facility on 04/29/2022, the former administrator stated that the facility usually does not hold a resident's money and that a resident is usually requested to place their belongings in a locked drawer or open a resident funds account. The former administrator stated that Resident #113's sister was supposed to pick up the money. The facility has a safe but the safe was unlocked. We were unable to determine when Resident #113's cash, credit cards, and gift cards were lost.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 31145 Based on policy review, interview, and facility investigation review, it was determined that the facility failed to implement the abuse policy by failing to do a thorough investigation of alleged abuse and neglect. This was evident for 7 (#92, #112, #115, #100, #291, #114, #8) of 13 residents reviewed for abuse and neglect. The findings include: On 9/11/22 at 8:16 AM an entrance conference was conducted with the Nursing Home Administrator (NHA) and the Abuse Policy was requested. Review of the Abuse, Neglect and Exploitation Policy revealed, V. Investigation of Alleged Abuse, Neglect and Exploitation. B. Written procedures for investigations include: 6. Providing complete and thorough documentation of the investigation. On 9/19/22 at 8:25 AM the surveyor requested from the Nursing Home Administrator (NHA) a copy of all the investigations for the facility reported incidents. On 9/19/22 at 10:17 AM the NHA stated, I can't find any documentation related to the incidents that I have marked with an X. 1) On 9/19/22 at 11:33 AM a review of facility reported incident MD00181929 revealed on 8/7/22 Resident #92 alleged that a female staff member grabbed Resident #92's arm and left a bruise. Review of the facility's documentation of the investigation revealed a statement was taken from the geriatric nursing assistant (GNA) that was assigned to the resident, a second GNA who was told about the incident and a statement from the nurse. The facility summary stated that the entire unit of the GNA assignment was interviewed, but there was no evidence of the interviews provided to the surveyor. There were no other staff interviews from any other shifts provided to the surveyor. The facility's investigation was not thorough. On 9/19/22 at 1:50 PM an interview was conducted with the NHA regarding the investigation. The surveyor asked the NHA if she had documentation of the resident interviews. The NHA stated, I would have expected social work to do that. On 9/20/22 at 2:42 PM an interview was conducted with social work, Staff #3 regarding the investigation. Staff #3 stated, I do not investigate abuse. When asked if she did resident interviews she stated, no. 2) On 9/19/22 at 2:30 PM a review of facility reported incident MD00177557 revealed Resident #112 was observed with bruises and a skin tear on the right back of the hand. Resident #112 alleged that he/she was attacked by an aide the night before. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's documentation that was given to the surveyor consisted of a 5/25/22 pain evaluation, a 5/23/22 fall risk evaluation, a 5/23/22 and 5/25/22 Braden evaluation, a 5/25/22 incident report, 5/22/22 to 5/27/22 progress notes, a copy of physician's orders, a copy of the care plan, and a written statement from the previous Director of Nursing. There were no employee or resident interviews or statements and there was no schedule review to determine who worked on previous shifts prior to the alleged incident. On 9/27/22 at 8:40 AM the NHA confirmed that there were no resident and employee interviews and no documentation of the investigation. 3) On 9/19/22 at 2:30 PM a review of facility reported incident MD00178184 revealed Resident #112 alleged that on 6/4/22 a 6-foot, 300-pound male hit the resident hard on the head. There was no investigation given to the surveyor. There were no employee interviews, resident interviews, or schedule reviews to determine who worked. There was no further information given to validate that the alleged abuse was thoroughly investigated. 4) On 9/19/22 at 4:21 PM a review of facility reported incident MD00156771 revealed Resident #115 reported to the phlebotomist on 7/30/20 that a GNA, hollers at me, then threw covers on me and threw the bed remote at me. The phlebotomist reported the alleged event to administration. Review of the facility's investigation revealed the GNA that was assigned to the resident was interviewed and the phlebotomist was interviewed. The nurse and other staff working were not interviewed. There were no other residents interviewed. The investigation was incomplete. On 9/27/22 at 8:40 AM a review of the incident was conducted with the Interim Director of Nursing who confirmed the investigation was not complete and no other residents were interviewed. 5) On 9/19/22 at 5:00 PM a review of facility reported incident MD00181484 revealed on 3/8/22 Resident #100 was observed with discoloration on the left foot. Per the submitted report, the resident stated he/she had a recent fall and said that someone ran their wheelchair on his/her foot. There was no documentation provided to the surveyor regarding the facility reported incident. There was no further information given to validate that the alleged abuse was thoroughly investigated. 6) On 9/26/22 at 2:00 PM a review of facility reported incident MD00172750 revealed Resident #291's daughter had multiple concerns, alleging neglect. There was no investigative documentation provided to surveyor. There were no employee or resident interviews. There was no further information given to validate that the alleged neglect was thoroughly investigated. 7) On 9/26/22 at 4:00 PM a review of facility reported incident MD00172696 revealed Resident #114 alleged that he/she was inappropriately touched during dialysis treatment and did not report it to the facility until 2 weeks later. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no investigative documentation provided to surveyor. There were no employee or resident interviews. There was no further information given to validate that the alleged abuse was thoroughly investigated. 8) On 9/26/22 at 4:15 PM a review of facility reported incident MD00181483 revealed Resident #8 alleged that a GNA pushed the resident close to the bed rail and Resident #8 reported it was a terrified feeling. Resident #8 also reported that he/she didn't like GNA's tone of voice with high pitch. There was no documentation provided to the surveyor regarding the facility reported incident. There was no further information given to validate that the alleged abuse was thoroughly investigated. All the facility reported incidents were reviewed with the Interim Director of Nursing on 9/28/22 at 12:15 PM.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on interview and record review it was determined the facility failed to report allegations of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ) and failed to submit the results of the investigation within 5 days. This was evident for 7 (#112, #115, #100, #291, #114, #8, #101) of 13 residents reviewed for abuse during the annual survey. The findings include: On 9/19/22 at 8:25 AM the surveyor requested from the Nursing Home Administrator (NHA) all documentation of the investigations that were related to the facility reported incidents that were sent to OHCQ. On 9/19/22 at 10:17 AM the NHA stated that she could not find any documentation related to the facility reported incidents. 1) On 9/19/22 at 2:30 PM a review of facility reported incident MD00178184 revealed on 6/4/22 Resident #112 alleged that a male who was 6 feet, 300 pounds hit the resident hard on the head. There was no documentation provided to the surveyor regarding the facility reported incident. There were no email or fax confirmations as to when the initial and 5-day investigation was reported to OHCQ. There was no further information given to validate the timely reporting of alleged abuse from the NHA. 2) On 9/19/22 at 4:41 PM a review of facility reported incident MD00156771 revealed Resident #115 alleged that on 7/30/20 a geriatric nursing assistant (GNA) hollers at me then threw covers on me and threw the bed remote at me. There was no documentation provided to the surveyor of the time the incident occurred and the time it was reported to OHCQ. 3) On 9/19/22 at 5:00 PM a review of facility reported incident MD00181484 revealed on 3/8/22 Resident #100 was observed with discoloration on the left foot. Per the submitted report the resident stated he/she had a recent fall and said that someone ran their wheelchair on his/her foot. There was no documentation provided to the surveyor regarding the facility reported incident. There were no email or fax confirmations as to when the initial and 5-day investigation was reported to OHCQ. There was no further information given to validate the timely reporting of alleged abuse from the NHA. 4) On 9/26/22 at 2:00 PM a review of facility reported incident MD00172750 revealed Resident #291's daughter had multiple concerns, alleging neglect. There was no investigative documentation provided to the surveyor. There were no email or fax confirmations as to when the initial and 5-day investigation was reported to OHCQ. There was no further information given to validate the timely reporting of alleged neglect from the NHA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) On 9/26/22 at 4:00 PM a review of facility reported incident MD00172696 revealed Resident #114 alleged that he/she was inappropriately touched during dialysis treatment 2 weeks prior and admitted not reporting to the facility staff until this evening. The intake appears to have been received at OHCQ on 10/7/21. There was no documentation provided to the surveyor regarding the facility reported incident. There were no email or fax confirmations as to when the initial and 5-day investigation was reported to OHCQ. There was no further information given to validate the timely reporting of alleged abuse from the NHA. 6) On 9/26/22 at 4:15 PM a review of facility reported incident MD00181483 revealed Resident #8 alleged that a geriatric nursing assistant (GNA) pushed the resident close to the bed rail and Resident #8 reported it was a terrified feeling. Resident #8 also report that he/she didn't like GNA's tone of voice with high pitch. There was no documentation provided to the surveyor regarding the facility reported incident. There were no email or fax confirmations as to when the initial and 5-day investigation was reported to OHCQ. There was no further information given to validate the timely reporting of alleged abuse from the NHA. As of 9/28/22 at 8:00 PM there was no further documentation provided to surveyors related to the facility reported incidents. 43096 7) A review of the facility self-report, MD00177067, on 9/26/22 at 09:34 AM revealed that Resident #101 stated that he/she took pills from the staff member when he/she was not fully awake. Per the facility's investigation regarding this incident, a physical therapist identified this concern from Resident #101's verbal report on 4/7/22. The facility report form named receipt of grievance/concern, dated 4/7/22 was written by a physical therapist (Staff #80) that stated, patient reported a couple of nights ago while sleeping with mouth open, a nurse just poured all his/her meds his/her mouth almost making her/him choke. Further review of records revealed that an initial self-report form was submitted to OHCQ on 4/7/22 at 3:46 PM. During an interview with the Interim DON on 9/26/22 at 12:22 PM, the interim DON stated this incident was initiated by the PT's (Physical Therapy) report. PT's report triggered this incident, and the facility staff started investigating. She confirmed that the facility staff could not identify the event's allocated time. The surveyor discussed the issue with the interim DON on 9/28/22 at 1:30 PM. The interim DON confirmed she did not find any supportive documentation that this incident was reported within 2 hours of the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on interview, review of facility reported incident investigations and policy, it was determined the facility failed to thoroughly investigate allegations of abuse and neglect. This was evident for 10 (#92, #112, #115, #100, #291, #114, #8, #101, #45, #64) of 13 residents reviewed for abuse and neglect. The findings include: On 9/19/22 at 8:25 AM the surveyor requested from the Nursing Home Administrator (NHA) a copy of all the investigations for the facility reported incidents. On 9/19/22 at 10:17 AM the NHA stated, I can't find any documentation related to the incidents that I have marked with an X. 1) On 9/19/22 at 11:33 AM a review of facility reported incident MD00181929 revealed on 8/7/22 Resident #92 alleged that a female staff member grabbed Resident #92's arm and left a bruise. Review of the facility's documentation of the investigation revealed a statement was taken from the geriatric nursing assistant (GNA) that was assigned to the resident, a second GNA who was told about the incident and a statement from the nurse. The facility summary stated that the entire unit of the GNA assignment was interviewed, but there was no evidence of the interviews provided to the surveyor. There were no other staff interviews from any other shifts provided to the surveyor. The facility's investigation was not thorough. On 9/19/22 at 1:50 PM an interview was conducted with the NHA regarding the investigation. The surveyor asked the NHA if she had documentation of the resident interviews. The NHA stated, I would have expected social work to do that. On 9/20/22 at 2:42 PM an interview was conducted with social work, Staff #3 regarding the investigation. Staff #3 stated, I do not investigate abuse. When asked if she did resident interviews she stated, no. 2) On 9/19/22 at 2:30 PM a review of facility reported incident MD00177557 revealed Resident #112 was observed with bruises and a skin tear on the right back of the hand. Resident #112 alleged that he/she was attacked by an aide the night before. Review of the facility's documentation that was given to the surveyor consisted of a 5/25/22 pain evaluation, a 5/23/22 fall risk evaluation, a 5/23/22 and 5/25/22 Braden evaluation, a 5/25/22 incident report, 5/22/22 to 5/27/22 progress notes, a copy of physician's orders, a copy of the care plan, and a written statement from the previous Director of Nursing. There were no employee or resident interviews or statements and there was no schedule review to determine who worked on previous shifts prior to the alleged incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 8:40 AM the NHA confirmed that there were no resident and employee interviews and no documentation of the investigation. 3) On 9/19/22 at 2:30 PM a review of facility reported incident MD00178184 revealed Resident #112 alleged that on 6/4/22 a 6-foot, 300-pound male hit the resident hard on the head. There was no investigation given to the surveyor. There were no employee interviews, resident interviews, or schedule reviews to determine who worked. There was no further information given to validate that the alleged abuse was thoroughly investigated. 4) On 9/19/22 at 4:21 PM a review of facility reported incident MD00156771 revealed Resident #115 reported to the phlebotomist on 7/30/20 that a GNA, hollers at me, then threw covers on me and threw the bed remote at me. The phlebotomist reported the alleged event to administration. Review of the facility's investigation revealed the GNA that was assigned to the resident was interviewed and the phlebotomist was interviewed. The nurse and other staff working were not interviewed. There were no other residents interviewed. The investigation was incomplete. On 9/27/22 at 8:40 AM a review of the incident was conducted with the Interim Director of Nursing (DON) who confirmed the investigation was not complete and no other residents were interviewed. 5) On 9/19/22 at 5:00 PM a review of facility reported incident MD00181484 revealed on 3/8/22 Resident #100 was observed with discoloration on the left foot. Per the submitted report the resident stated he/she had a recent fall and said that someone ran their wheelchair on his/her foot. There was no documentation provided to the surveyor regarding the facility reported incident. There was no further information given to validate that the alleged abuse was thoroughly investigated. 6) On 9/26/22 at 2:00 PM a review of facility reported incident MD00172750 revealed Resident #291's daughter had multiple concerns, alleging neglect. There was no investigative documentation provided to surveyor. There were no employee or resident interviews. There was no further information given to validate that the alleged neglect was thoroughly investigated. 7) On 9/26/22 at 4:00 PM a review of facility reported incident MD00172696 revealed Resident #114 alleged that he/she was inappropriately touched during dialysis treatment and did not report to the facility until 2 weeks later. There was no investigative documentation provided to surveyor. There were no employee or resident interviews. There was no further information given to validate that the alleged abuse was thoroughly investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8) On 9/26/22 at 4:15 PM a review of facility reported incident MD00181483 revealed Resident #8 alleged that a geriatric nursing assistant (GNA) pushed the resident close to the bed rail and Resident #8 reported it was a terrified feeling. Resident #8 also reported that he/she didn't like GNA's tone of voice with high pitch. There was no documentation provided to the surveyor regarding the facility reported incident. There was no further information given to validate that the alleged abuse was thoroughly investigated. All of the facility reported incidents were reviewed with the Interim DON on 9/28/22 at 12:15 PM. 43096 9) A review of the facility self-report, MD00177067, on 9/26/22 at 09:34 AM revealed that Resident #101 stated he/she did not receive changing timely, and he/she took in pills from the staff member when he/she was not fully awake. Per the facility's investigation regarding this incident, a physical therapist (staff #80) identified this concern from Resident #101's verbal report on 4/7/22. Further review of the facility investigation documentation revealed that the facility submitted a follow-up report to OHCQ on 4/11/22. The follow-up report showed Resident #101 stated, Registered Nurse (RN #81) would not change the resident's wound and had an issue with the nurse. However, the facility's investigative documentation did not include any statements from RN #81, other staff, or any other residents. During an interview with the interim DON on 9/26/22 at 12:22 PM, the interim DON stated that Staff #80 reported this incident, and the facility started investigating. The interim DON also explained during the facility's investigation, the facility's management team found RN #81 had a history of probation orders from other states. They decided to terminate her. Since the facility's investigation documentation did not include any statements, the surveyor asked the interim DON for any documentation to support the facility investigated thoroughly. The interim DON replied, I ordered to get statements from other residents. Still looking for the documentation. The facility staff failed to submit supportive evidence about this incident's investigation to the surveyor team until the exit conference held on 9/28/22 at 7 PM. 18819 10) A review of the facility Abuse, Neglect and Exploitation policy, with an initiation and review date of 10/12/20, on 09/26/22, revealed that the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Under section V - Investigation of Alleged Abuse, Neglect, and Exploitation - A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigating include: 1. Identifying staff responsible for the investigation, 2. Exercising caution in handling evidence, 3. Investigating different types of alleged violations, 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause, and 6. Providing complete and thorough documentation of the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/26/22 at 11:25 AM, a review of facility self-report incident, MD00177014, revealed that Resident #45's family member reported to the facility administrative staff that Resident #45 had not been provided incontinence care on 04/05/22 from 6 PM thru 12 midnight. The initial facility report to the State Survey Agency did not 1) identify an alleged perpetrator, 2) list any witnesses, and 3) did indicate the local police were notified on 04/05/22. On 09/26/22 at 3:46 PM, a phone call was placed to interview the local investigating police officer who was contacted on 04/05/22. The nurse surveyor was unable to interview the local investigating police officer and there was not a return phone call from the officer. Further review of Resident #45's medical record revealed that the Resident was admitted to the facility in December 2011 with diagnoses that include but are not limited to traumatic brain injury, quadriplegia, peg tube insertion, seizures, suprapubic catheter, dysphagia, and contractures in the extremities. Resident #45 was totally dependent upon the facility staff for all aspects of his/her care. Resident #45 had a Brief Interview for Mental Status (BIMS) assessment, conducted by a facility staff member, on 05/11/22 and 07/28/22 during the quarterly review process. Resident #45 was assessed to have a 15/15 score during both quarterly assessments. A score of 13 to 15 suggests the resident is cognitively intact. A review of the facility's investigation packet into the 04/05/22 allegation of abuse revealed the facility failed to obtain any witness statements. Further review of Resident 45's nursing and physician progress notes around the 04/05/22 date did not specifically address Resident #45's allegation of abuse. In an interview with the facility interim DON and NHA on 09/28/22 at 5 PM, the facility staff members were made aware of the concerns that the facility failed to do a thorough investigation. 11) A review of the facility Abuse, Neglect and Exploitation policy, with an initiation and review date of 10/12/20, on 09/26/22, revealed that the policy of this facility is to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Under section V - Investigation of Alleged Abuse, Neglect, and Exploitation - A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigating include: 1. Identifying staff responsible for the investigation, 2. Exercising caution in handling evidence, 3. Investigating different types of alleged violations, 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause, and 6. Providing complete and thorough documentation of the investigation. A request to review the facility investigations for facility reported incidents MD00180969 and MD00180970 were given to the facility Administrator on 09/26/22 at 1:30 PM. The investigations were regarding Resident #64's allegation of staff to resident abuse on 04/24/22 at 7 PM. A follow up interview with the facility Administrator on 09/27/22 at 9:55 AM, the facility administrator stated that he/she could not find any investigation documents regarding Resident #64's allegation of staff to resident abuse that allegedly occurred on 04/24/22 at 7 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/27/22 at 11:33 AM, the facility Administrator produced documentation into facility reported incidents MD00180969 and MD00180970. A review of the initial facility report, to the State Survey Agency revealed that the report was initially sent on 04/28/22 and did not: 1) identify an alleged perpetrator, 2) list any witnesses, and 3) list the investigating police officer's name or case number. Included in the investigation documentation was a written statement from Resident #64, that was not dated as to when it was written but did list a date as to when the alleged abuse occurred on 04/24/22 at 7 PM. Resident #64's and his/her family member did sign the statement. There were no other resident witness or staff witness statements, a statement from the alleged perpetrator, or a police report attached to the facility investigation for review. Further review of Resident #64's medical record revealed that the Resident was admitted to the facility on [DATE] with diagnoses that include but are not limited to a stroke, Atrial Fibrillation, hearing loss, dysphagia, and major depressive disorder. Resident #64 is dependent upon the facility staff for many aspects of his/her care. Resident #64 had a Brief Interview for Mental Status (BIMS) assessment, conducted by a facility staff member, on 03/25/22 and 06/28/22 during the annual and quarterly review process. Resident #64 was assessed to have a 14/15 score during both the annual and quarterly assessments. A score of 13 to 15 suggests the resident is cognitively intact. In an interview with the former facility administrator (staff member #52) on 09/28/22 at 10:09 AM, the former Administrator stated that the investigation determined that the allegations were more of a customer service issue than resident abuse.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on medical record review and staff interview it was determined that the facility 1) failed to ensure the discharge of a resident was documented in the medical record to include, the resident's status at the time of discharge, any required discharge instructions, the reason for the discharge and 2) failed to document that information was provided to the acute care facility when a resident was transferred there emergently. This was identified for 3 (#148 #10, #27) of 9 residents reviewed for discharge during the annual survey. The findings include. 1) On 09/22/22 at 4 PM, Resident #148's closed medical record was reviewed in relation to complaint intake MD00177030. Resident #148 was discharged on [DATE]. Progress notes indicating the resident discharge were not found. Documentation related to the resident's status at the time of discharge, discharge instructions, a discharge plan, or the reason for the discharge was not found in Resident #148's medical record. On an electronic Transfer/Discharge Report under the miscellaneous information section, there was a Transfer/Discharge to Private home/apartment without a forwarding address or how or by whom the resident left the facility. On 9/23/22 at 8:33 AM the medical records coordinator (staff #5) was informed of the electronic records' lack of discharge documentation. She was asked to provide the hard (paper) chart and any information she could find related to Resident #148's discharge. She returned with the resident's closed hard chart indicating she reviewed the resident's electronic medical record and reported she did not find information related to the resident's discharge on 5/13/22. A review of the hard chart did not reveal any additional information related to the resident's discharge from the facility. At approximately 11:30 AM on 9/23/22 the nursing home administrator was informed of the documentation that was not found by the medical records person. No other documentation was provided related to Resident #148's discharge. 31145 2) On 9/21/22 at 7:44 AM observation was made of Resident #10's room, and it was noted the resident was not in the room. Registered Nurse (RN) #14 was asked where Resident #10 was and RN #14 stated Resident #10 was sent out to the hospital on 9/16/22 due to the resident's toe, looked bad. Review of Resident #10's medical record on 09/21/22 at 08:05 AM revealed a 9/16/22 at 13:10 (1:10 PM) nurse practitioner progress note which documented the chief complaint was, recurring right great toe trauma that has now developed into an arterial ulcer. The plan documented, wound significant worse, suspected fasciitis. Pt. started on PO (by mouth) ABX (antibiotics) day prior. Recommend transfer to ED (emergency department) for evaluation. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #10's 9/16/22 change in condition note was incomplete. There was no documentation that the receiving facility was notified of the transfer. 3) On 9/11/22 at 11:11 AM Resident #27's medical record was reviewed and revealed a MDS assessment for a discharge return not anticipated dated 8/18/22. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Further review of the medical record revealed there were not any progress notes between the dates of 8/18/22 and 8/23/22 when the resident was readmitted . On 9/16/22 at 8:44 AM continued medical record review revealed a hospital discharge summary dated 8/23/22 which documented Resident #27 was admitted to the hospital for a urinary tract infection and bacteremia and was being discharged back to the facility. On 9/16/22 at 9:15 AM the Nursing Home Administrator (NHA) was informed that there was no documentation about the transfer to the hospital. The surveyor informed the NHA that it initially could not be determined if the resident was discharged home or elsewhere. The NHA stated Resident #27 was transferred to the hospital.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 31145 Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 4 (#27, #10, #29, #91) of 6 residents reviewed for hospitalization . The findings include: 1) On 9/12/22 at 1:37 PM a review of Resident #27's medical record was conducted. It appeared that Resident #27 was sent to the hospital on 8/18/22 as there was an MDS Discharge Return Not Anticipated assessment listed under the MDS section of the medical record. There was no documentation in the medical record about Resident #27's discharge to the hospital on 8/18/22. A hospital discharge summary dated 8/23/22 confirmed that Resident #27 was admitted to the hospital on 8/18/22. There was no written documentation in the medical record that the responsible party and/or resident was notified in writing of the hospital transfer. 2) On 9/21/22 at 7:44 AM observation was made of Resident #10's room. Resident #10 was not in the room. At that time Registered Nurse (RN) #14 was asked where the resident was and RN #14 stated, Oh, [he/she] got sent out on the 16th because [his/her] toes was looking bad. Review of Resident #10's electronic and paper medical record on 9/21/22 at 8:05 AM revealed on 9/16/22, Resident #10 was transferred to the hospital for a change in medical condition. Further review of Resident #10's medical record revealed there was no written documentation that the responsible party and/or resident was notified in writing of the hospital transfer. On 9/16/22 at 9:15 AM an interview was conducted with the Nursing Home Administrator (NHA) who confirmed there was no documentation in the medical record related to written notification of transfer to the hospital. 43096 3) On 9/22/22 at 12:40 PM, Resident #58 verbally reported his/her concern related to Resident #29's transfer which occurred on 9/21/22. Resident #58 stated Resident #29 transferred to the hospital on 9/21/22, and family members of Resident #29 visited the facility to see the Resident without knowing Resident #29's status. A medical record review of Resident #29 was conducted on 9/22/22 at 1:20 PM. A progress note, a part of the medical record, written by RN #79 on 9/21/22 at 6:44 AM, stated, Resident was yelling out loud. Resident was found to be sweating profusely. Resident blood sugar checked was 48. Resident given glucose; Blood sugar went up to 64. Resident continued to yell out. Resident wanted to go the hospital. Resident assessed by supervisor. Resident sent to ER for evaluation. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	An interview was conducted with RN #79 via phone on 9/22/22 at 3:11 PM. RN #79 recalled the incident occurred around 9/20/22 at midnight. Also, RN #79 stated that she assumed the supervisor called 911, the physician, and family members. She said, All I did was stay with the resident at the bedside. My supervisor brought papers (current order and face sheet), and I handed them to EMT. Further review of the medical record did not reveal documentation that the Resident or Responsible Party (RP) was informed in writing related to the transfer to the hospital. On 9/23/22 at 10:23 AM, the NHA was interviewed and revealed that there was no creditable evidence related to the resident or RP receiving notification in writing of the transfer. 4) On 9/27/22 at 8:08 AM, a review of Resident #91's electronic and paper medical records revealed Resident #91 was transferred to the hospital on 8/6/22 for a change in medical condition. Further review of Resident #91's medical record documentation revealed the responsible party was notified. However, there was no written documentation that the responsible party was notified in writing of the hospital transfer. The Interim Director of Nursing was informed on 9/28/22 at 1:30 PM.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview it was determined the facility staff failed to 1) conduct an accurate, comprehensive assessment by failing to accurately assess a resident's dental status, mood and cognitive status, bowel and bladder status, and dialysis on comprehensive (Minimum Data Set) assessments and failed to 2) complete an admission MDS assessment within 14 days of a resident's admission to the facility. This was evident for 4 (#27, #59, #103, #291) of 23 residents reviewed for 4 different care areas and 1 (#141) of 1 newly admitted resident reviewed for the annual survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on these individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 9/12/22 at 1:08 PM an interview was conducted with Resident #27 who stated his/her dentures got lost when he/she was transferred to the hospital. On 9/15/22 at 2:45 PM Resident #27's spouse expressed concern to the surveyor about Resident #27's missing dentures that fell on the floor the evening that the resident was sent to the hospital and have not been found. Resident #27 was transferred to the hospital on 8/18/22. On 9/16/22 at 8:44 AM a medical record review for Resident #27 was conducted and revealed a 7/8/22 admission MDS assessment that documented in section L0200, Dental, B. no natural teeth or tooth fragments (edentulous). The 8/28/22 admission MDS assessment documented no issues (not edentulous) in section L0200. Review of the 8/23/22 nursing admission assessment documented, no teeth - lost dentures at the hospital. The 8/28/22 admission MDS was incorrect as the resident was edentulous and was missing his/her dentures. 2) On 9/26/22 at 4:25 PM a review of Resident #59's medical record was conducted. Resident #59 was admitted to the facility in June 2020 with diagnoses including, but not limited to, unstable angina, diabetes mellitus with diabetic neuropathy, COPD, and end stage renal disease. Review of the comprehensive MDS assessment with an assessment reference date of 1/28/22, Section C, Cognitive Patterns, and section D, Mood was not assessed. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/22 at 12:51 PM an interview was conducted with the Director of Social Work who stated she does Section C and D of the MDS assessments but if she doesn't get to them the MDS coordinator will do them. The Director of Social Work stated that she was only in the building 2 days per week, and she said, I try to hit the important stuff, try to get my MDS done, talk to families. I probably miss a good portion of what I am supposed to do. She continued, the MDS coordinator left last week due to frustrations and corporate is doing the MDS now. 3) On 9/23/22 at 8:00 AM a review of Resident #103's medical record was conducted. Resident #103 was admitted to the facility in January 2022 with diagnoses that included, but were not limited to, contusion of the right hip and repeated falls. Review of hospital notes dated 1/24/22 documented that a urinary catheter was inserted on 1/24/22 at 23:56 (11:56 PM). Indication: immobilization required (trauma/surgery). Review of a 1/25/22 nursing admission assessment documented in Section J, Bladder/Bowel, comment section, resident has a foley catheter in place. A Foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. A 1/26/22 bowel and bladder assessment documented, Indwelling catheter, Does the resident have an indwelling catheter? YES. Review of the admission MDS with an assessment reference date of 1/31/22, Section H Bladder and Bowel, H0100 Appliances, coded, none of the above. Further review of the admission MDS, section C, Cognition and Section D, Mood, was not assessed. 4) On 9/26/22 at 2:00 PM a review of Resident #291's medical record was conducted. Resident #291 was admitted to the facility in August 2021 with diagnoses including, but not limited to, dependence on renal dialysis, diverticulitis of intestine, and chronic atrial fibrillation. Review of the admission MDS with an Assessment Reference Date of 8/31/21, Section O0100, Special Treatment, Procedures, and Programs failed to capture Dialysis. Review of Resident #291's August 2021 physician's orders documented, Dialysis M-W-F. Review of Resident #291's August 2021 Medication Administration Record (MAR) documented that staff obtained post dialysis weights every Monday, Wednesday, and Friday. For August 2021 it was signed off on Friday, 8/27/21 and Monday, 8/30/21. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/14/22 at 11:25 AM an interview was conducted with Staff #24, the MDS Resource Coordinator who stated, I work remotely sometimes and sometimes I am in the building. As of lately I have been here daily. Usually, 3 days here and 2 days remote. My hire date was June 2022. There was someone else here doing MDS. Resource MDS means I am a floater. I personally have not done a lot of the MDS. Staff #24 stated that she was helping social work doing the BIMS and PHQs now to make sure they were not having that problem. Staff #24 stated that Social Work should be doing sections C and D. She should have time. She comes on Tuesdays and Fridays, so I now started doing a check to ensure that the MDS sections are done. On 9/27/22 at 11:06 AM with the Interim Director of Nursing (DON) a discussion was held regarding the MDS errors. 15701 5) Resident #141 was admitted to the facility on [DATE]. A review of Resident #141's medical record on 9/26/22 revealed the comprehensive 5-day admission assessment dated [DATE] was still in progress and was not completed within 14 days of the resident's admission to the facility. On 9/26/22 at 1 PM the Interim DON was informed of the overdue admission assessment. She summoned the MDS assessment coordinator (staff #24), so she could be informed of the MDS assessment that was still in progress. Staff #24 responded that she was working on the assessment. On 9/26/22 the assessment was overdue by 6 days as it was day 20 of Resident #141's admission to the facility.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 31145 Based on medical record review and interview, it was determined the facility staff failed to complete a Significant Change Minimum Data Set (MDS) assessment when the resident met significant change guidelines for entering Hospice care. This was evident for 1 (#49) of 1 resident reviewed for Hospice care during the annual survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. On 9/11/22 at 10:03 AM a medical record review was conducted for Resident #49. The review revealed Resident #49 was initially admitted to Hospice care on 8/27/21. A significant MDS assessment was not done after the resident was admitted to Hospice. A quarterly MDS assessment was done on 9/16/21. On 9/14/22 at 11:25 AM an interview was conducted with Staff #24, the MDS Resource Coordinator who stated, I work remotely sometimes and sometimes I am in the building. My hire date was June 2022. There was someone else here doing MDS assessments. I personally have not done a lot of the MDS assessments here. Discussed with the Interim Director of Nursing on 9/28/22 at 12:15 PM.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 31145 Based on observation, medical record review and interview, it was determined the facility staff failed to conduct a complete and accurate assessment by failing to assess a resident's oxygen use and failing to assess cognition and mood. This was evident for 1 (#10) of 2 residents reviewed for respiratory, 1 (#62) of 8 residents reviewed for accidents, and 1 (#59) of 9 residents reviewed for quality of care. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on these individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 9/11/22 at 9:26 AM observation was made of a portable oxygen tank on the back of Resident #10's wheelchair in the resident's room. On 9/14/22 at 2:10 PM Registered Nurse (RN) #14 was asked about the oxygen and the response was, I don't know why [he/she] has the oxygen; maybe it is because dialysis might put it on [him/her] if the sats (oxygen saturation level) drops. On 9/15/22 10:30 AM a medical record review was done for Resident #10. The vital sign section of the medical record documented Resident #10 received oxygen on 1/31/22. Review of Resident #10's quarterly MDS assessment with an assessment reference date of 2/10/22 failed to capture oxygen use in section O0100, in the previous 14 days. The oxygen use of 1/31/22 should have been captured, therefore made the assessment inaccurate. 2) On 9/15/22 at 9:21 AM a review of Resident #62's medical record was conducted. Resident #62 was admitted to the facility in April 2022 with diagnoses that included, but were not limited to, Alzheimer's disease, unspecified dementia with behavioral disturbance and senile degeneration of the brain. Review of the quarterly 6/15/22 and 8/5/22 MDS assessments, Section C, Cognition and Section D, Mood, were not assessed which made the assessments incomplete. 3) On 9/26/22 at 4:25 PM a review of Resident #59's medical record was conducted. Resident #59 was admitted to the facility in June 2020 with diagnoses including, but not limited to, unstable angina, diabetes mellitus with diabetic neuropathy, COPD, and end stage renal disease. Review of the quarterly MDS assessment with an assessment reference date of 1/7/22, Section C, Cognitive Patterns, was not assessed, which made the assessment incomplete. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/14/22 at 11:25 AM an interview was conducted with Staff #24, the MDS Resource Coordinator who stated, My hire date was June 2022. There was someone else here doing MDS assessments. Resource MDS means I am a floater. I personally have not done a lot of the MDS. Staff #24 stated that she was helping social work doing Sections C and D. Staff #24 stated that Social Work should be doing sections C and D. She should have time. She comes on Tuesdays and Fridays, so I now started doing a check to ensure that the MDS sections are done. Discussed with the Interim Director of Nursing on 9/28/22 at 12:15 PM.

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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. 31145 Based on observation, medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#34) of 7 residents reviewed for accidents, 1 (#62) of 6 residents reviewed for unnecessary medications, and 1 (#92) of 3 closed records reviewed and during the annual survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 9/21/22 at 7:39 AM observation was made of Resident #34 lying in bed with bilateral 1/2 side rails up. On 9/21/22 at 4:30 PM a medical record review was conducted for Resident #34 and revealed a recent side rail assessment had not been done. The last side rail assessment was done on 4/15/22. The 4/16/22 bed safety review documented the resident had behavioral symptoms that may place them at risk for accident hazards. The hazard was cognitively impaired. The resident's level of consciousness/cognition was disoriented x 3 at all times. It was documented that the resident was not able to communicate their needs due to cognitively impaired. It was documented that the resident did not have a fall within the last 6 months. This was an inaccurate assessment as further review of the medical record revealed the resident had a fall on 2/18/22 on the floor beside the bed and on 3/27/22 had a fall from the wheelchair. Additionally, on 4/20/22 the resident was found on the floor on [his/her] backside trying to get off floor. On 7/8/22 the resident had a fall on the floor in front of the bed. Review of the fall's care plan documented, 7/8/2022 fell from [his/her] bed, unwitnessed with no apparent injury upon assessment. Rehab notified. Review of the MDS assessment with an assessment reference date (ARD) of 7/20/22 documented the resident was extensive assistance with 2 people for bed mobility, however, was extensive assistance with 1 person on the 6/25/22 assessment. On 9/22/22 at 7:40 AM an interview of geriatric nursing assistant (GNA) #12 was conducted and she was asked if Resident #34 always had bed rails up when in bed. GNA #12 stated, yes, because [he/she] is a fall's risk and they are always up. Further review of the 7/20/22 and 6/23/22 quarterly MDS assessment, Section P0100A, restraints, failed to capture the use of side rails. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the RAI (Resident Assessment Instrument) manual, the definition of restraint is, Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP). Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. Remove easily means that the manual method or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over). Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A. 2) On 9/15/22 at 9:21 AM a review of Resident #62's medical record was conducted and revealed Resident #62 was admitted to the facility in April 2022. A 4/5/22 admission history and physical was done by the admitting physician who documented, was started on anti-psychotic and was placed in nursing home. [He/She] was seen by Psychiatry on 02/14/2022 to address [his/her] behavioral disturbance. The note documented the resident was started on Depakote (mood stabilizer), Seroquel (antipsychotic), and Remeron (antidepressant). Review of the admission MDS with an ARD of 4/12/22, N0450. Antipsychotic Medication Review, checked, no, antipsychotics were not received. This was inaccurate as the resident received the antipsychotic medication Seroquel 100 mg. twice per day. 3) On 9/20/22 at 10:18 AM a review of Resident #92's closed medical record was conducted. Review of physician's orders revealed the order for Spironolactone Tablet 25 milligrams to be given every day related to hypertension. The order start date was 6/12/22. Spironolactone is a potassium-sparing diuretic (water pill) that prevents the body from absorbing too much salt and keeps the potassium levels from getting too low. Review of the MDS with an ARD of 6/23/22, Section N, Medications, failed to capture 5 days of diuretics. The resident received Spironolactone on 6/18, 6/19, 6/20, 6/22 and 6/23/22. Review of the MDS with an ARD of 6/29/22, Section N, Medications, failed to capture 5 days of diuretics. The resident received Spironolactone on 6/25, 6/26, 6/27, 6/28 and 6/29/22. Review of the MDS with an ARD of 8/17/22, Section N, Medications, failed to capture 2 days of diuretics. The resident received Spironolactone on 8/2 and 8/6/22. On 9/14/22 at 11:25 AM an interview was conducted with Staff #24, the MDS Resource Coordinator who stated, there was someone else here doing MDS assessments. I personally have not done a lot of the MDS assessments. On 9/27/22 at 11:06 AM with the Interim Director of Nursing (DON) a discussion was held regarding the MDS errors.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on interview and record review, it was determined that the facility failed to provide residents and or resident's responsible party (RP) a copy of their baseline care plan along with a copy of their admission medications. This was evident for 9 (#62, #97, #103, #107, #450, #36, #88, #141, #96) of 54 residents reviewed during the annual survey. The findings include: The baseline care plan is given to residents within 48 hours of their admission and details a variety of components of the care that the facility intends to provide to that resident. In addition to the baseline care plan, residents are also expected to receive a list of their admission medications. This allows residents and their representatives to be more informed about the care that they receive. 1) On 9/12/22 at 10:48 AM an interview was conducted with the responsible party (RP) for Resident #62. The RP was asked about care plan meetings, and she stated, they called me when [he/she] was admitted in April of this year. I had 1 care plan meeting since then. The RP stated she did not get anything in writing when Resident #62 was admitted . She stated she did not get a copy of the care plan and the only papers she received was a bill and a notice of when the next care plan meeting would be. On 9/15/22 at 7:37 AM a record review for Resident #62 was conducted. Both the paper and electronic medical record failed to produce a signed copy of the baseline care plan. There was a baseline care plan that was completed in the electronic medical record dated 4/4/22, but it was not signed. There was no documentation that it was reviewed with the RP. 2) On 9/26/22 at 9:07 AM a record review was conducted for Resident #97. Resident #97 was admitted to the facility in January 2021 with diagnoses including Sepsis due to Methicillin susceptible staphylococcus Aureus, acute exacerbation of COPD, end stage renal disease requiring renal dialysis and type 2 diabetes mellitus with a foot ulcer. Further review of Resident #97's medical record failed to produce a baseline care plan. On 9/26/22 at 11:35 AM the NHA confirmed there was no baseline care plan. On 9/26/22 at 12:15 PM discussed with the Interim Director of Nursing (DON). 3) On 9/23/22 at 8:00 AM a record review was conducted for Resident #103. Resident #103 was admitted to the facility in January 2022 with diagnoses including but not limited to contusion of right hip and repeated falls. Further review of the medical record failed to produce a baseline care plan. On 9/27/22 at 11:06 AM discussed with the Interim DON. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) On 9/26/22 at 11:15 AM a record review was conducted for Resident #107. Resident #107 was admitted to the facility in May 2021 with diagnoses that included nontraumatic subarachnoid hemorrhage, acute respiratory failure, and cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery. Further review of the medical record revealed a baseline care plan was completed in the electronic medical record, however there was no signature on the care plan and no documentation that the care plan was given to the resident or RP for review along with a list of the medications the resident was receiving at that time. 5) On 9/22/22 at 3:43 PM a record review was conducted for Resident #450. Resident #450 was admitted to the facility in December 2021 with diagnoses that included sepsis, type 2 diabetes mellitus and non-pressure chronic ulcer of right lower leg. Further review of the medical record revealed a baseline care plan that was initiated on 12/1/21, however the care plan was not signed by the staff completing the care plan or the resident. There was no documentation that the baseline care plan had been given to the resident along with a list of medications the resident was receiving at that time. On 9/28/22 at 12:15 PM the issue was discussed with the Interim Director of Nursing. 43096 6) On 9/11/22 at 10:39 AM, an interview was conducted with Resident #36's spouse. The spouse stated he/she did not receive any documentation related to Resident #36's care plan on admission, and Resident #36's family stated they did not know his/her plan for treatment. On 9/14/22 at 11:05 AM an interview was conducted with LPN #30. LPN #30 stated, for the new admit assessment, I do full screening, head to toe assessment, verify vaccinations status. I do not give a copy of baseline care plan and copy of medication. Only given when the family member requests it. On 9/16/22 at 1:00 PM, a review of Resident #36 's electronic and paper medical record revealed the baseline care plan of the resident was completed on 7/21/22 without the staff member's name and title. Further review of the medical records showed no evidence to support Resident #36's care plan was reviewed and informed to the resident or resident's responsible party. The concern was shared with the interim DON on 9/28/22 at 1:30 PM. No additional supportive documentation was submitted by the interim DON. 15701 7) Resident #88 was admitted to the facility on [DATE]. Interview of Resident #88 on 9/11/22 revealed he/she recently had a care plan meeting. Resident #88 denied receiving a care plan summary nor a list of medications. Resident #88's medical record was reviewed on 9/12/22. Review of the Peak Baseline Care Plans revealed there was no date that that baseline care plan was reviewed with the resident or a signature that the resident received a copy of the care plan or medication list. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care Conference Note dated 9/9/22 did not include an acknowledgement of the resident being provided a care plan summary or medication list. 8) On 9/14/22 at 11:30 AM, a review of Resident #141's electronic and paper medical records revealed the resident was admitted to the facility on [DATE]. Review of the Peak Baseline Care Plan failed to have the staff member's name, title, and date of completion of the care plan. There was no date that that baseline care plan was reviewed with the resident or a signature that the resident received a copy of the care plan or medication list. The Peak baseline care plan was incomplete and listed as in progress. Further review of medical records revealed no documentation about the facility staff providing information to the resident for the baseline care plan. 44441 9) A review of Resident #96's medical records on 9/22/2022 at 9:29 AM revealed that the resident was admitted to the facility on [DATE] for rehabilitation after neck surgery with a sacral ulcer and a foley catheter (A flexible plastic tube inserted into the bladder to provide continuous urine drainage). A continuous review of the medical record revealed that there was no Peak baseline care plan put in place for this resident. A review of the comprehensive care plan dated (2/1/2021) showed there were no baseline care plans put in place within 48 hours for the sacral ulcer or the foley catheter. The medical record was reviewed with the interim DON on 9/22/2022 at 1:30 PM. The surveyor made her aware that there was only one intervention initiated on 2/1/2021 which did not include interventions for the Foley catheter or sacral wound. Upon request, a copy of the care plan was provided by the DON showing only one care area initiated on 2/1/2021.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation, medical record review, and staff interview it was determined that facility staff failed to develop and initiate comprehensive, resident centered care plans for residents residing in the facility. This was evident for 13 (#10, #27, #97, #34, #49, #62, #107, #141, #1, #38, #63, #95, #99) of 54 residents reviewed during the annual survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) On 9/11/22 at 9:26 AM observation was made of a portable oxygen tank on the back of the wheelchair for Resident #10. There was a nasal cannula attached to the oxygen tank. A nasal cannula consists of a flexible tube that is placed under the nose. The tube includes two prongs that go inside the nostrils to deliver oxygen. On 9/14/22 at 2:10 PM an interview was conducted of Registered Nurse (RN) #3. RN #3 stated she did not know why the resident had oxygen. The surveyor said, even with the nasal cannula wrapped around the back of his chair. RN #3 said, don't know, maybe because dialysis might put it on [him/her] if [his/her] sats (oxygen saturation) drop. On 9/15/22 at 10:30 AM a record review of the vital sign section of Resident #10's electronic medical record revealed documentation that oxygen was used on 1/23/21, 2/12/21 and 1/31/22. Further review of the medical record failed to produce a care plan for oxygen therapy. 2a) On 9/12/22 at 1:08 PM an interview was conducted with Resident #27. Resident #27 was asked if he/she had natural teeth or dentures. Resident #27 stated, I have dentures but they got lost when I went to the hospital. On 9/15/22 at 2:45 PM Resident #27's spouse was in the room and expressed concern to the surveyor about the missing dentures that got lost the evening that Resident #27 fell and was sent to the hospital. Resident #27 stated the dentures were on the floor and they haven't seen them yet. The spouse stated she told the administrator and was told they were being looked for. On 9/16/22 at 8:44 AM a medical record review was conducted for Resident #27. A 8/23/22 nursing admission assessment documented, no teeth - lost dentures at the hospital. The resident was ordered a regular diet, mechanical soft - chopped meat texture, dental soft diet with additional portions. Continued review of the medical record failed to produce an individualized care plan for dentures and what to do for the resident until the dentures were replaced. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b) On 9/15/22 at 2:21 PM a medical record review was conducted for Resident #27. Resident #27 was admitted to the facility in July 2022 with diagnoses that included, but were not limited to, repeated falls, atherosclerotic heart disease, chronic kidney disease and major depressive disorder, recurrent. The resident was hospitalized for 5 days in August 2022 and returned to the facility after being treated for bacteremia and a urinary tract infection. Resident #27 contracted COVID-19 on 8/30/22. Review of the weight section of Resident #27's medical record revealed the resident weighed 130 lbs. (pounds) upon admission on 7/1/22, 130.8 lbs on 7/5/22, 133.6 lbs. on 7/13/22 and 135.6 lbs. on 7/27/22. Review of hospital notes dated 8/19/22 documented the resident's weight at 130 lbs. Review of the nutritional care plan, has potential nutritional problem r/t GERD (related to Gastroesophageal reflux disease) was created by the Healthcare Virtual Assistant on 8/31/22 and revised by the MDS Coordinator on 9/12/22. There were 3 interventions on the care plan; administer medications as ordered. monitor/document for side effects and effectiveness provide, serve diet as ordered. Monitor intake and record q (every) meal and RD to evaluate and make diet change recommendations PRN (when necessary). The care plan was not individualized for Resident #27. There was nothing about a nutritional supplement, nothing about taking weights and how often, nothing about specific foods the resident liked and should be offered and there was nothing about a specific diet. There was no evidence that the resident was involved in the creation of the care plan. The nutrtional problem was documented as related to GERD. There were no interventions related to GERD. 3) On 9/26/22 at 9:07 AM a review of Resident #97's medical record was conducted. Resident #97 was admitted to the facility on [DATE] with a medical history that included, but was not limited to, end stage renal disease that required hemodialysis, sepsis secondary to a diabetic right leg lower extremity ulcer, diabetes mellitus, COPD (Chronic Obstructive Pulmonary Disease), atrial fibrillation and Atherosclerotic heart disease. Further review of the medical record revealed the facility failed to create and implement a care plan for dialysis, wound care, diabetes, COPD, heart disease, pain, activities of daily living, and nutrition. The only care plans created were for activities, safe discharge and actual fall. On 9/26/22 at 11:35 AM the Nursing Home Administrator (NHA) gave the surveyor a paper back that had requested items from the surveyor from the medical record. Care plans were not checked off as provided to the surveyor. On 9/28/22 at 12:15 PM reviewed the concern with the Interim Director of Nursing (DON) who confirmed the finding. 4a) On 9/21/22 at 4:30 PM a review of Resident #34's medical record revealed an activities assessment that was done on 1/20/22. The assessment documented Resident #34 preferred 1:1 activity/visit, liked to watch tv/movies, and liked to watch football. The assessment documented it was somewhat important to go outside to get fresh air when the weather was good; do favorite activities; keep up with the news; listen to music the resident likes and have snacks available between meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An activities comprehensive assessment dated [DATE] documented the same likes with the changes, do my favorite activities; go outside to get fresh air when the weather is good; somewhat important to have snacks available between meals; choose bedtime; listen to music that likes; keep up with the news. Review of Resident #34's care plan, independent/dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t (if dependent) Physical Limitations that was created on 1/21/22 by an activities aide and revised on 2/10/22 by the healthcare virtual assistant (HVA) documented a goal, will participate in activities of choice 1-3 times weekly. Interventions included, Encourage verbalization and socialization during one to one in room visits 1-3 times week and Follow infection control procedures in coordination with nursing. The care plan was not resident centered as it did not correlate with the likes on the activities assessment. Cross Reference F679 4b) On 9/21/22 at 7:39 AM observation was made of Resident #34 lying in bed with bilateral 1/2 side rails up. Review of the medical revealed there was not a care plan for side rails. On 9/22/22 at 7:40 AM GNA #27 was interviewed and asked if the side rails were always up when in Resident #34 was in bed and she said, yes, because [he/she] is a fall's risk and they are always up. Cross Reference F700 4c) On 9/21/22 at 9:20 AM observation was made of Resident #34 in a 45-degree angle in bed with the over the bed tray table in front of the resident. There was scrapple with scrambled egg on top of toast. The butter was not opened and the jelly was not opened. There was a regular plastic cup on the tray, no lid that was sideways and empty. The silverware was still in the plastic sleeve. The resident was pointing to something that the surveyor did not understand. At that time the surveyor asked GNA #57 if she was assigned to the resident. GNA #57 stated she wasn't but she asked what she could do for the resident. The surveyor asked if the resident used utensils and she said yes. She came in the room and got the utensils out of the package and cut the resident's food up. A second observation was made of Resident #34 on 9/21/22 at 10:49 AM. Resident #34 was still in bed, was not wearing TED stockings (support hose as ordered by physician) and was in a hospital gown. The resident's hair was desheveled and the resident had overgrown facial hair. The resident's fingernails were also long. Review of Resident #34's care plan, has an ADL (activities of daily living) self-care performance deficit r/t Dementia, Impaired balance, Limited Mobility had the interventions, check nail length and trim and clean on bath day and as necessary. The care plan was not followed. The care plan was not resident centered as it did not state how often the resident should be shaved. The care plan did not state the feeding assistance required or anything about cuting food up for the resident. Review of physician's orders documented, pt. to utilize [NAME] cup during meals daily as tolerated that was written on 1/28/22 and Staff assist with all meals. The [NAME] Cup is a lightweight, easy-to-grip adapted drinking cup designed to prevent spills. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Use of the Kennedy cup and staff assist with all meals was not included in the care plan. 5) On 9/11/22 at 10:03 AM Resident #49's medical record was reviewed and revealed Resident #49 started Hospice care on 8/7/21. A hospice care plan was created on 9/13/22, which was 13 months after entering hospice. There were only 2 interventions, Assist [name] with any ADL needed and notify [name] of any changes to condition. 6a) On 9/14/22 at 11:06 AM a review of Resident #62's medical record was conducted and revealed Resident #62 had the diagnosis of Alzheimer's disease, senile degeneration of the brain and unspecified dementia with behavioral disturbance. Further review of the medical record revealed Resident #62 wore a wanderguard for wandering beginning in April 2022. A 8/29/22 nursing progress note documented, resident had episodes of wandering. Review of care plans for Resident #62 failed to produce a care plan for wandering. 6b) On 9/12/22 at 10:40 AM an interview was conducted with Resident #62's responsible party (RP). The RP stated, we go once a week each to visit. When I come [he/she] is usually sitting in a chair by the nurse's station. [He/She] is either in [his/her] room asleep in a chair or by the nurse's station. The residents are bored to death. [He/she] worked [his/her] whole life and to do nothing just drives [him/her] crazy. Review of Resident #62's care plans failed to produce evidence that an activities care plan was created for Resident #62. 6c) On 9/12/22 at 10:40 AM Resident #62's responsible party (RP) stated she has been requesting Resident #62 to be seen by dental since admission because his/her dentures did not fit right. A 6/3/22 communication with family note documented, eats well even without [his/her] dentures. A 9/9/22 at 14:37 (2:37 PM) nursing progress note documented, Daughter in to visit during lunch time. Daughter asked for resident to be seen by a dentist due to [his/her] dentures not fitting well and resident unable to eat [his/her] lunch with them in. [name] is aware and gave order for resident to have a dental consult done. Review of care plans for Resident #62 failed to produce a care plan related to dentures. 6d) Continued review of Resident #62's care plans revealed the care plan, has a nutritional problem r/t significant weight change, poor PO intake, in the setting of Alzheimers/dementia with the intervention, provide, serve diet as ordered. Monitor intake and record q (every) meal. Review of GNA tasks for the amount eaten for September 2022 was blank for day/breakfast shift and day/lunch shift on 9/1, 9/2, 9/3, 9/5-9/11, 9/13-9/17, 9/19, 9/20, 9/25 and 9/26/22. For the evening/dinner shift the tasks were blank for 9/1, 9/2, 9/10, 9/11, 9/16, 9/17 and 9/24/22. The care plan was not followed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) On 9/26/22 at 11:15 AM a record review was conducted for Resident #107. Resident #107 was admitted in May 2021 with diagnoses that included, but were not limited to, nontraumatic subarachnoid hemorrhage from intracranial artery, cerebral infarction due to occlusion or stenosis of left middle cerebral artery and acute respiratory failure. On 9/26/22 at 11:15 AM a review of complaint MD00170005 for Resident #107 was conducted. The complainant alleged the staff were not providing appropriate care for Resident #107 and that the resident only had 1 shower since admission to the facility in May of 2021. The resident was discharged from the facility on 9/23/21. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #107's admission MDS with an assessment reference date of 5/29/21, Section G, documented the resident was totally dependent on staff for personal hygiene, bathing, dressing and toileting. Review of Resident #107's activities of daily living (ADL) care plan documented the problem as, the resident has an ADL self-care performance deficit that was initiated on 7/14/21 with 1 intervention, requires mechanical lift with assistance of 2 staff for transfers that was initiated on 7/29/21. The care plan failed to include all ADL care that staff would have a need to know in order to properly take care of Resident #107. Furthermore, the care plan was initiated 8 weeks after admission and the intervention was added 10 weeks after admission. 15701 8) On 9/12/22 at 2:14 PM, Resident #141 was not observed in his/her room and the GNA (Staff #51) revealed the resident was at dialysis. Resident #141's medical record was reviewed on 9/16/22 at 8:15 AM. Resident #141 was admitted to the facility on [DATE]. Review of Resident #141's medical records revealed the resident was diagnosed to have acute renal failure and was receiving hemodialysis three times per week. Review of Resident #141's care plan revealed the plan of care was initiated on 9/7/22 by a Healthcare Virtual Assistant (Staff #78). Review of the resident's care plan did not address care and services related to acute renal failure and scheduled hemodialysis three times per week. On 09/16/22 at 9:03 AM an interview was conducted with the nursing home administrator. She provided information related to the Healthcare Virtual Assistant (HVA). She indicated that the HVA does not meet with the resident or family and the HVA is utilized for paper compliance. She was informed, the resident's care plan was not developed to reflect a resident person-centered care plan due to the omission of care and services for acute renal failure and scheduled hemodialysis. 18819 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9) Depakote is one of the first generation of a class of medications called antiepileptic drugs. Depakote is used to treat complex partial seizures, simple and complex absence seizures, as well as acute manic symptoms in patients with bipolar disorder. During an observation of Resident #1 on 09/11/22 at 9:50 AM, Resident #1 was observed lying in bed apparently talking with someone. Resident #1 was cursing, yelling, and pulling off his/her clothing. There were no family or staff members present in the room. A review of Resident #1's medical record on 09/11/22 revealed that Resident #1 was admitted to the facility on [DATE] with diagnoses that include but are not limited to: diabetes, abnormal posture, macular degeneration, hypertension and dysphagia oral phase. A review of Resident #1's medical record on 09/21/22 revealed Resident #1 was receiving the following antiseizure medication, Depakote, 125 mg., orally, twice daily, for the indication of dementia with behaviors. Further review of Resident #1's medical record failed to reveal a care plan to address a plan, goals, and nursing interventions to address Resident #1's behaviors and possible side effects of the medication. 43096 10) An observation for Resident #38 on 9/11/22 at 9:11 AM and a review of the resident's medical record on 9/15/22 at 2:23 PM revealed that Resident #38 had a left foot wound since his/her admission in July 2022. However, a review of Resident #38's medical record on 9/15/22 at 2:30 PM revealed that there was no care plan related to the resident's left foot wound care. 11) The medical record of Resident #63 was reviewed on 9/21/22 at 11:40 AM. The review of the change in condition report dated 1/10/22 written by a nursing staff revealed that Resident #63 was diagnosed COVID-19 positive on 1/10/22. However, a further review of Resident #63's medical record revealed that there was no care plan related to COVID-19 care. 12a) Review of complaint MD00178416 on 9/23/22 at 7:50 AM revealed that Resident #95 had chronic issues with urinary catheter care and urinary tract infections since June 2022. Further review of Resident #95's medical record documented that Resident #95 was admitted to the facility in May 2022, and a urinary catheter had been in place before the admission due to urine retention. However, further review of Resident #95's medical record revealed that there was no care plan for the urinary catheter. 12b) A review of Resident #95's medical record on 9/23/22 at 9:00 AM revealed that an initial wound assessment was done by [name of company] (contracted wound care team) Nurse Practitioner (NP #91) on 5/16/22. The review of the initial wound assessment revealed that Resident #95 had a pressure ulcer on the left buttock. However, a further review of Resident #95's medical record revealed that there was no care plan related to wound care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13) A review of complaint MD00166828 on 9/26/22 at 10:30 AM revealed that Resident #99 was admitted to the facility in January 2021 for ambulatory dysfunction s/p (status post) fall and transferred to the hospital in February 2021. Also, the complaint report documented that Resident #99 failed to follow the neurologist, no precautions were placed for the fall, and the facility staff did not manage the resident's pain (headache). Resident #99 had pain. Further review of Resident #99's discharge summary from the hospital dated 12/31/20, before being admitted to the facility, revealed that Resident #99 received a VP shunt (a small plastic tube that helps drain extra cerebrospinal fluid from the brain) due to a post-traumatic fall with an accompanying headache. Also, a written note dated 1/1/21 by a telehealth provider (on-call agency provider) that the discharge summary was reviewed and approved. An MDS (Minimum Data Set: a powerful tool for implementing standardized assessment and facilitating care management in nursing homes) assessment dated [DATE] coded pain under J0300. During an interview with Resident #99's Responsible Party (RP) on 9/26/22 at 10:38 AM, the RP stated that Resident #99 had a severe headache since his/her admission. The RP also stated that the facility only ordered Ibuprofen for the resident's headache, and no other intervention was applied. However, a review of Resident #99's care plan on 9/26/22 at 1:00 PM revealed no care plan related to the resident's headache. The surveyor reviewed the resident's care plans with the Interim DON during an interview on 9/28/22 at 1:30 PM. The Interim DON confirmed there was no care plan related to the resident's specific health conditions that needed nursing staff care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on medical record review and interview, it was determined the facility staff failed to 1) review and revise resident care plans to reflect accurate and current interventions, and 2) ensure the full interdisciplinary team including residents and/or their responsible parties were invited to the care plan meetings. This was evident for 10 (#55, #5, #34, #62, #92, #107, #106, #99, #141, #19) of 54 residents reviewed during the annual survey. The findings include: The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes and non-critical access hospitals with Medicare swing bed agreements. The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status which forms the foundation of the comprehensive assessment for all residents (regardless of payer) of long-term care facilities certified to participate in Medicare or Medicaid. Each care plan provides a framework for guiding the review of trigger areas and clarifying a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. These thorough assessments provide the interdisciplinary team additional information to help them develop a comprehensive plan of care. By modifying the care plans provided in this resource, you'll fit the individual needs of your residents while satisfying the requirements of the new assessment process. 1) A review of Resident #55's medical record on 09/26/22 revealed that Resident #55 was admitted to the facility on [DATE] with diagnoses that include but are not limited to diabetes, hypertension, chronic obstructive pulmonary disease, peripheral vascular disease, and bilateral above the knee amputation of the right and left leg. Resident #55 had been assessed as being dependent upon the facility staff for many aspects of his/her care. Resident #55 had a Brief Interview for Mental Status (BIMS) assessment, conducted by a facility staff member, on 08/21/22 during the annual assessment process. Resident #55 was assessed to have a 04/15 score during the annual assessments. A score of 0/15 to 7/15 suggests the resident had severe cognitive impairment. On 08/18/22 a baseline care plan was developed and indicated that Resident #55 was at risk for falls related to gait and balance problems. The goal of the care plan was to: 1) minimize the risks of falls through the review date, and 2) that Resident #55 will not sustain a serious injury through the review. Nursing interventions included: 1) anticipating and meeting the resident's needs, 2) ensuring the bed is in the lowest position, 3) physical therapy to evaluate and treat as ordered and as needed (PRN), 4) The resident needs a safe environment with: keep floors free from spills and/or clutter, adequate glare-free light, a working, and reachable call light, the bed in a low position at night, side rails as ordered, handrails on walls, personal items within reach. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/23/22, the nursing staff initiated an Actual Fall care plan for Resident #55 related to poor safety awareness. The actual fall care plan was revised on 09/06/22 with the following revisions by the healthcare virtual assistant: 1) Resident #55 will resume usual activities without further incident through the review date, 2) ensure that commonly used items are placed within reach, 3) ensure the chair is locked when the resident is in sitting position, and 4) reinforce to call for assistance. Further review of Resident #55's medical record revealed that on 08/18/22 at 6:17 AM, resident #55's nurse documented a change in condition review sheet that indicated Resident #55 was found on the floor by staff members. In the statement, Resident #55 indicated that he/she rolled off the bed. Resident #55 was assessed by the nurse and there were no complaints of pain or injury. A review of the fall incident report only listed one Predisposing Situation Factor as being admitted within 72 hours of the fall. Further review of nursing documentation, dated 09/10/22 at 4:19 PM, revealed Resident #55's nurse documented that staff observed Resident #55 sitting on the floor. Resident #55 informed the nurse that he/she was trying to walk. Resident #55 denied any pain, injury, or hitting her head. Later that evening on 09/10/22 at 8:15 PM, Resident #55's nurse was again made aware by an aide that Resident #55 was again observed on the floor. Resident #55 denied any pain, injury, or hitting her head. Resident #55's physician and the facility administrator were made aware of Resident #55's falls at this time. Resident #55's physician instructed the nurse to obtain some laboratory tests. Further review of Resident #55's medical record revealed a nursing note, dated 09/22/22 at 10:33 AM, indicating that staff observed Resident #55 on the floor again on 09/18/22 around dinner time. Resident #55 stated that he/she had rolled off the bed. Resident #55 complained of his/her left hip hurting at this time. Resident #55 was administered Tylenol at this time. In an interview with the facility interim Director of Nurses (DON) on 09/22/22 at 11 AM, the interim DON stated that there were no facility investigations or root cause analyses of Resident #55's falls that occurred on 09/10/22 at 4:19 PM, 09/10/22 at 10:47 PM, or 09/18/22 at dinner time. Reviews of Resident #55's fall prevention care plan failed to reveal any updates or revisions to prevent Resident #55 from continued falls. 2) In an interview with Resident #5 on 09/12/22 at 2:06 PM, Resident #5 stated that S/he has not attended any care plan meetings in year 2022. A review of Resident #5's medical record on 09/12/22 failed to reveal any documentation that Resident #5 or his/her family had been invited to a quarterly care plan meeting in the year 2022. In an interview with the facility social worker on 09/23/22 at 10:37 AM, the facility social worker stated and confirmed that Resident #5 had not had a care plan meeting in the year 2022. 31145 3a) On 9/14/22 at 10:44 AM an interview was conducted with the responsible party (RP) for Resident #34. The RP stated she was very disappointed in the care at the facility and she was trying to get the resident moved out of the facility. The RP stated the facility, is not responsive at all. Have never scheduled a care plan meeting and [he/she] has been at the facility since January. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/20/22 at 12:51 PM a medical record review was conducted for Resident #34. There was no evidence that a care plan meeting had been held with the interdisciplinary team. Furthermore, there was no evidence that the care plans that were created for Resident #34 were evaluated. On 9/20/22 at 2:42 PM an interview was conducted with the Social Worker, Staff #3. Staff #3 stated she had a care plan meeting with the RP and yes, it was probably just me on the call. Staff #3 admitted that the IDT did not have a care plan meeting with the RP. 3b) Review of the dietary care plan for Resident #34 documented, is at potential nutritional risk r/t need for modified texture diet that was initiated on 1/24/22 and revised on 2/10/22. The interventions on the care plan were, Encourage good hydration by providing fluids with meals and med pass, Encourage good meal intake according to diet order (allow double portions), RD to evaluate per protocol or PRN to provide updated recommendations, and Diet, weights as ordered. There was no evidence in the medical record that the care plan was evaluated and updated to reflect weight loss. 4) On 9/14/22 at 11:06 AM a review of Resident #62's medical record was conducted and revealed Resident #62 had the diagnosis of Alzheimer's disease, senile degeneration of the brain and unspecified dementia with behavioral disturbance. Further review of Resident #62's medical record revealed care plans were in place, however there were no care plan evaluations. 09/13/22 at 12:51 PM an interview was conducted with Staff #3 who stated, I have not been doing written evaluations of care plans. 5) On 9/19/22 at 11:13 AM a review of Resident #92's medical record revealed care plans were in place but there was no evidence that the care plans were evaluated. 6) On 9/26/22 at 11:15 AM a review of complaint MD00170005 documented that it was very difficult to reach staff to coordinate the resident's (Resident #107) plan of care and that there had not been any care plan meetings held for the resident. A review of Resident #107's medical record was void of any care plan meeting notes or documentation that a care plan meeting was held. On 9/26/22 at 2:54 PM the Nursing Home Administrator (NHA) confirmed there were no care plan meeting notes and no evidence of care plan meetings held. On 9/26/22 at 4:57 PM an interview was conducted with Resident #107's responsible party (RP) who stated, there was no care plan meeting. No one was available. Discussed with the Interim Director of Nursing on 9/28/22 at 12:15 PM. 43096 7) The surveyor reviewed Resident #106's medical record for the investigation MD00172868 on 9/26/22 at 1:55 PM. The review revealed that Resident #106 had quarterly MDS assessments completed on 4/9/21, 5/16/21, 8/16/21, 11/15/21, and 2/8/22. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, the review revealed that care plan revisions were not documented on each quarterly MDS assessment. There was no evidence in the medical record that a care plan meeting had been held with the resident and the interdisciplinary team around the time of either quarterly MDS. The Director of Social Services (SS Director) was interviewed on 9/23/22 around 11:00 AM. During the interview, the SS Director stated that the social work department was responsible for scheduling and arranging the care plan meetings. The SS Director further confirmed that there was no evidence of a care plan meeting. 8) A review of a complaint MD00166828 on 9/26/22 at 10:54 AM revealed that Resident #99 was admitted to the facility on [DATE] for ambulatory dysfunction s/p (status post) fall and transferred to the hospital in February 2021. Also, the complaint report stated that Resident #99 failed to follow the neurologist, no precautions were placed for the fall, and the facility staff did not manage the resident's pain. A further review of Resident #99's medical record revealed that Resident #99 had fall incidents on 1/30/21 and 1/31/21. Resident #99's care plan related to high risk for falls was initiated on 1/8/21, including interventions; anticipate and meet the resident's needs, educate the resident/ family/caregivers about safety reminders and what to do if a fall occurs., and treat as ordered or PRN (as needed). However, no care plan revision was documented after the fall incidents occurred. During an interview with the Interim DON on 9/28/22 at 1:30 PM, the Interim DON confirmed that there was no documentation to support that the care plan was revised for Resident #99 related to fall incidents. 15701 9) Resident #141's medical record was reviewed on 9/16/22 at 8:15 AM. Resident #141 was admitted the facility on 9/6/22. Review of Resident #141's medical records revealed the resident was diagnosed to have acute renal failure and was receiving hemodialysis three times per week. Review of Resident #141's medical record on 9/22/22 revealed a care plan meeting was attended by the social worker and the director of rehabilitation along with the resident and resident's family on 9/20/22. Review of the care plan signature sheet failed to indicate that a nurse and a nursing assistant were involved in the meeting. Review of the resident's care plan on 9/22/22 failed to show care planning related to the resident receiving care and services related to receiving hemodialysis three times per week. During an interview with the interim DON on 9/22/22 at 4:29 PM several care area concerns were discussed with review of the medical record. Discussed the documented care plan meeting for Resident #141 on 9/20/22. Review of the care plan with the interim DON shown that there was not a care area related to care and services for hemodialysis. Review of the medical record on 9/26/22 revealed, the nursing home administrator had created a care area related to the resident receiving hemodialysis and interventions related to care. 44441 (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on interview and medical record review it was determined the facility failed to implement effective discharge planning by failing to re-evaluate changes that would have resulted in a resident discharging to another facility. This was evident for 1 (#34) of 3 residents reviewed for discharge. The findings include: On 9/14/22 at 10:44 AM an interview was conducted with the guardian for Resident #34. The guardian stated she was very disappointed in the facility and was attempting to get Resident #34 moved to a different facility. The guardian stated the facility was, not responsive at all, has never scheduled a care plan meeting and [he/she] has been at the facility since January. The guardian stated, all of [his/her] belongings are packed up and sitting next to the bed. On 9/20/22 at 12:51 PM a record review was conducted for Resident #34 and revealed the resident was admitted to the facility in January 2022 with diagnoses that included, but were not limited to, Parkinson's disease, unspecified dementia, mood disturbance, and anxiety. Review of a social service progress note dated 7/27/22 at 12:40 PM, that was a late entry for 6/24/22, documented that a voicemail was received from Resident #34's guardian requesting a referral to be made to [facility name] for Resident #34. The note documented the social worker spoke to the admission director at the other facility, however she stated that the resident would need a COVID-19 booster. It was documented that they would reach out to the facility to see if they could do the resident's booster. The social service progress note dated 7/27/22 also included a late entry for date of service 6/27/22 which documented that an email was sent to the NHA regarding this transfer and needing [his/her] booster. The social service progress note dated 7/27/22 also included a late entry for date of service 7/6/22 which documented, this writer did not hear anything, she emailed the DON (Director of Nursing) [name], on 7/6/22, regarding the booster, she stated she would follow up with the ADON (Assistant Director of Nursing). On 9/20/22 at 2:42 PM the social work director, Staff #3, was interviewed about the status of the transfer to another facility. Staff #3 stated that she was not sure if Resident #34 received the booster shot. Staff #3 also stated she made a referral to another facility and was not sure of the status. She stated she did not document that she made another referral. She stated the other facility was in the same situation, that the resident needed a booster because of a bed shortage. Staff #3 stated the facility had a booster clinic in August. Staff #3 stated she did not have any further information. Further review of the medical record revealed documentation that Resident #4 received a COVID-19 booster on 8/16/22. The facility failed to follow-up with discharge planning. Discussed with the Interim Director of Nursing on 9/28/22 at 12:15 PM.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 31145 Based on interview, medical record review and observation, it was determined the facility staff failed to provide thorough grooming and personal hygiene services for 4 (#34, #107, #38, #5) of 11 residents reviewed for activities of daily living (ADL) care during the annual survey. The findings include: 1) On 9/14/22 at 10:44 AM an interview was conducted with Resident #34's resident representative (RP). The RP stated, I am very disappointed in the care. We are attempting to get [him/her] moved. [Facility name] is not responsive at all. They have never scheduled a care plan meeting and [he/she] has been there since January. [He/she] should be clean shaven. There is always food on [him/her]. All of [his/her] belongings are packed up and sitting next to the bed. On 9/20/22 at 12:51 PM a medical record review was conducted for Resident #34. Resident #34 was admitted to the facility in January 2022 with diagnoses that included, but were not limited to Parkinson's disease, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of physician's orders revealed an order for the resident to utilize a Kennedy cup during meals and for staff to assist with all meals. A Kennedy cup prevents the liquid from spilling out, even when the cup is turned over. There was also a physician's order, that was written on 1/18/22 for support hose (TEDS) on in the morning and removed at bedtime every day. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #34's quarterly MDS with an assessment reference date of 7/20/22 documented that the resident was totally dependent on staff for personal hygiene and bathing, required extensive assistance with dressing and was coded supervision for meals. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of Resident #34's ADL care plan documented, ADL self-care performance deficit r/t Dementia, Impaired balance, Limited Mobility that was initiated on 1/27/22. The care plan documented interventions such as, check nail length and trim and clean on bath day and as necessary. The care plan did not document the amount of assistance that was needed with dressing, failed to document anything related to food and feeding and was not specific as to all ADL needs of the resident. On 9/20/22 at 4:20 PM observation was made of Resident #34 lying in bed. Resident #34's hair was disheveled, and the resident had overgrown facial hair. Resident #34 was wearing a hospital gown. Resident #34's feet and legs were bare. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/21/22 at 9:04 AM observation was made of Resident #34's roommate eating breakfast while Resident #34 was still waiting for a breakfast tray. On 9/21/22 at 9:20 AM observation was made of Resident #34 in bed with the tray table in front of him/her with a breakfast tray on top. There was scrapple with scrambled egg on top of toast. The butter and jelly containers were not opened. There was a regular plastic cup on the tray with no lid. The plastic cup was sideways and empty. The silverware was still in the plastic wrapper. The resident was pointing to something that the surveyor could not understand. At that time the surveyor went into the hallway and asked Geriatric Nursing Assistant (GNA) #57 if she was assigned to the resident. GNA #57 stated she was not, however she asked what she could do for Resident #34. The surveyor asked if the resident used utensils and GNA #57 said yes. The surveyor showed GNA #57 that the utensils were still in the plastic wrapper. GNA #57 got the utensils out of the package and cut the resident's food into bite size pieces. On 9/21/22 at 12:09 PM Resident #34 was observed in bed wearing a hospital gown. Resident #34 had overgrown facial hair, debris under his/her long nails and his/her hair was disheveled. Resident #34's legs and feet were bare. On 9/21/22 at 1:06 PM an interview was conducted with Staff #25 (dietician). Staff #25 stated that she saw the resident on 9/20/22 and she cut up the resident's sandwich and saw the resident get the top of the bread off. I cut it up and [he/she] automatically took the food. I went to the kitchen to go over what finger foods are. [She/He] needs to have wedge like pieces and I wanted to make sure everyone was aware of that. Staff #25 continued, Visually, [he/she] looked like someone I wanted to check in on. On 9/21/22 at 5:00 PM the surveyor requested for the Nursing Home Administrator (NHA) to see Resident #34. With the NHA, Resident #34's room was observed along with the resident. The NHA agreed that Resident #34's fingernails were long, he/she was not shaved, and his/her hair was disheveled. The surveyor asked the NHA what Resident #34 was wearing on his/her feet. Resident #34 was wearing gray slipper socks. Per the physician's orders, Resident #34 was to wear TED stockings. TED (Thrombo-Embolus Deterrent) stockings are also known as compression stockings or anti-embolism stockings. They help reduce the risk of developing a deep vein thrombosis (DVT) or blood clot and help reduce the risk of swelling (edema). Informed the NHA that the past 2 days the TEDS were signed off as worn, when they weren't worn. 2) On 9/26/22 at 11:15 AM a review of complaint MD00170005 for Resident #107 was conducted. The complainant alleged the staff were not providing appropriate care for Resident #107 and that the resident only had 1 shower since admission to the facility in May of 2021. The resident was discharged from the facility on 9/23/21. On 9/26/22 at 1:54 PM a request was made to the NHA requesting a copy of Resident #107's record for showers, bathing, and documentation with assistance with ADLs which would be under the GNA tasks in the electronic medical record system. On 9/26/22 at 2:54 PM the NHA stated there was no documentation found for GNA tasks for showers and bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/26/22 at 3:30 PM an interview was conducted with Staff #89, a previous Director of Nursing, who stated, there were never any issues with this resident's showers, but for other residents, yes. The surveyor informed Staff #89 that there was no documentation of care and she stated, that is because with all the agency they did not chart. There was no evidence provided to the surveyor that ADL care was performed for Resident #107. 43096 3) Resident #38 was observed with uncleaned and long nails on both hands on 9/11/22 at 9:50 AM. The surveyor asked Resident #38 if keeping long nails were his/her preference. The resident answered, no, no one clipped my nails. Also, I asked to shave my face, but one aide said they couldn't do it for me. On 9/16/22 at 8:30 AM, Resident #38's medical records were reviewed. The MDS of the resident, dated 7/20/22, section G-Functional status, coded the self-performance level of Resident #38's hygiene as extensive assistance and one- person physical assist needed. Further review of the GNA tasks records, a part of the medical record, revealed that Resident #38's hygiene was checked off at least once a day by GNAs in September. During an interview with the NHA on 9/16/22 at 10:10 AM, the surveyor shared concerns about Resident #38 not receiving personal hygiene care. 18819 4) In an interview with Resident #5 on 09/11/22 at 10:40 AM, Resident #5 stated that the facility was short-staffed with nursing personnel. During the week you may have 1 to 2 nursing staff members between 30 residents, but on the weekends it is worse. Resident #5 stated that he/she has not received a shower in 2 months and that the administrator is not willing to listen to the residents. A review of Resident #5's medical record on 09/14/22 revealed that Resident #5 suffers from a stroke, left-sided weakness, diabetes, neuropathy, obesity, Atrial fibrillation, and a valve replacement. Resident #5 is dependent upon the facility staff for several aspects of care including transfers, bed mobility, toilet use/incontinence care, and personal hygiene. In an interview with Resident #5 on 09/23/22 at 4:10 PM, Resident #5 stated that he/she called for his nursing assistant, at 10 AM on 09/23/22 this morning, due to needing incontinence care. Resident #5 stated that she/he did not receive incontinence care until just before noon on 09/23/22. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with GNA #50 on 09/27/22 at 1:50 PM, GNA #50 stated recalling being assigned and providing care for Resident #5 during the 7 AM to 3 PM shift on 09/23/22. GNA #50 stated Resident #5 initially called for assistance during the breakfast meal when staff was passing out residents' breakfast meal trays. GNA #50 stated that he/she went to Resident #5's room at this time and Resident #5 requested incontinence care. GNA #50 informed Resident #5 that he/she was passing out meal trays and would return after passing all of the residents' breakfast meal trays. GNA #50 stated that he/she returned to Resident #5's room at approximately 10 AM to bring Resident #5 his/her meal tray. GNA #50 stated that again Resident #5 requested to have incontinence care. GNA #50 stated that he/she left Resident #5's room at this time. GNA #50 stated that he/she returned with GNA #67 and they provided incontinence care to Resident #5. In an interview with GNA #67 on 09/27/22 at 2:57 PM, GNA #67 stated that he/she recalled assisting GNA #50 with providing incontinence care to Resident #5 on 09/23/22. GNA #67 stated that GNA #50 had initiated providing care for Resident #5 before he/she was asked to assist due to the fact that Resident #5 was rude to GNA #50. GNA #67 stated that it took 30 minutes to provide incontinence care and change the linens on Resident #5's bed. GNA #67 also stated that there is a facility policy that staff are not allowed to provide incontinence care when the meal carts arrive on the nursing units and need to be passed out. A review of Resident #5's care plans on 09/27/22 revealed an activity of daily living (ADL) self-performance deficit care plan related to Resident #5's left-sided hemiplegia, stroke, weakness, reduced mobility, left-hand contracture, that was initiated on 08/23/2011. The goal for the care plan was that Resident #5 will maintain their current level of function in participating with ADL's through the review date. Nursing interventions for toilet use instructed the nursing staff that the resident was totally dependent on staff for toilet use. In an interview with the Interim Director of Nurses (DON) on 09/27/22 at 5:05 PM, the facility interim DON stated that he/she was not aware of any policy that instructed the nursing staff not to provide incontinence care to a resident when passing out meal trays.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on interview, observation, and medical record review, it was determined the facility failed to implement an ongoing program of activities based on the abilities, interests and treatment needs of residents that resided in the facility. This was evident for 5 (#34, #62, #36, #5, #45) of 7 residents reviewed for activities and 2 (#9, #63) of 17 residents observed on the Homestead Unit, however affected all residents in the facility. This was evident during the annual survey. The findings include: 1) On 9/13/22 at 12:51 PM an interview was conducted with Staff #3. Staff #3 was asked about activities at the facility. Staff #3 stated, [name], who was the activities director just left 2 weeks ago. He was trying but now there are only 2 activity aides here. He was trying to do things with them, doing crafts and movies. The issue was being given money. There is no budget to do things with the residents. 2) On 9/16/22 at 9:30 AM Staff #27, (activities assistant) was interviewed and stated she had been employed at the facility since June 2022. Staff #27 stated, we do not have a director and the other full timer is suspended pending investigation. Staff #27 stated, no activities happened yesterday. We don't have a budget to do things, like to buy arts and crafts supplies. At the end of the month if there is money left over we get it. The most we spent in a month was $100. We don't have money to have parties like we used to. We can do birthdays and we will go out and buy things with our own money, but we aren't supposed to spend our own money, but if we don't then who will. We try to have activities on the dementia unit. I will go back there to see how it is going and because they are understaffed they can't get people out of bed and they turn me away. If there are people back there we will paint, have bingo, and make bracelets. I have tried to do movies but the DVD player is broke. I'll hand out candy and I paint their nails. I will do 1:1 visits with people but can't do a 1:1 activity. Activities really don't start until 10:30 AM. I don't do logs for 1:1 visits. 3) Observation was made on 9/20/22 at 4:20 PM of Resident #34 lying in bed. In the resident's room to the right of the bed was a television (tv) that was flipped over and lying on its face, the screen. On top of the back of the tv was a French fry and TED stockings (supportive hose). There was a soiled diaper on the floor in front of the closet. There also was a spoon on plastic lying on the floor next to 1 french fry. The curtain was pulled so the resident did not have anything to look at, no activities, no tv on, no radio, just lying in bed staring at the privacy curtain that was pulled in front of the bed and the side walls. A second observation was made on 9/21/22 at 7:39 AM of Resident #34 sleeping in bed. There was a bottle of cleaner spray on the floor. The tv was face down on the table and there was a cup, plate, spoon, and TED stockings lying on the top of the tv. The privacy curtain was pulled in the front of the bed so the resident could not see his/her roommate. At 10:49 AM Resident #34 was in bed and at 12:09 PM Resident #34 was in bed. The tv was not on, there was no radio and there were no books or magazines. At 12:53 PM the resident was out of bed, dressed and sitting in a wheelchair in the dining area with other residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/21/22 at 4:30 PM a review of Resident #34's medical record revealed an activities assessment that was done on 1/20/22. The assessment documented Resident #34 preferred 1:1 activity/visit, liked to watch tv/movies, and liked to watch football. The assessment documented it was somewhat important to go outside to get fresh air when the weather was good; do favorite activities; keep up with the news; listen to music the resident likes and have snacks available between meals. An activities comprehensive assessment dated [DATE] documented the same likes with the changes, do my favorite activities; go outside to get fresh air when the weather is good; somewhat important to have snacks available between meals; choose bedtime; listen to music that likes; keep up with the news. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Review of Resident #34's care plan, independent/dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t (if dependent) Physical Limitations that was created on 1/21/22 by an activities aide and revised on 2/10/22 by the healthcare virtual assistant (HVA) documented a goal, will participate in activities of choice 1-3 times weekly. Interventions included, Encourage verbalization and socialization during one to one in room visits 1-3 times week and Follow infection control procedures in coordination with nursing. The care plan was not resident centered as it did not correlate with the likes on the activities assessment. On 9/21/22 at 5:00 PM the surveyor requested the Nursing Home Administrator (NHA) to accompany the surveyor to visit Resident #34. The surveyor showed the NHA the resident's room along with observing the resident. The NHA was shown the overturned TV with the items on top and how the screen was lying flat on the table. The NHA stated, I told maintenance to take care of that. At that time the surveyor informed the NHA about the resident not having any activities and being in the room in silence. 4) On 9/12/22 at 10:40 AM an interview was conducted with Resident #62's responsible party (RP). The RP stated, we go once a week each to visit. When I come [he/she] is usually sitting in a chair by the nurse's station. [He/She] is either in [his/her] room asleep in a chair or by the nurse's station. The residents are bored to death. [He/she] worked [his/her] whole life and to do nothing just drives [him/her] crazy. On 9/14/22 at 11:55 AM a medical record review was conducted for Resident #62 who was admitted to the facility in April 2022 with diagnoses that included, but were not limited to, Alzheimer's disease, senile degeneration of the brain, and unspecified dementia with behavioral disturbance. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/14/22 at 1:48 PM observation was made of Resident #62 wandering around the locked dementia unit. Resident #62 was following the aide into the nourishment room. In addition to Resident #62, other residents were also wandering around the unit. There were no activities occurring in the unit. Further observations of Resident #62 revealed nurses had the resident sit at the nurse's station or in a chair in front of the nurse's station. Review of Resident #62's care plans failed to produce evidence that an activities care plan was created for Resident #62. There were no activity notes documented in Resident #62's medical record. 5) On 9/14/22 at 2:03 PM Resident #9 went into another resident's room and was going through the resident's closet while the resident was yelling at Resident #9 telling him/her that he/she was rude. The nurse and the GNA were on the COVID unit at that time. The resident was yelling at Resident #9, what are you doing? Resident #9 wheeled him/herself out of the room and went into rooms #320, #322, and across the hall. There were still no activities happening in the unit and no staff to intervene in the behaviors. 6) On 9/15/22 at 10:45 AM one the of GNAs was trying to find an activity for Resident #63 because the resident kept attempting to stand from the wheelchair. There were no formal activities for any of the residents in the Homestead unit. 7) On 9/15/22 at 10:46 AM GNA #12 was interviewed and stated it was probably her fourth time on the Homestead (dementia) unit. GNA #12 was from an agency. She stated, there are no organized activities back here. They used to but they don't do much back here anymore. I do feel bad for the residents because they are on the lockdown unit and these people should be able to do a lot more activities because it is only these hallways. Like [name] is very OCD and it would be nice to give him a big board and something to help calm his behavior. I have worked in a lot of other facilities where there are activities and there really is nothing happening here. 43096 8) During an interview with Resident #36's spouse on 9/11/22 at 10:39 AM, the spouse stated Resident #36 was lying on the bed all day without any interactions. The spouse also mentioned, there was no television either. A review of Resident #36's medical record revealed that Resident #36 was admitted to the facility in July 2022 for s/p (status post) recent fall. Also, the resident had a diagnosis of dementia. On 9/13/22 around 10:00 AM, the surveyor observed that Resident #36 was sitting in the wheelchair by his/herself in the room. A second observation on 9/14/22 around 11:00 AM, the resident was sitting in the wheelchair with the spouse at the activity area near the Wye Oak nursing station watching television. On 9/16/22 at 12:45 PM, the surveyor reviewed Resident #36's medical record related to the resident's activities. The review revealed no documentation regarding Resident #36's activities. The surveyor tried to interview activity staff. However, two other surveyors confirmed that activity assist (staff #27) left the parking lot at 10:30 AM on 9/16/22. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/16/22 at 1:40 PM, Resident #58 reported his/her concerns related to the lack of activities staff. Resident #58 stated that Staff #27 resigned this morning (9/16/22). During an interview with the Interim Director of Nursing (DON) on 9/28/22 at 1:30 PM, the surveyor asked about Resident #36's activities. The Interim DON confirmed that the facility did not have any supportive evidence that the facility provided individual or group activities for the resident. 18819 9) Activities refer to any endeavor, other than routine ADL's, in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence. In an interview with Resident #5 on 09/12/22 at 1:58 PM, Resident #5 stated that the activities in the facility do not meet his/her needs. Resident #5 stated that she/he is young. A review of Resident #5's medical record on 09/14/22 revealed that Resident #5 was admitted to the facility on [DATE] and suffers from a stroke with left-sided weakness, diabetes, neuropathy, obesity, Atrial fibrillation, and a valve replacement. Resident #5 is dependent upon the facility staff for several aspects of his/her care including transfers, bed mobility, toilet use/incontinence care, and personal hygiene. A review of Resident #5's medical record on 09/20/22 revealed a 08/23/21 initiated care plan indicating Resident #5 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physician limitations. The goal of the care plan was that Resident #5 will attend/participate in activities of choice 3 times monthly by the next review date (09/20/22). Staff interventions included: Activity staff will offer 1:1 room activities if Resident #5 is unable to attend out of room events, Activity staff will remind Resident #5 of upcoming activity events and provide him with a monthly activity calendar, ensure that the activities Resident #5 is participating in are compatible with physical and mental capabilities, follow infection control procedures in coordination with nursing, It is important for me to have family or a close friend involved in discussion about my care, Resident #5 needs assistance to activity functions, Resident #5's preferred activities are talking on his cell phone and using it to search the web, reading articles, watching TV, tempt your taste buds, coffee cart, in room visits and special events. Further review of Resident #5's medical record failed to reveal any activity staff progress notes/documentation since 2021. In an interview with staff member #28 on 09/19/22 at 12:09 PM, staff member #28 stated that the activity staff do not know where to document 1:1 visits that the activity staff held with a resident. The activity staff do not have access to a resident's electronic medical record and the activity staff do not write any type of activity progress notes on paper. 2) In an interview with Resident #45 on 09/13/22 at 2:33 PM, Resident #45 stated that he/she would like to do more activities, especially outside of the room activities (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #45 was admitted to the facility in December 2011 with diagnoses that include but are not limited to traumatic brain injury, quadriplegia, peg tube insertion, seizures, suprapubic catheter, dysphagia, and contractures in the extremities. Resident #45 is totally dependent upon the facility staff for all aspects of his/her care. Resident #45 had a Brief Interview for Mental Status (BIMS) assessment, conducted by a facility staff member, on 05/11/22 and 07/28/22 during the quarterly review process. Resident #45 was assessed to have a 15/15 score during both quarterly assessments. A score of 13 to 15 suggests the resident is cognitively intact. A review of Resident #45's care plans on 09/13/22 revealed a 08/18/21 initiated care plan indicating Resident #45 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physician limitations. The goal of the care plan was that Resident #45 will attend/participate in activities of choice 1-3 times weekly by the next review date (11/26/22). Staff interventions included: Activity staff will offer 1:1 room activities if Resident #5 is unable to attend out of room events, Activity staff will remind Resident #45 of upcoming activity events and provide him with a monthly calendar, ensure that the activities Resident #45 is participating in are compatible with physical capabilities, follow infection control procedures in coordination with nursing, Resident #45 needs assistance/escort to activity functions, Resident #45's preferred activities are listening to music, communicating with friends and family via IPAD, watching TV, reminiscing, and playing games on his tablet. Further review of Resident #45's medical record failed to reveal any activity staff progress notes/documentation. Further review of Resident #45's medical record failed to reveal any activity staff progress notes/documentation since August 2021. In an interview with staff member #28 on 09/19/22 at 12:09 PM, staff member #28 stated that the activity staff do not know where to document 1:1 visits that the activity staff held with a resident. The activity staff do not have access to a resident's electronic medical record and the activity staff do not write any type of activity progress notes on paper.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on interview and observation it was determined the facility failed to have an activities program that was directed by a qualified professional. This was evident during the 14 days the surveyors were onsite for the annual survey and had the potential to affect all residents. The findings include: On 9/13/22 at 12:51 PM an interview was conducted with Staff #3 who stated the facility was without an activity's director. Staff #3 stated the activities director had left and the replacement just left 2 weeks ago. He was trying to do things with them, doing crafts and movies. The issue was being given money to do things with the residents. There is no budget. Now there are only 2 activity aides here. On 9/16/22 at 9:30 AM an interview was conducted with Staff #27, an activities assistant, who stated she had been employed at the facility since June 2022. Staff #27 stated, we do not have a director and the other full timer is suspended pending investigation. Staff #27 stated, no activities happened yesterday. Staff #27 stated, When I came, I didn't have a director so there was no direction, and I haven't been trained. I have asked to go to other facilities to be trained and I don't get any help. When [name] was here there was a calendar, and I am going off that, but he is gone. He has been gone about 3 weeks. When I came there was 1 activity a day if that. Staff #27 stated that the Nursing Home Administrator (NHA) knew but didn't have time to talk to the activity staff. Staff #27 stated, I am being thrown out there, I don't know anything, and they are giving me all of these responsibilities. Observations were made throughout the survey, from 9/11/22 to 9/28/22 that there were no organized activities. On a few occasions there were approximately 2 to 4 residents that met in the dining area and did a small activity. There were no organized activities on the Homestead unit (secure dementia unit). Cross reference F679 Discussed with the Interim Director of Nursing on 9/28/22 at 12:15 PM.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaints, reviews of medical records, and staff interviews, it was determined that the facility failed to 1) ensure residents received medications as ordered by the physician, 2) document care given to a resident prior to being transferred to the hospital, 3) follow physician's orders, implement interventions and document when resident had a fall and 4) change a resident's nebulizer tubing and documenting when changed. This was evident for 8 (#45, #27, #92, #34, #97, #38, #36, #19) of 54 residents reviewed during an annual survey. The findings include: 1) In an interview with Resident #45 on 09/13/22 at 2:48 PM, Resident #45 complained that he/she does not receive his/her medications on time. Resident #45 stated that he/she currently has a supra-pubic catheter to urinate because he/she cannot just urinate. Resident #45 stated that he/she needs to make sure the nursing staff administers the bladder antispasmodics on time. Resident #45 stated that he/she is scheduled for another bladder procedure to help relieve the bladder spasms. A review of Resident #45's medical record on 09/15/22 revealed that he/she was admitted to the facility in December 2011 with diagnoses that include but are not limited to traumatic brain injury, quadriplegia, peg tube insertion, seizures, suprapubic catheter, dysphagia, aphasic, and contractures in the extremities. Resident #45 was totally dependent upon the facility staff for all aspects of his/her care. Resident #45 had a Brief Interview for Mental Status (BIMS) assessment, conducted by a facility staff member, on 05/11/22 and 07/28/22 during the quarterly review process. Resident #45 was assessed to have a 15/15 score during both quarterly assessments. A score of 13/15 to 15/15 suggests the resident is cognitively intact. While conducting survey process tasks on the 200 nursing unit on 09/15/22 at 11:41 AM, this surveyor observed Resident #45's family member walked onto the unit and proceed to enter Resident #45's room. Moments later, Resident #45's family member exited the room and walked swiftly to the 200-hall nurses' station. In an interview with Resident #45's family member at this time, Resident #45's family member stated that Resident #45 had not received any of his/her 9 AM medications. In an interview with GNA #67 on 09/15/22 at 11:45 AM, who was also standing at the nurses station, GNA #67 stated that he/she had just answered Resident #45's call bell and informed Resident #45's charge nurse that Resident #45 had not received his/her morning medications. A review of Resident #45's September 2022 medication administration record (MAR) on 09/15/22 at 11:46 AM revealed that Resident #45 failed to receive the following medications timely as instructed by Resident #45's physician: 1) Omeprazole, 20 mg, via G-tube, at 9 AM, for a gastric ulcer. 2) Banatrol, 1 packet, via G-tube, at 9 AM, for loose stools. 3) Carboxymethylcellulose eye gel 1%, to both eyes, at 9 AM, for dry eyes. 4) Clonazepam 0.5 mg, via G-tube, at 8 AM, for seizures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Famotidine, 20 mg, via G-tube, at 8 AM, for gastric reflux. 6) Levetiracetam, 1000 mg, via G-tube, at 9 AM, for seizures. 7) Methscopolamine Bromide, 2.5 mg, via G-tube, at 9 AM, for bladder spasms. 8) Metoclopramide, 5 mg, via G-tube, at 8 AM, for bowel regimen. 9) Metoprolol Tartrate, 25 mg, via G-tube, at 8 AM, for hypertension. 10) Polyethylene Glycol, 17 grams, via G-tube, at 8 AM, for constipation. In an interview with Resident #45's charge nurse (staff member #30) on 09/15/22 at 11:56 AM, Staff member #30 stated and confirmed that he/she had not administered Resident #45's 09/15/22 morning medications to him/her. Staff member #30 stated that he/she usually does not work on the 200 unit and stated that there are many residents on the 200 hall that are heavy and require blood pressures and many medications. Staff member #30 stated that as soon as he/she was done changing another resident's dressing, that he/she would administer Resident #45 his/her medications. An observation of staff member #30 on 09/15/22 at 12:12 PM, staff member #30 entered Resident #45's room with a tray full medications to administer. 31145 2) On 9/15/22 at 2:21 PM a medical record review was conducted for Resident #27. Resident #27 was admitted to the facility in July 2022 with diagnoses that included, but were not limited to, repeated falls, atherosclerotic heart disease, chronic kidney disease and major depressive disorder, recurrent. Review of the medical record revealed a void in documentation from 8/18/22 to 8/23/22. Review of the MDS section of the medical record revealed a discharge return not anticipated assessment that was done on 8/18/22 and then an entry assessment on 8/23/22. A 8/15/22 at 16:08 (4 PM) progress note documented Resident #27 complained of pain and nausea after self transferring between chairs. Tylenol was administered. The next progress note was dated 8/16/22 at 14:01 (2:01 PM) which documented, Change in Condition which had nothing in the note. A Change in Condition Assessment was in the assessment section which documented a fall without injury. A 8/18/22 at 11:13 AM nursing progress note documented a call from the resident's spouse related to a fall. The next progress note in the system was dated 8/24/22. Review of the hospital discharge (d/c) summary dated 8/23/22 documented Resident #27 was admitted to the hospital on 8/18/22 with a chief complaint of fever and malaise. The d/c summary documented the resident had been having falls and had been generally weak. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation of the care that Resident #27 received leading up to the hospitalization . There was no documentaton in the medical record as to what the signs and symptoms were that made the facility staff call 911 to send the resident out. On 9/16/22 at 9:15 AM the Nursing Home Administrator (NHA) was informed there was no documentation about Resident #27's transfer out of the facility. The surveyor expressed to the NHA that it was unknown if the resident was transferred home or sent to the hospital. The NHA stated the resident was transferred to the hospital. Discussed with the Interim Director of Nursing (DON) on 9/28/22 at 12:15 PM. 5) On 9/20/22 at 10:18 AM a review of Resident #92's medical record was conducted. Resident #92 was admitted to the facility in June 2021 with diagnoses that included, but were not limited to, end stage renal disease secondary to vasculitis, on dialysis 3 times per week, chronic anemia, and mesonephric adenoma of the bladder. Review of Resident #92's paper medical record revealed an Advanced Dialysis Center Physicians Order Sheet dated 7/8/22 that documented the order, Change Calcium Acetate to one with breakfast and two with dinner. Calcium acetate is used to treat hyperphosphatemia (too much phosphate in the blood) in patients with end stage kidney disease who are on dialysis. Calcium acetate works by binding with the phosphate in the food you eat, so that it is eliminated from the body without being absorbed. Facility staff noted the order on 7/12/20 which was (4) days later. Facility staff failed to timely follow physician's orders. 6) On 9/20/22 at 4:20 PM observation was made of Resident #34 and his/her room. There was a television on a table that was flipped over on its face/screen. On top of the back of the television was a French fry and a pair of TED stockings. TED (Thrombo-Embolus Deterrent) stockings are also known as compression stockings, anti-embolism stockings, or support hose. They help reduce the risk of developing a deep vein thrombosis (DVT) or blood clot and help reduce the risk of swelling (edema). On 9/21/22 at 7:39 AM observation was made of the TED stockings lying on top of the television. Further observations on 9/21/22 at 12:09 PM revealed the TED stockings were still on top of the television. At 12:53 PM on 9/21/22 the resident was observed out of bed wearing gray slipper socks without TED stockings. Review of physician's orders for Resident #34 documented, Support hose. On in the morning and remove at bedtime. The order was written on 1/18/22. Review of Resident #34's Treatment Administration Record (TAR) for September 2022 documented on 9/20/22 and 9/21/22 that Resident #34 wore TED stockings. On 9/21/22 at 5:00 PM the NHA toured with the surveyor and observed Resident #34. The NHA was asked to note what the resident was wearing on his/her feet. Resident #34 was wearing gray slipper socks and not TED stockings. At that time the NHA was informed that the past 2 days the TED stockings were signed off as worn, when they were not worn. The physician's orders were not followed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) On 9/26/22 at 9:07 AM a review of Resident #97's medical record was conducted. Resident #97 was admitted to the facility on [DATE] with a medical history that included, but was not limited to, end stage renal disease that required hemodialysis, sepsis secondary to a right leg lower extremity ulcer that required to be treated with the medication Vancomycin via IV (Intravenous) which means within a vein. This allows the medicine or fluid to enter the bloodstream right away, diabetes mellitus, COPD (Chronic Obstructive Pulmonary Disease), atrial fibrillation and peripheral vascular disease. Review of the discharge summary from the acute care facility dated 1/19/21 documented, patient will need to follow-up with podiatry within 1 week of discharge and after follow-up with them, they can decide whether patient needs to be on prolonged antibiotic course. Podiatry is a branch of medicine devoted to the study, diagnosis, and medical and surgical treatment of disorders of the foot, ankle, and lower extremity. The discharge summary also documented, please check CBC, BMP, CRP and Vanco trough level on 1/25/21. Further review of the medical record failed to produce a consultation or follow-up visit from podiatry and failed to produce blood tests results for 1/25/22. On 9/26/22 at 11:35 AM the Nursing Home Administrator stated that no labs were found. Cross Reference F770 and F687. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Continued review of the medical record revealed the facility failed to create and implement a baseline care plan that would have directed care until the IDT (interdisciplinary team) met and discussed the care requirements with the resident to create interventions to meet the resident's goals. Furthermore, the facility failed to create and implement care plans for Resident #97's wound care for the vascular diabetic ulcer on the right lower leg, dialysis for Resident #97's end stage renal disease along with nutrition, pain, activities of daily living, heart disease and a respiratory care plan for COPD. Cross Reference F655 and F656. On 9/28/22 at 12:15 PM reviewed the medical record with the Interim Director of Nursing who confirmed the findings. 43096 8) During an interview with Resident #38 on 9/11/22 at 9:50 AM, Resident #38 stated she/he fell from the wheelchair last Wednesday (9/7/22) and hit back and neck. The Resident added she/he had not received treatment or assessment by nursing staff. On 9/14/22 at 10:58 AM, a review of medical record for Resident #38 was conducted. Resident #38 was alert and oriented, and the BIMS (Brief Interview for Mental Status: a screen used to identify a resident's current cognition and to help determine if any interventions need to occur. 13-15 score means intact cognitive response) score was 15/15 on 7/20/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the medical record revealed a written note by Staff #1. Staff #1 wrote a progress note on 9/9/22 at 10:38 AM; Resident stated he/she was ambulating by him/herself using rolling walker to the Bathroom, got dizzy and lost balance and fell to the floor. He/she stated, picked him/herself up, did not hit anywhere, and failed to report the incident to the nurse. However, there was no other documentation for Resident #38's assessment or interventions related to the fall in the electronic medical records. An interview was conducted with Staff #1 on 9/16/22 at 10:10 AM. During the interview, Staff #1 stated Resident #38 reported the fall to the rehab director on 9/9/22, and the fall incident was shared at the facility's risk meeting. Since Staff #1 had ordered the nurse staff to do head to toe assessment, the assessment dated [DATE] was not mentioned as fall evaluation. During an interview with the Rehab director (Staff #54) on 9/19/22 at 8:32 AM, she explained that the therapy team (physical, occupational, and speech therapy) received all of the residents' fall reports and evaluated residents who had a fall. The therapy team identified staff # 54, stated Resident #38's 9/8/22 fall via risk management documentation, and fall assessments were completed in the Rehab's documentation system. Staff #54 submitted a copy of treatment encounter note(s) dated 9/8/22 at 12:38 PM for Resident #38. The form stated, Pt reported having an unwitnessed fall yesterday, 9/7/22 The surveyor reviewed Resident #38's care plan on 9/14/22 at 11:27 AM. The care plan was revised on 9/9/22 under risk for fall-related left foot, and right foot wound/swelling as, Resident #38 had an actual fall related to poor balance on 9/7. On 9/28/22 at 1:30 PM, an interview was conducted with the interim Director of Nursing (DON). Since the Resident's medical record and staff interview had some discrepancies between the fall incident occurred to date and the facility's assessments, the surveyor asked the interim DON about Resident #38's fall. The interim DON stated the assessments and interventions were not applied timely. 9) On 9/20/22 around 11 AM, the surveyor observed Resident #36 was sitting in the wheelchair at the activity area in front of Wye Oak nursing station with the Resident's spouse. Resident #36 had 2x2 gauze dressing above his/her Right temple. Since the Resident had not had the dressing on previous observation (during the week of 9/11/22), the surveyor asked the Resident's spouse about it. The spouse replied the Resident had a fall last week. On 9/21/22 at 8:10 AM, a review of Resident #36's medical record was conducted. There was no written documentation found related to the Resident's fall from the week of 9/11/22 to 9/21/22 in the electronic medical records (PCC). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed Practice Nurse (LPN #7) on 9/21/22 at 8:38 AM, LPN #7 showed the shift-to-shift report binder, used for nurse's handover notes, which included Resident #36's fall on 9/16/22 at 5:45 PM. The note indicated Resident #36 had a small bruise on the Right temple with this fall. LPN #7 also showed a risk manager screen on PCC. *Risk Manager is a part of the facility's medical record which was able to sort on PCC. On 9/21/22 at 9:20 AM, the interim DON confirmed that the data under the risk manager tab was a part of residents' medical records. However, details under the risk manager were not placed under each Resident's chart, and it would be able to activate with a special request. Also, the form named fall report, printed and submitted by LPN #7 on 9/21/22 at 8:38 AM, was marked privileged and confidential- not part of the medical record- do not copy test. The fall report, a part of risk manager documentation, written date 9/16/22 at 5:52 PM, showed Resident #36 was found on the Resident's room floor in a prone position with a face skin tear. Additionally, the skilled nursing evaluation dated 9/16/22 at 7:42 PM and the Pain evaluation dated 9/17/22 at 00:55 AM were linked in risk manager documentation. However, none of them mentioned Resident #36's fall on 9/16/22. During an interview with the interim DON on 9/21/22 at 9:21 AM, the interim DON was asked how to verify Skilled Nursing Evaluation dated 9/16/22 at 7:43 PM and Pain Evaluation dated 9/17/22 at 00:55 AM were related to Resident #36's fall on 9/16/22 or nursing staff's routine assessment. No answer replied from the interim DON. 44441 10) A nebulizer is a small machine that turns liquid medication into a mist. A nasal cannula is a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels, the device has 2 prongs and sits below the nose. On 09/12/22 at 08:03 AM, Resident #19 was observed in his/her room receiving oxygen therapy via a nasal cannula connected to an oxygen concentrator machine. S/he also had a nebulizer machine at his/her bedside table. The tubing on the nebulizer machine was dated 6/12. as the date it was last changed. A review of the resident's medical records revealed that Resident #19 was admitted on [DATE]. S/he was ordered oxygen continuous at 2 Liters/min via nasal cannula (NC) and Ipratropium-Albuterol solution, 1 vial orally via nebulizer every 4 hours as needed for shortness of breath. Further review of the orders revealed an order placed on 6/5/22 at 09:42 AM for Nebulizer tubing, change weekly every evening and night shift every Sat, date and initial tubing, place in a plastic bag at bedside". A review of the Treatment Administration Record (TAR) on 9/12/22 showed that the order was placed on 06/05/22 and was noted that the evening and night shift staff signed off on the (TAR) every week, for the months of June, July, August, and September of 2022 indicating that they change the tubing 25 times since the initiation of the order. The tubing at the bedside table attached to the nebulizer machine was dated 6/12 as confirmed by 2 surveyors on 9/14/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/20/22 at 11:00 AM, the Licensed Practical Nurse (LPN) staff #30 was taken to the resident's room and shown the nebulizer tubing still with the date of 6/12 and asked how often the tubing was ordered to be changed. Staff #30 said that the night shift was responsible for changing the tubing once a week, nightly. S/he took the nebulizer tubing away and trashed it.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on medical record review, observation, and interviews it was determined the facility staff failed to ensure wounds were accurately assessed on admission and failed to provide appropriate treatment and services to promote healing of pressure ulcers. This was evident for 4 (#141, #95, #55, #108) 5 residents reviewed for pressure ulcers. A pressure ulcer, also known as pressure sore or decubitus ulcer, is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). 1) On 9/14/22 Resident #141 was asked about his/her sacral wound and if the wound received treatments. The resident indicated not often enough. Resident #141's medical record was reviewed on 9/14/22. Review of the Peak Admission /Readmission Evaluation Section C, Skin condition revealed Right buttock pressure. Review of a nutritional assessment completed on 9/8/22 revealed the resident had one stage 2 pressure wound. There was not any documentation to reveal wound measurements and/or the status of wounds. Review of the treatment administration record (TAR) on 9/14/22 revealed a prescribed daily cleansing treatment to bilateral buttocks, application of Medi honey, and covered with a border foam dressing. There were daily initials by nursing staff to indicate treatment to the buttock wounds except for 9/9 and 9/13/22. On both days there was a code of #9 that = other/see nurses note. Review of the progress note section did not reveal any notes written on 9/9 or 9/13/22. A baseline care plan in the assessment section of the medical record was shown to be In Progress and not completed. There was not any documentation related to the resident having a wound. Review of the care plan revealed that the care plan was created by a Healthcare Virtual Assistant on 9/7/22. There was a plan of care related to the resident having multiple bruising and scabs on upper and lower extremities but there was not any care plan documentation of the resident having a stage 2 pressure ulcers on the bilateral buttocks. There was a documented goal of the resident's bruises to heal by review date. There was not any documentation in the medical record to indicate the resident was evaluated by a physician since admission. Review of nursing progress note did not reveal any status condition or measurements of buttock wounds. On 9/15/22 at 10:18 AM an interview was conducted with a Certified Registered Nurse Practitioner (Staff #62). She revealed that she was at the facility on Tuesdays and Thursdays to analyze wounds. She revealed that she had not seen Resident #141 to evaluate his/her wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record on 9/16/22 revealed a 9/15/22 note by the wound nurse practitioner with a documented evaluation of the resident's wounds. This evaluation was 9 days after the resident's admission to the facility. The wound nurse documented the wounds were assessed to be bilateral stage 3 wounds on the buttocks. The nurse practitioner documented a prescribed order of, Apply thin layer of Venelex and cover with border gauze BID (2 times per day). Wound care concerns along with other care concerns for Resident #141 was shared with the interim Director of Nursing (DON) on 4/22/22 at 4:29 PM. 43096 2) A review of complaint MD00178416 on 9/23/22 at 7:50 AM revealed that the facility staff did not address Resident #95's wound. An interview with Resident #95's son on 9/23/22 at 8:50 AM revealed the resident had back surgery before being admitted to this facility, and the resident had some bed sore on his/her back which treatment had been started during hospitalization . A review of Resident #95's medical record on 9/23/22 at 9:00 AM revealed that the resident was admitted to this facility on 5/10/22, and an initial wound assessment was done by [name of company] (contracted wound care team) Nurse Practitioner (NP #91) on 5/16/22. The review of the initial wound assessment revealed Resident #95 had a pressure ulcer on the left buttock, dressing change frequency noted twice a day, and dressing noted as other: see note. Further review of Resident #95's progress notes revealed a progress note written by a different NP (Staff #62) on 5/16/22; wound plan of care: see [name of company] documentation for full wound description and recommended nursing plan of care. Plan of care assessment & plan - patient, has a pressure injury; pressure reduction and turning precautions discussed with staff at the time of visit recommended, including heel protection and pressure reduction to bony prominences. The surveyor reviewed Resident #95's medical records (Treatment Administration Record, skin assessment, order summary, and care plan) on 9/23/22 at 9:46 AM. The review of the Treatment Administration Record (TAR) for May 2022 to July 2022 revealed that skin assessment daily was checked off by nursing staff daily starting on 5/11/22. The review of skin assessment revealed there were 3 assessments documented; an assessment dated [DATE] recorded as, skin intact- no, if no, are areas new no and an assessment dated [DATE] recorded as, skin intact-yes, and an assessment dated [DATE] recorded as skin intact- no, if no are areas new- no. Additionally, the review of the order summary for Resident #95 revealed the order of cleanse bilateral buttock/sacral area with normal saline, pat dry, and cover with zinc oxide with no covering was initiated on 6/29/22. There was no order before 6/29/22. A review of Resident #95's care plan revealed no care plan for the resident related to his/her wound care. In an interview with Staff #62 on 9/23/22 at 11:04 AM, Staff #62 stated the facility had had a wound nurse 1 to 2 months ago who did rounds with her, put the order in, and educated nursing staff for the wound care. Staff #62 added that since all the wound nurses left, she communicated directly to the nurses as needed but usually put orders on her note (progress note). Staff #62 stated she expected the nurses to follow the order from her note. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Also, Staff #62 confirmed that the facility had a wound nurse in May 2022. During an interview with the Nursing Home Administrator (NHA) on 9/26/22 at 9:11 AM, the NHA was informed of the above concerns. 18819 3) A review of Resident #55's medical record on 09/26/22 revealed that Resident #55 was admitted to the facility on [DATE] with diagnoses that include but are not limited to diabetes, hypertension, chronic obstructive pulmonary disease, peripheral vascular disease, and bilateral above the knee amputation of the right and left leg. Resident #55 was assessed by the nursing staff on 08/17/22 at 10:18 PM and was only noted with a scar to the groin area (site #24). The rest of Resident #55's skin was noted to be intact. The nursing staff completed a Braden Scale for Predicting Pressure Sore Risk assessment on 08/17/22 at 10:18 PM and assessed Resident #55 to be at a Moderate Risk for developing a pressure wound with a score of 13/18. On 08/19/22 a baseline care plan was developed and indicated that Resident #55 is at risk for skin breakdown related to limited mobility. The goal for Resident #55 will be to maintain or develop clean and intact skin by the review date. Nursing interventions included: encouraging good nutrition and hydration in order to promote healthier skin, to follow facility protocols for treatment of injury, to identify/document potential causative factors and eliminate/resolve where possible, Pad side rails, wheelchair arms or any other source of potential injury if possible, pressure redistributing mattress to bed and a cushion to the wheelchair, to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. In a review of the facility's Skin Assessment policy on 09/26/22 which had an implementation date of 10/01/21 and no revision date, revealed under the heading, Policy: It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. The facility policy also listed: Explanation and Compliance Guidelines: A full body, or head-to-toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. A review of Resident #55's admission orders revealed a physician's order, dated 08/18/22 at 12:29 AM, instructing the nursing staff to perform a skin assessment daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #55's medical record revealed a Nurse Practitioner Wound Consultant note, dated 08/23/22 at 11:15 AM, that indicated Resident #55 was now observed with a Stage II pressure ulcer on the sacrum. The pressure ulcer measured 3.33 cm x 2.68 cm x 8.92 cm. The depth was noted to be 0.10 cm. No odor was noted. The edges were attached. The Nurse Practitioner Wound Consultant indicated the wound was present prior to admission to the facility. Treatment for the pressure wound included: a dressing change to the wound three times a day, a wedge/foam cushion for offloading, and a wheelchair cushion, pressure reduction, and turning precautions were discussed with the staff at the time of the visit, recommended heel protection and pressure reduction to bony prominence's, and the staff was educated on all aspects of care. The Nurse Practitioner Wound Consultant requested to keep the wound site covered and avoid contamination with feces at all times. No documentation was found in the medical record that indicated Resident #55's physician or responsible party was notified at this time. A review of Resident #55's physician assessments, dated 08/18/22 at 3:08 PM, and 08/18/22 at 1:49 AM failed to reveal any documentation that Resident #55 was admitted with a pressure wound. The facility physicians failed to document a skin assessment for Resident #55 on 08/18/22 at 1:49 AM or 3:08 PM. In an interview with Resident #55's responsible party on 09/23/22 at 4:44 PM, Resident #55's responsible party stated that he/she had only been contacted by the nursing staff for a couple of falls. The last phone call from the nursing staff was from yesterday, 09/22/22 for a fall. The staff told me Resident #55 had a fall and was okay. A review of Resident #55's hospital discharge record on 09/26/22 failed to reveal any hospital staff documentation that Resident #55 had a sacral wound upon discharge to the facility on [DATE]. A review of Resident #55 admission MDS assessment, with an ARD date of 08/21/22, revealed section M, Skin Conditions, indicated Resident #55 was admitted without any existing pressure ulcers. A review of Resident #55's August 2022 nursing staff documentation, regarding turning and repositioning every 2 hours, failed to reveal any documentation the nursing staff performed turning and repositioning for Resident #55 on the following days: Friday, 08/19/22 - day and evening shifts. Saturday, 08/20/22 - day shift. Sunday, 08/21/22 - day and evening shifts. A review of Resident #55's August 2022 nursing staff documentation, regarding the percentage of meals eaten, failed to reveal any documentation of the nursing staff had documented percentage of meals consumed for Resident #55 on the following days: Friday, 08/19/22 - breakfast and lunch meals. Saturday, 08/20/22 - breakfast and lunch meals. Sunday, 08/21/22 - breakfast, lunch, and dinner meals. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tuesday, 08/23/22 - dinner meal. In an interview with the facility Nurse Practitioner Wound Consultant (CRNP) on 09/23/22 at 12:40 PM, the facility CRNP stated that he/she is alerted by staff when a resident develops a wound. The facility CRNP also stated that he/she does not write wound orders and that it is the nursing unit managers who do this. Further review of Resident #55's medical record failed to reveal any documented physician order as to what dressing type the nursing staff should apply to Resident #55's Stage II wound after the wound was assessed by the Wound CRNP on 08/23/22 at 11:15 AM. In an interview with Resident #55's physician on 09/28/22 at 10:45 AM, he stated that the facility wound consultant is the practitioner who documents on resident's wounds. The nursing staff is to follow up by contacting the Wound CRNP for any wounds. 44484 4) On 9/21/22 at 11:00 AM Resident #108's medical record was reviewed and revealed Resident #108 was admitted in September 2014, with a diagnosis that included Multiple Sclerosis, Neuromuscular dysfunction of bladder, Quadriplegia (paralysis all 4 limbs), Contractures of Bilateral elbows, ankles, and left hand, and Seizures. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of progress notes documented Resident #108 was sent to an acute care facility on 12/18/20. Review of the discharge MDS with an assessment reference date of 12/18/20 documented in Section M, Skin, that there were no pressure ulcers. Review of progress notes dated 12/23/20 documented that Resident #108 was received back at the facility at 5:30 PM. The note documented that the resident had a pressure ulcer that was a stage 2 on the sacrum and areas on the heels and ankle. Resident #108 was sent back out to the acute care facility on 1/18/21 and returned on 1/22/21. The re-admission assessment documented, 2 skin openings to the left buttocks. opening to left heel. abration to left calf. The physician ordered waffle boots intact to both feet while in bed every shift for skin protection. The physician also ordered for the resident to be turned and repositioned every 2 hours while in bed and weekly skin checks. Further review of the medical record revealed the resident was followed by the wound care nurse practitioner (NP). There were notes from the NP regarding measurements and the status of the wounds dated 1/5/21, 1/12/21, 3/16/21, 3/23/21, 3/30/21, and 4/13/21. Facility staff documented that weekly skin checks were done on 1/6/21, 1/29/21, 3/9/21, 3/11/21, 3/16/21, 3/23/21, 3/30/21, 4/6/21, and 4/13/21. Facility staff failed to do skin checks every week which would have included a description of the wound along with measurements. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Treatment Administration Record (TAR) for March 2021 revealed blanks for floating heals every shift to prevent skin breakdown and waffle boots intact to both feet while in bed on 3/2, 3/8, 3/18, 3/19, 3/21, 3/25 and 3/29/21 during day shift, and on 3/7/21 night shift. Review of the care plan, the resident has actual for pressure ulcer development r/t MS and Immobility had only 2 interventions: monitor/document/report PRN any changes in skin status: appearance, color, wound healing, s/sx of infection, wound size, stage and teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. The care plan for pressure ulcer was not comprehensive for Resident #108. It did not describe the treatments and interventions to promote healing. On 9/23/21 at 12:00 PM an interview was conducted with Staff #62 (nurse practitioner) and she was asked if she remembered Resident #108. After the surveyor showed her photos of the resident's pressure ulcer with a picture of the resident she replied No, I do not remember that resident. On 9/23/21 at 12:30 PM the NHA was informed of the findings.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and interview it was determined facility staff failed to obtain podiatry consultation for a resident as ordered by the discharging physician. This was evident for 1 (#97) of 9 residents reviewed for quality of care during the annual survey. The findings include: On 9/26/22 at 9:07 AM a review of Resident #97's medical record was conducted. Resident #97 was admitted to the facility on [DATE] with a medical history that included, but was not limited to, end stage renal disease that required hemodialysis and sepsis secondary to a right leg lower extremity ulcer that required to be treated with the medication Vancomycin via IV (Intravenous) which means within a vein. This allows the medicine or fluid to enter the bloodstream right away. Review of the discharge summary from the acute care facility dated 1/19/21 documented, patient will need to follow-up with podiatry within 1 week of discharge and after follow-up with them, they can decide whether patient needs to be on prolonged antibiotic course. Podiatry is a branch of medicine devoted to the study, diagnosis, and medical and surgical treatment of disorders of the foot, ankle, and lower extremity. Further review of the medical record failed to produce a consultation or follow-up visit from podiatry. On 9/26/22 at 11:35 AM the Nursing Home Administrator stated that there was no podiatry appointment found in the medical record. On 9/26/22 at 12:15 PM a review of the resident's medical record was conducted with the Interim Director of Nursing, and she was informed of the failure to follow-up with podiatry.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on a resident complaint, medical record reviews, and staff interview, it was determined that the facility failed to ensure that residents with a limited range of motion received the appropriate treatment and services to prevent further decline in their range of motion. This was evident for 2 (Residents #5, #45) of 4 residents reviewed for range of motion. The findings include: 1) In an interview with Resident #5 on 09/12/22 at 1:59 PM, Resident #5 stated that he/she has some movement in his/her left leg but needs more therapy to walk again. In an interview with Resident #5's family member on 09/12/22 at 2:02 PM, Resident #5's family member stated that Resident #5 was only receiving 30 minutes of therapy a day due to his/her health insurance policy when he/she was admitted to the facility, but that was 3 years ago. Resident #5's family member stated that the hospital physician informed Resident #5 that he/she should be able to walk again with continued therapy. A review of Resident #5's medical record on 09/14/22 revealed that Resident #5 was admitted to the facility on [DATE] and suffers from a stroke with left-sided weakness, diabetes, neuropathy, obesity, Atrial fibrillation, and a valve replacement. Resident #5 is dependent upon the facility staff for several aspects of his/her care including transfers, bed mobility, toilet use/incontinence care, and personal hygiene. A review of Resident #5's occupational therapy documentation on 09/13/22 revealed that a physician's order was written on 06/28/22 at 3 PM, instructing the nursing staff to get Resident #5 out of bed at 2 PM for 3 hours and then place Resident #5 back in bed around 5 PM. A second order was written on 08/16/22 instructing the nursing staff to assist Resident #5 into his/her wheelchair to maximize out-of-bed activity performance and ensure the progression of function skills. Reviews of Resident #5's August and September 2022 Treatment Administration Records thru 09/13/22, revealed that the nursing staff documented assisting Resident #5 into his/her wheelchair 8 times. A review of Resident #5's MDS Kardex Report on 09/14/22 at 12:12 PM, failed to list any nursing restorative program interventions to perform with Resident #5. This part of the form was left blank. A further review of Resident #5's medical record revealed a physician's order, dated 07/13/22, instructing the nursing staff to add Resident #5 to the Restorative Nursing Program indefinitely. In an interview with the facility nursing restorative GNA, staff member #67, on 09/20/22 at 7:26 PM, staff member #67 stated and confirmed that Resident #5 was not receiving any restorative nursing services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with a former facility occupational therapist (staff member #55) on 09/27/22 at 8:44 PM, staff member #55 stated that he/she recalled Resident #5 and that upon discharge from therapy services, staff member #55 wrote an order to get Resident #5 out of bed. Staff member #55 stated that the facility did not have a nursing restorative program when he/she stopped working at the facility. 2) In an interview with Resident #45 on 09/13/22 at 2:53 PM, Resident #45 stated that he/she needs more therapy. Resident #45 stated that he/she has a contracture and uses a splint on the left wrist. Resident #45 was admitted to the facility in December 2011 with diagnoses that include but are not limited to traumatic brain injury, quadriplegia, peg tube insertion, seizures, suprapubic catheter, dysphagia, and contractures in the extremities. Resident #45 was totally dependent upon the facility staff for all aspects of his/her care. Resident #45 had a Brief Interview for Mental Status (BIMS) assessment, conducted by a facility staff member, on 05/11/22 and 07/28/22 during the quarterly review process. Resident #45 was assessed to have a 15/15 score during both quarterly assessments. A score of 13 to 15 suggests the resident was cognitively intact. A review of Resident #45's care plans on 09/13/22 revealed a limited physical mobility care plan related to quadriplegia that was initiated on 06/22/20 and revised by the facility's Healthcare Virtual Assistant on 05/19/22. The goal was to keep resident #45 free of complications related to immobility, including contractures, thrombus formation, and skin breakdown, through the next review date. Further review of Resident #45's medical record on 09/13/22 revealed that on 06/22/20, the nursing staff initiated a nursing intervention onto Resident #45's limited physical mobility care plan instructing staff to provide gentle range of motion as tolerated with daily care. Further review of Resident #45's September 2022 treatment administration record (TAR) and the GNA documentation failed to reveal any documentation that facility staff were following the limited physical mobility care plan and providing Resident #45 with a gentle range of motion with daily care. In an interview with Resident #45 on 09/13/22 at 2:35 PM, Resident #45 stated that S/he has not had a care plan meeting in over a year. A review of Resident #45's clinical health record on 09/13/22 revealed that the last time the facility staff held a care plan meeting for Resident #45 was on 11/19/21. In an interview with the facility social worker on 09/23/22 at 10:37 AM, the facility social worker stated that S/he was still looking for any other documentation that Resident #45 had a care plan meeting in the year 2022. In an interview with the facility's restorative nursing assistant (staff member #67) on 09/20/22 at 2:05 PM, staff member #67 stated and confirmed that Resident #45 was not currently receiving restorative nursing services. In an interview with a former facility occupational therapist (staff member #55) on 09/27/22 at 8:44 PM, staff member #55 stated that he/she recalled Resident #45 and that upon discharge from therapy services, staff member #55 wrote an order to get Resident #45 out of bed and for positioning. Staff member #55 stated that the facility did not have a nursing restorative program when he/she stopped working at the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 31145 Based on medical record review and interview it was determined that the facility failed to 1) ensure a resident admitted to the facility with a urinary catheter was comprehensively assessed to continue with a foley catheter and 2) develop a care plan which included the use of the catheter and associated interventions. The failure of the facility to assess the foley catheter usage placed the resident at risk for infection. This was evident for 1 (#103) of 2 residents reviewed for bowel and bladder incontinence during the annual survey. The findings include: On 9/23/22 at 8:00 AM the medical record of Resident #103 was reviewed. Resident #103 was admitted to the facility in January 2022 from an acute care facility following a fall and sustaining a contusion to the right hip. A contusion is an injury that causes bleeding and tissue damage underneath the skin, usually without breaking the skin. Resident #103 also had diagnoses that included, but were not limited to, repeat falls, anemia, cardiomyopathy, and type 2 diabetes mellitus. Review of the 1/25/22 nursing admission assessment documented Resident #103 had a foley catheter. A foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. A 1/26/22 bowel and bladder assessment documented, Indwelling catheter, Does the resident have an indwelling catheter? YES, If the resident has an indwelling catheter is there a plan for removal? No. Bladder status was documented as yes, has an indwelling catheter. A 1/27/22 physician's H&P (history and physical) did not mention about GU (genitourinary) status. Review of hospital notes dated 1/24/22 documented urinary catheter was inserted 1/24/22 at 23:56 (11:56 PM). Indication: immobilization required (trauma/surgery). Review of the entire medical record failed to indicate if Resident #103 had a foley catheter or had urinary incontinence. There was no physician's order for a foley catheter. GNA (geriatric nursing assistant) documentation documented bladder incontinence even though documentation was spotty and not thorough. Review of GNA documentation for January 2022 from 1/25/22 to 1/31/22, all 3 shifts (day, evening, night) revealed there were only 3 times that there was documentation. On 1/26, 1/27 and 1/31 evening shift. All the other days and shifts were blank. For February 2022 from 2/1/22 to 2/4/22 there were blanks on day shift 2/1, 2/2, 2/3, evening shift 2/4 and night shift 2/1/22. Review of complaint MD00175347 alleged that numerous attempts were made to have the resident's diaper changed after being left soiled. It was unknown if the resident was soiled from bowel or bladder. An attempt to contact the complainant on 9/23/22 at 10:50 AM was unsuccessful. (continued on next page)

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Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility also failed to create a baseline care plan for urinary incontinence and/or foley catheter use. On 9/27/22 at 11:06 AM, with the Interim Director of Nursing (DON), a review of the medical record and discussion was held regarding the lack of accurate documentation related to the foley catheter and the resident's urinary continence status. On 9/28/22 at 12:15 PM the surveyor discussed the issue again with the interim DON and she stated she did not have any further information and confirmed the findings with the surveyor.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on a resident complaint, staff interviews, and clinical record reviews, it was determined that 1) the facility failed to ensure a totally dependent resident's tube feeding and hydration nutritional needs were met. This occurred when Resident #45's tube feeding orders were changed without instruction from Resident #45's physician or guidance from the facility nutritionist. These new tube feeding orders were also not monitored. This caused Resident #45 to lose a significant amount of weight (18%) in 2 months which caused Resident #45 harm. Additionally, the facility 2) failed to provide a resident a therapeutic diet, 3) failed to intervene in a timely manner when a weight loss was documented, and 4) failed to re-weigh a resident after a 6 day hospital admission and initiate a physician ordered nutritional supplement. This was evident for 5 (#45, #141, #27, #34, #63) of 12 residents reviewed for nutrition during the annual survey. The findings include: 1) In an interview with Resident #45 on 09/13/22 at 2:43 PM, Resident #45 informed the surveyor that he/she lost weight since the nursing staff was administering Resident #45's tube feeding at a slower rate and was only receiving the tube feeding for 12 hours a day. Resident #45 was admitted to the facility in December 2011 with diagnoses that include but are not limited to traumatic brain injury, quadriplegia, peg tube insertion, seizures, suprapubic catheter, dysphagia, and contractures in the extremities. Resident #45 was totally dependent upon the facility staff for all aspects of his/her care. Resident #45 had a Brief Interview for Mental Status (BIMS) assessment, conducted by a facility staff member, on 05/11/22 and 07/28/22 during the quarterly review process. Resident #45 was assessed to have a 15/15 score during both quarterly assessments. A score of 13 to 15 suggests the resident is cognitively intact. A review of Resident #45's clinical health record on 09/13/22 revealed that on 04/18/22 at 1:13 PM, the nursing staff documented that Resident #45 weighed 133.7 pounds. On 06/21/22 at 3:36 PM, the nursing staff documented that Resident #45 weighed 109.6 pounds. Resident #45 lost 24.1 pounds (18%) from 04/18 thru 06/21/22. A review of Resident #45's previously recorded weights revealed the following: 12/04/21 - 137.7 pounds 02/02/22 - 135.4 pounds 03/01/22 - 131.3 pounds (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A review of the facility weight monitoring policy, (that was initiated on 09/28/2020 and reviewed/revised on 07/08/21) on 09/16/22 at 2 PM, revealed the following initial statement: The facility is committed to maintaining quality care by implementing below weight practice guidelines to maintain adequate nutritional status and assure the standard of practice is met for residents served. Under the weight process guidelines, #4 revealed the following: Interventions will be identified, implemented, monitored, and modified (as appropriate), consistent with the resident's needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status. Resident #45's weight had been stable on the current physician-prescribed tube feeding and hydration orders which were initiated on 11/10/21. A review of Resident #45's 02/21/22 nutritional assessment documented that Resident #45's calculated nutrient needs are being met with tube feeding. Resident #45 has a usual body weight of 130 pounds, a BMI of 20.6, and an ideal body weight of 154 pounds, with a height of 68 inches. On 02/21/22 the facility dietician noted the physician-prescribed tube feeding orders were as follows: 1) Nothing by Mouth (NPO) 2) Product and Rate - Jevity 1.5, to run at 105 ml/hour, over a 12-hour infusion. 3) Volume 1260 ml. 4) Flush - 150 ml water, every 4 hours 5) Total flush over 24 hours (ml) - 900 ml 6) Total volume infused over 24 hours (ml) - 2160 ml 7) Total calories - 1890. 8) Total protein - 80 grams. 9) Total Free Water - 1858 ml On 04/22/22, RN #31 documented a new physician's order to lower Resident #45's tube feeding to the following: Infuse Jevity 1.5, for Nutrition related to gastrostomy status, Formula: Jevity 1.5 Rate: 75 ml/hr., Duration: 12 hours, Volume: 900 ml. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview with the former facility dietician, staff member #63, on 09/20/22 at 12:28 PM, the former facility dietician stated that he/she worked at the facility from February 2022 thru the first week in August 2022 and became aware of Resident #45's significant weight loss that was identified in June 2022. The former facility dietician stated that Resident #45 lost a significant amount of weight in a short period of time with no interventions. The former facility dietician stated that he/she was not made aware when a nurse changed Resident #45's tube feeding orders on 04/22/22. No one contacted me. The former facility dietician stated that there was no communication between nursing and him/her. The former facility dietician stated that the nursing staff also missed obtaining a May 22 weight on Resident #45 which allowed Resident #45's weight to continue to drop. The former facility dietician stated that he/she sent an email to the nursing administration about Resident #45's significant weight loss. The former facility dietician stated, Resident #45 fell through the cracks. After Resident #45's significant weight loss was identified, the former facility dietician stated that the corporate dietician had a meeting with the facility's clinical staff. The former facility dietician stated that he/she would have increased the length of time (duration) of Resident #45's tube feeding and not lowered the rate. Further review of Resident #45's 06/29/22 physician orders, revealed that new tube feeding orders were put into place that instructed the nursing staff to administer Resident #45's tube feeding, Jevity 1.5, one time a day, to infuse at 65 ml/hour over 16 hours from 4 PM to 8 AM. A review of Resident #45's care plans on 09/15/22 revealed a 01/19/2021 focused care plan that indicated Resident #45 needed to gain some weight while receiving tube feeding and flushes. This care plan was revised on 02/14/22 by the facility's Healthcare Virtual Assistant. On 05/10/22, the revised goal for Resident #45 is to tolerate his/her tube feeding and flushes so that he/she is able to gain and maintain weight with a BMI in the range of 22- 25 during the review period. Nursing interventions included: weighing Resident #45 as ordered, monitoring tolerance to TF and flushes, monitoring the need for other nutrition interventions, monitoring and evaluating any weight loss to determine percentage lost, following the facility protocol for weight loss, and if weight decline persists, contact physician and dietician immediately. In an interview with the facility's corporate dietician, staff member #53, the facility dietician stated that he/she recalled having a conversation with the former facility dietician, staff member #63, when Resident #45's significant weight loss was identified at the end of June 2022. The corporate dietician recalled that the former dietician #63 did not recall being informed when Resident #45's tube feeding rate was lowered and that the facility dietician was having difficulty getting answers from staff. The corporate dietician stated that he/she reviewed Resident #45's significant weight loss with the facility clinical team and thought that Resident #45's 06/21/22 weight of 109.6 may have been inaccurate. The corporate dietician stated that he/she was not able to find anything in Resident #45's clinical record as to why Resident #45's tube feeding rate was changed on 04/22/22. The corporate dietician stated that he/she was aware that Resident #45 did have episodes of vomiting and diarrhea and considered that Resident #45 may have had a malabsorption intestinal issue. The corporate dietician stated that she/she had taken Resident #45's significant weight loss to the monthly weight committee (QAPI) in July 2022. Body mass index, BMI, according to CDC.GOV is a value derived from the mass and height of a person. A healthy range is between 18.5 to 24. If your BMI is 18.5-20, you're a bit underweight and can't afford to lose more. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview with the current facility dietician, staff member #25, on 09/20/22 at 9:56 AM, the current facility dietician stated that Resident #45's BMI in February 2022 was documented at 20.5 which was within the normal range for Resident #45. The current facility dietician stated that Resident #45's current BMI, as of the 09/14/22 nutritional assessment, is 17.3. The goal now for Resident #45 is to get his/her BMI above 19. In an interview with Resident #45's physician on 09/20/22 at 9:44 AM, Resident #45's physician stated that he/she was unaware why Resident #45's tube feeding orders were changed on 04/22/22. Resident #45's physician stated that he/she recalled having conversations with staff about Resident #45's weight loss and muscle atrophy in June 2022. Resident #45's physician also stated that Resident #45's family was aware of the weight loss. In an interview with the facility interim Director of Nurses (DON) on 09/28/22 at 6 PM, the interim DON stated that she/he looked into Resident #45's significant weight loss and discovered that RN #31 had discussed Resident #45's diarrhea issue with the former facility dietician, staff member #48, in February 2022 before staff member #48 stopped working in the facility. The interim DON stated that RN #31 had taken it upon himself/herself to change Resident #45's tube feeding orders on 04/22/2022 to help Resident #45's issues with diarrhea without notifying Resident #45's physician. 15701 2) The facility staff failed to intervene in a timely manner when a weight loss was documented for Resident #141. A review of Resident #141's medical record related to nutritional concerns on 9/20/22 at 2:15 PM revealed the resident was admitted to the facility on [DATE]. A nutritional assessment was completed on 9/8/22 by the dialysis dietitian. The dietitian documented weight of 200 pounds (Lbs.) that was taken on 9/6/22. The nutritional summary revealed, Resident is at nutrition risk related to inadequate oral intake with elevated nutritional needs for wound healing and likely inadequate nutrient intake. A review of the vital signs weight section of the electronic health record revealed a second weight was documented on 9/19/22 at 10:03 PM as 160.8 Lbs. by a nurse (staff #47). The electronic health record automatically documented a weight comparison noting a 19.6 % significant weight loss of 39.2 Lbs. Further review of the medical record did not reveal any type of physician or dietician notification. A review of the facility's Weight Monitoring policy dated 9/28/20 with a Reviewed/Revised date of 2/11/21 revealed Weight Analysis: The newly recorded weight should be compared to the previous recorded weight and it further defined significant weight change percentages. All weights are to be entered into the Point Click Care (PCC), under the weights and vital signs portal. Unit Managers and/or ADON to validate prior to PCC entry, with a further indication of physician, dietician, and resident's responsible party notifications of weight gain/loss trends need to be documented by a licensed nurse in the clinical record. Multiple care area concerns were shared with the Interim DON on 9/22/22 at 4:29 PM including the documentation of a 39 Lbs. weight loss without further documentation or physician notification. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 9/26/22 at 12:51 PM the Interim DON had a follow-up discussion and had Staff #47 involved. Staff #47 indicated that she entered a post dialysis weight and apologized for not recognizing Resident #141's significant weight loss. 31145 4) On 9/15/22 at 2:21 PM a medical record review was conducted for Resident #27. Resident #27 was admitted to the facility in July 2022 with diagnoses that included, but were not limited to, repeated falls, atherosclerotic heart disease, chronic kidney disease and major depressive disorder, recurrent. The resident was hospitalized for 5 days in August 2022 and returned to the facility after being treated for bacteremia and a urinary tract infection. Resident #27 contracted COVID-19 on 8/30/22. Review of the weight section of Resident #27's medical record revealed the resident weighed 130 lbs. (pounds) upon admission on 7/1/22, 130.8 lbs on 7/5/22, 133.6 lbs. on 7/13/22 and 135.6 lbs. on 7/27/22. Review of hospital notes dated 8/19/22 documented the resident's weight at 130 lbs. Review of the nursing readmission evaluation dated 8/23/22 at 17:10 (5:10 PM) documented the weight of 135.6 lbs. that was taken on 7/27/22, prior to hospitalization . As noted above, the resident lost 5.6 lbs while hospitalized . The nursing staff failed to re-weigh the resident upon re-admission. A nutritional assessment was done on 8/26/22 by the previous dietician and the weight of 135.6 lbs. on 7/27/22 was also used. The dietician did not order any nutritional supplements. Review of the hospital discharge instructions dated 8/23/22 documented, will need continued nutritional supplement. Review of the weight monitoring policy that was given to the surveyor by the Interim Director of Nursing (DON) on 9/16/22 at 12:30 PM revealed the second paragraph which stated, residents are to be weighed upon admission and/or re-admission, as well as monthly and/or on as needed basis. Under the weight process guidelines, #2 documented, A comprehensive nutritional assessment will be completed by the Registered dietician upon or post admission or re-admission. Assessments should include the following information, b. weight. There was no documentation found in the medical record that the previous dietician requested a more recent weight due to the resident being hospitalized for 6 days. On 9/16/22 at 1:38 PM an interview was conducted with Registered dietician, Staff #25 who stated she has only been at the facility since August 15, 2022 and that she has been training and another dietician was filling in. Staff #25 stated she was officially starting Monday, 9/19/22. Staff #25 stated, I would expect the resident to be weighed when they come back from the hospital. If greater than 3 days I would see the resident. I have not seen [him/her] prior to today. The surveyor showed Staff #25 the nutritional assessment dated [DATE] and that the other dietician used the weight from 7/27/22. Staff #25 stated she would have expected Resident #27 to be weighed and should have used the new weight for the assessment. Staff #25 was also shown the discharge summary from the hospital that stated to continue on a nutritional supplement. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 9/19/22 at 9:03 AM a review of medical record revealed Resident #27 still had not been weighed and the nutritional supplement still had not been addressed. Discussed with the Interim DON on 9/28/22 at 12:15 PM. 5) On 9/21/22 at 9:53 AM a record review was conducted for Resident #34 and revealed the resident was admitted to the facility in January 2022 with diagnoses that included, but were not limited to, Parkinson's disease, unspecified dementia, mood disturbance, and anxiety. Resident #34's medical record revealed the resident weighed 156.6 lbs. (pounds) on 6/21/22 and 145 lbs. on 7/13/22, which was a 7.4% weight loss in 1 month. There was no weight obtained in August 2022. The MDS (Minimum Data Set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #34's quarterly MDS with an assessment reference date of 7/20/22 coded a 7.4% weight loss in 1 month. Review of a nutritional assessment dated [DATE] documented, Patient has significant weight loss of 7.4% within 1 month with weight history 6/21/2022 156.6#, 7/13/2022 145# BMI 22 (normal). RD (Registered Dietician) does not believe recent weight is accurate. RD requested reweight but this has not been obtained. This was documented from the previous RD who was no longer employed at the facility. Further review of Resident #34's medical record failed to produce documentation that the physician or the responsible party were notified of the weight loss. Review of physician's orders for Resident #34 revealed the order, pt. to utilize [NAME] cup during meals daily as tolerated and staff assist with all meals. The physician's order was written on 1/28/22. The [NAME] Cup is a lightweight, easy-to-grip adapted drinking cup designed to prevent spills. On 9/21/22 at 9:20 AM observation was made of Resident #34 in bed with the tray table in front of him/her with a breakfast tray on top. There was scrapple with scrambled egg on top of toast. The butter and jelly containers were not opened. There was a regular plastic cup on the tray with no lid. The plastic cup was sideways and empty. The silverware was still in the plastic wrapper. The resident was pointing to something that the surveyor could not understand. At that time the surveyor went into the hallway and asked Geriatric Nursing Assistant (GNA) #57 if she was assigned to the resident. GNA #57 stated she was not, however she asked what she could do for Resident #34. The surveyor asked if the resident used utensils and GNA #57 said yes. The surveyor showed GNA #57 that the utensils were still in the plastic wrapper. GNA #57 got the utensils out of the package and cut the resident's food into bite size pieces. Resident #34 started picking up the bite size pieces and put them in his/her mouth. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility staff failed to follow physician's orders for a [NAME] Cup. Furthermore, review of Resident #34's Treatment Administration Record (TAR) documented on 9/21/22 that the nurse signed off that Resident #34 utilized a [NAME] Cup at breakfast (8:00 AM) and lunch (12:00 PM) which was inaccurate. On 9/21/22 at 11:16 AM an interview was conducted with Physician #77 who stated, I was not notified of the weight loss. I would have expected to be notified. Since July many nurses have quit their positions. Notifying me and making sure vitals are done and orders are carried out is what we rely on. It is not feasible to check weights myself. We rely on staff. It is an issue as I rely on staff. The time we have to backtrack to see if these things are getting done, we get paranoid. On 9/21/22 at 1:06 PM an interview was conducted with Dietician #25 who stated she had just started at the facility and was in the process of seeing all residents. Dietician #25 stated she saw the resident yesterday and put Resident #34 on weekly weights. Staff #25 stated she cut up the resident's sandwich and saw the resident get the top of the bread off. I cut it up and [he/she] automatically took the food. I went to the kitchen to go over what finger foods are. [She/He] needs to have wedge like pieces and I wanted to make sure everyone was aware of that. Staff #25 continued, Visually, [he/she] looked like someone I wanted to check in on. On 9/21/22 at 1:43 PM a discussion was conducted with the Medical Director about Resident #34's weight loss. The Medical Director stated, the physician should have been notified of the weight loss. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of the dietary care plan for Resident #34 documented, is at potential nutritional risk r/t need for modified texture diet that was initiated on 1/24/22 and revised on 2/10/22. The interventions on the care plan were, Encourage good hydration by providing fluids with meals and med pass, Encourage good meal intake according to diet order (allow double portions), RD to evaluate per protocol or PRN to provide updated recommendations, and Diet, weights as ordered. There was no evidence in the medical record that the care plan was evaluated and updated to reflect weight loss. 43096 3) On 9/21/22 at 1:30 PM, Resident #63's medical records were reviewed for a portion of complaint investigation MD00179202. The review revealed that Resident #63 was initially admitted to this facility in June 2021 with the diagnosis of end-stage renal disease and needed hemodialysis three times a week. Resident #63 was transferred to the hospital due to a condition change on 1/20/22 and readmitted to the facility on [DATE]. Further review of Resident #63's weights and vitals summary revealed that the resident's body weight was 171.16 pounds, post-dialysis on 12/11/21 and 157.08 pounds post-dialysis on 2/4/22. However, no documentation (notification to physician, notification to responsible party, care plan, interventions, dietician note, and skilled nursing note) was found in Resident #63's medical record regarding a 14.08-pound weight loss (12.15%) within 57 days. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview with the Medical Director (Staff # 34) and the Interim DON on 9/21/22 at 1:51 PM, the surveyor asked what the acceptable weight loss for dialysis residents was. Staff #34 stated that even though the acceptable weight loss would be variable depending on each status, less than 5% loss would be acceptable. The surveyor shared Resident #63's case: staying in the hospital for 16 days, weight checked 9 days later after being readmitted , and 12% weight loss recorded. Staff #34 confirmed that the weight change was not usual and stated he expected to be notified. The facility policy, Weight Monitoring with a revised date of 7/8/21 was reviewed on 9/23/22. The policy review revealed: residents are to be weighed upon admission and/or re-admission as well as monthly and/or on as-needed basis. Dietician assessment and follow-up needs to be documented in resident's clinical record. MD (Doctor of Medicine) /RP (Responsible Party) / RD (Registered Dietician) notification of weight gain/loss trends need to be documented by a licensed nurse in the clinical record. The above concern was discussed with the Interim DON on 9/28/22 at 1:30 PM.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on a complaint, reviews of a medical record, and staff interviews, it was determined the facility staff failed to ensure that a resident was provided pain medication when requested and that a resident had ordered pain medication on admission. This was evident for 2 (#5, #98) of 9 residents reviewed for pain management during the annual survey. The findings include: 1) A review of complaint MD00181990 on 09/11/22 revealed an allegation that residents in the facility were not receiving their medications. In an interview with Resident #5 on 09/12/22 at 2 PM, Resident #5 stated that he/she did not receive any pain medication for 3 days, due to being unavailable, after being readmitted to the facility on [DATE]. A review of Resident #5's medical record on 09/14/22 revealed that Resident #5 suffers from a stroke, left-sided weakness, diabetes, neuropathy, obesity, Atrial fibrillation, chronic pain, and a cardiac valve replacement. Resident #5 is dependent upon the facility staff for several aspects of care including transfers, bed mobility, toilet use/incontinence care, and personal hygiene. Resident #5 was sent to the hospital on 08/30/22 for complaints of chest pain. Review of Resident #5's hospital discharge summary revealed the hospital physician instructed Resident #5 to continue taking the following medications: 1) Tylenol, 1000 mg, orally, every 8 hours as needed for pain. 2) Oxycontin ER, 10 mg, orally, twice daily. 3) Oxycodone, 5 mg, orally, every 6 hours as needed for pain. A review of Resident #5's September 2022 Medication Administration Record (MAR) on 09/14/22 revealed that Resident #5 did not receive a dose of Oxycontin or Oxycodone from 09/01/22 until 09/05/22. In an interview with the facility pharmacy manager on 09/15/22 at 2:05 PM, the pharmacy manager stated that the nursing staff failed to obtain a signed controlled substance form, C-II form, from Resident #5's physician. The pharmacy received a physician-signed C-II form on 09/04/22, for Resident #5's Oxycontin and Oxycodone. In an interview with RN #16 on 09/20/22 at 1:58 PM, RN #16 stated that Resident #5 ran out of his/her Oxycontin and Oxycodone again. RN #16 stated he/she was able to obtain a physician-signed C-II form for both medications and faxed them to the pharmacy. In an interview with Resident #5 on 09/20/22 at 3:35 PM, Resident #5 stated that the facility ran out of his/her pain medication again. Resident #5 stated that the nurses gave him/her Tylenol, but the Tylenol does not relieve his/her pain and that currently his/her pain is a 9/10. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44441 2) On 9/19/22 at 09:50 AM Resident #98's closed medical record review revealed that the resident was admitted to the facility on [DATE] at approximately 5:30 PM after neck surgery. The resident also has a history of chronic pain and used narcotics (a drug that relieves pain) at home. A review of the new admission order revealed an order written on 8/26/21 for Oxycodone 30 mg. Immediate release (fast acting) for pain every 4 hours as needed (PRN). A review of the medical record revealed that upon Resident #98's arrival at the facility, s/he requested pain medication, but the facility could not guarantee when the pain medication would be available for the resident. A review of the progress note written by the former administrator on 8/27/21 at 1:33 PM stated that He called 911 early AM to go to the hospital since his pain meds were not in the facility. The Director of Nursing (DON) was made aware that there was a complaint allegation that a resident was in the facility and did not get his/her pain medication as ordered, the resident called 911 and was taken back to the hospital. The DON was asked about the process for obtaining medications not available in the facility. S/he explained that medications not available could take up to 4-6 hours for delivery from the pharmacy. Upon request, she provided a list of narcotic medications stocked by the facility on 9/20/22 at 3:10 PM. A review of the list of narcotic medications stocked by the facility for the month of September 2021 revealed that oxycodone 30 mg. Immediate release was not listed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on observation, record review, administrative policy review, and interviews, it was determined the facility failed to assess residents for risk of entrapment from bed rails, obtain informed consent, and ensure bed rails were properly installed prior to the utilization of side rails for any resident. This was evident for 3 (Resident #141, #34, #36) of 9 residents reviewed for accidents during the annual survey. The findings include 1) Resident #141 was admitted to the facility on [DATE]. Upon initiation of the survey on 9/11/22 Resident #141 was observed daily lying-in bed with bilateral half-side rails in the up position. A review of the medical record on 9/22/22 revealed that the Peak Side Rail Evaluation was initiated by a Healthcare Virtual Assistant (Staff #78) and was not completed and was not signed by a nurse in the facility. The Peak Fall Risk Assessment was listed as In progress and was not completed. Informed consent for use of the side rails was not obtained. There was not a physician's order for use of side rails. A review of the resident's plan of care did not reveal a plan of care for the use of side rails. The medical record did not reveal documentation for utilization and/or purpose for the use of side rails. Review of the facility's policy, Proper use of bed rails which was reviewed and revised on 7/25/22 by Clinical Services documented the following: -Resident assessment must include an eval of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. -The resident assessment must also assess the resident's risk from using bed rails. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. -The facility will attempt to use appropriate alternatives prior to installing or using bed rails. -If no appropriate alternatives are identified, the medical record should include evidence of the following: -Purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful -Assessment of the resident, the bed, the mattress, and the rail for entrapment risk. The facility failed to follow its own policy related to the use of bedside rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31145 2) On 9/21/22 at 7:39 AM observation was made of Resident #34 lying in bed with bilateral 1/2 side rails in the raised position. On 9/21/22 at 4:30 PM a medical record review was conducted for Resident #34 and revealed a recent side rail assessment had not been done. The last side rail assessment was done on 4/15/22. The 4/16/22 bed safety review documented the resident had behavioral symptoms that may place them at risk for accident hazards. The hazard was cognitively impaired. The resident's level of consciousness/cognition was disoriented x 3 at all times. It was documented that the resident was not able to communicate their needs due to cognitively impaired. It was documented that the resident did not have a fall within the last 6 months. This was an inaccurate assessment as further review of the medical record revealed the resident had a fall on 2/18/22 on the floor beside the bed and on 3/27/22 had a fall from the wheelchair. Additionally, on 4/20/22 the resident was found on the floor on [his/her] backside trying to get off floor. On 7/8/22 the resident had a fall on the floor in front of the bed. A side rail consent dated 1/21/22 checked off 1/4 partial rail to the left and right upper and were recommended at all times when the resident was in bed. Checked off was a release schedule of during meals, during activities and during supervised visits. There was a bullet point for consent that documented, I do consent to the use of side rail(s) recommended above. I understand that I have the right to refuse the use of side rail(s) or can revoke this consent at any time. It was signed by a nurse on 1/21/22. It was not signed by the responsible party (RP). It was noted the nurse no longer worked at the facility. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of the MDS assessment with an assessment reference date (ARD) of 7/20/22 documented the resident was extensive assistance with 2 people for bed mobility, however, was extensive assistance with 1 person on the 6/25/22 assessment. On 9/22/22 at 7:40 AM an interview of geriatric nursing assistant (GNA) #12 was conducted and she was asked if Resident #34 always had bed rails up when in bed. GNA #12 stated, yes, because [he/she] is a fall's risk and they are always up. On 9/22/22 at 7:42 AM a review of the electronic and paper medical record revealed a blank form for consent for use of bed rails. There was no physician's order for the side rails and no care plan for the side rails. There was no documentation in the medical record of an evaluation of the alternatives that were attempted prior to the use of the side rails. There was no signed consent from the resident representative prior to the use of side rails. There was no assessment of the bed, the mattress, or the risk of entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/22 at 11:13 AM an interview was conducted in Resident #34's room with the Director of EVS (environmental services) and Maintenance, Staff #19, and the Regional Director of Plant Operations. Staff #19 was asked if he had a process in place to check side rails. Staff #19 stated he would have to check. He has only been in the position for the past 2 weeks. 43096 3) On 09/19/22 at 7:56 AM, a review of Resident #36's medical record was conducted. Resident #36's medical record revealed that the resident was admitted to the facility in July 2022 for rehabilitation after a bone fracture. Further review revealed Resident #36 had an order of side rails/guard rails ordered by attending Physician #76. The [spouse] is requesting side rails for safety purposes. Order date 7/25/22. However, further review of Resident #36's medical record revealed there was no assessment for side rail use, no consent for bed rail use, and no evaluation related to bed rail use. On 9/19/22, around 10:00 AM, the surveyor observed Resident #36 lying in bed with quarter bed rails up on both sides. During an interview with Licensed Practice Nurse (LPN) #49 on 09/19/22 at 12:30 PM, she stated that a consent form, resident assessment, and Physical & Occupational therapy consult were required for bed rail use. On 9/19/22 at 12:40 PM, the surveyor requested a copy of the policy for the bed rails. At 12:48 PM on 9/19/22, the Nursing Home Administrator (NHA) submitted the bed rail policy and stated, I knew that we did have an issue with bed rail use. Nothing was done for that. The surveyor shared concerns regarding Resident #36's bed rail use. During an interview with the Medical Director and the Interim Director of Nursing (DON) on 9/28/22 at 5:00 PM, the medical director confirmed that bed rails should be considered as a physical restriction. Also, he stated that Resident assessment, consent, and rails functioning tests are required.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on record review, staff interview, and observation, it was determined that the facility failed to ensure a physician supervised the care of a resident, as evidenced by the physician failing to evaluate a resident upon admission to the facility and failure to review a resident's weight loss. This was evident for 2 (#99, #106) of 33 complaints reviewed and 1(#34) of 12 residents reviewed for nutrition during the annual survey. The findings include: 1) On 9/26/22 at 10:54 AM, a review of the complaint MD00166828 revealed that Resident #99 was admitted to the facility on [DATE] for ambulatory dysfunction s/p (status post) fall. Further review of the medical record identified that a telehealth provider wrote the initial patient and medication assessment on the admitted with detail; patient has just arrived at this facility today and is awaiting full initial evaluation by primary team. [agency company name] is consulted today to check on patient status and to review medications and orders. However, there was no attending physician's assessment record about Resident #99 in the paper chart or electronic medical record until the resident was discharged from the facility on February 2021. During an interview with the interim Director of Nursing (DON) on 9/26/22 at 12:20 PM, she explained that the telehealth was an on-call coverage provider who worked holidays or weekends while the attending providers were off. The surveyor asked the interim DON whether the telehealth note was considered a primary physician's assessment or not. The interim DON confirmed, no, the on-call staff is just on call. The attending physician needs to assess residents. 2) On 9/26/22 at 1:55 PM, a portion of investigating complaint MD00172868 revealed Resident #106 was admitted to this facility on 2/6/21 for a subacute therapy-related recent fall. Further review of the medical record showed that a telehealth provider wrote a brief note for Resident #106's admission on the same day. Also, the admission note was written by an attending Nurse Practitioner (NP #49) on 2/11/21. However, there was no physician's history and physical assessment note related to Resident #106 in a paper chart or electronic medical record. The interim DON was advised of the concern on 9/28/22 at 1:30 PM regarding the attending physician's initial assessment/documentation was not recorded for newly admitted residents. The interim DON confirmed that physician's records were not found in the resident's medical records. 31145 3) On 9/21/22 at 9:53 AM a record review was conducted for Resident #34 and revealed the resident was admitted to the facility in January 2022 with diagnoses that included, but were not limited to, Parkinson's disease, unspecified dementia, mood disturbance, and anxiety. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34's medical record revealed the resident weighed 156.6 lbs. (pounds) on 6/21/22 and 145 lbs. on 7/13/22, which was a 7.4% weight loss in 1 month. Further review of Resident #34's medical record failed to produce documentation that the physician or the responsible party were notified of the weight loss. Review of physician's visits in the medical record failed to document that the resident had been seen by a physician since 6/23/22. On 9/21/22 at 11:16 AM an interview was conducted with Physician #77. Physician #77 looked in his tablet and stated he saw Resident #34 on 7/20/22. The surveyor informed Physician #77 his progress notes were not in the medical record. Physician #77 said that the notes should be there and he would have his office send them over. Cross Reference F711. The weight taken on 7/13/22 was documented in the medical record under the vital sign section. Physician #77 stated, since July many nurses have quit their positions, notifying us and making sure vitals are done and orders carried out is what we rely on. It is not feasible to check weights myself. I came here to put my time in and I have added [name of facility] and we rely on staff. It is an issue. I rely on staff. We were not notified of that weight. The time we have to backtrack to see if these things are getting done, we get paranoid. Review of Physician #77's 7/20/22 visit for Resident #34 documented, follow-up of chronic medical conditions and to establish care. Under the vital sign section of his note, height and weight were blank. The physician's plan documented, reviewed care with staff. I came to establish care with the patient. I see no changes at this time. The patient is stable and appears comfortable and in no distress. Physician #77 failed to thoroughly review Resident #34's medical record and failed to recognize the 7.4% weight loss in 1 month. The concerns were reviewed with the Interim Director of Nursing on 9/28/22 at 12:15 PM.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on medical record review and staff interview it was determined the physician progress notes were not in the resident medical records the day the resident was seen. This was evident for 6 (#105, #94, #141, #10, #34, #450) of 54 residents reviewed during the annual survey. The findings include: 1) Resident #105 was admitted to the facility on [DATE]. Resident #105's closed medical record was initially reviewed on 9/26/22 in relation to complaint MD00173347. A review of the resident's attending physician (staff #76) documentation revealed a History and Physical Note with a Visit date of 4/27/21 that was electronically signed on 5/2/21 and uploaded to the electronic medical record on 5/5/21. Continued review of Resident #105's medical record for the attending physician's notes revealed one SOAP Note with a visit date of 8/5/21, signed on 8/8/21 and uploaded to the electronic medical record on 8/11/21. On 9/27/22 an interview of the Nursing Home Administrator (NHA) was conducted at 1:13 PM. She was informed of an approximately 3-month gap of the lack of Resident #105's attending physician notes in the medical record. On 9/27/22 at 5:25 PM 7 printed physician notes electronically signed by Staff #76 were received. Additional interview of the NHA on 09/28/22 at 9:30 AM revealed that the attending physician's 7 notes were never in the resident's medical record. 2. Resident #94 was admitted to the facility on [DATE]. Resident #94's closed medical record was initially reviewed on 9/26/22 in relation to complaint MD00175387. A review of the medical record revealed that the attending physician's notes were not in the electronic medical record on the day the resident was seen. The following note examples were documented by Resident #94's attending physician (staff #76) A physician's progress note with an effective date of 2/24/22 at 10:23 AM had a created date of 3/2/22 at 13:48 [1:48 PM]. A physician's progress note with an effective date of 3/10/22 at 16:01 had a created date of 3/18/22 at 11:00 AM A physician's progress note with an effective date of 3/15/22 at 18:49 had a created date of 3/24/22 at 12:46 PM. A physician's progress note with an effective date of 4/5/22 at 19:21 had a created date of 4/12/22 at 23:30. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's progress note with an effective date of 4/26/22 at 4:19 AM had a created date of 5/2/22 at 18:08. 3) Resident #141 was admitted to the facility on [DATE]. Resident #141's medical record was initially reviewed on 9/11/22. On 9/12/22 at 10:00 AM Resident #141 was observed to receive a visit from a physician (staff #77). The doctor was interviewed at 10:16 AM. He revealed that he was an independent contractor and began resident visits a few times per week beginning at the end of July 2022. Review of Resident #141's medical record on 9/14/22 did not reveal any physician notes. On 9/15/22 at 9:50 AM Staff #77 was re-interviewed. The doctor indicated that he had seen/visited the resident on 9/7, 9/8, and 9/12/22. The doctor was informed that his notes were not found in the resident's medical record. Review of the resident's medical record on 9/20/22 revealed that a note was created by the doctor (staff #76) that was listed as the resident attending physician on 9/16/22 at 13:56 for an effective date of visit as 9/14/22 at 18:14. It was documented in the progress note that staff #77 was the writer, as the note was electronically signed on 9/16/22 at 12:05 AM. An interview was conducted with the Nursing Home Administrator at 1:40 PM on 9/20/22. She reviewed the attending physician's note and called the physician (Staff #76) at 1:45 PM. The call was on speaker and the attending physician indicated that he did not write the note. He acknowledged that the writer's name (staff #77) was documented in the body of the progress note. The doctor was informed of the new doctor's visit notes were not documented in the medical record for the three visits prior to 9/14/22. On 9/21/22 paper copies of the new doctor's visits were provided and placed on the hard chart (paper). A physician's History and Physical note with a documented visit date of 9/7/22 at 4:10 AM was electronically signed on 9/9/22 at 11:04 AM. A physician Soap note with a documented date of visit on 9/12/22 at 10:00 AM was electronically signed on 9/12/22 at 11:10 PM. 31145 4) On 9/15/22 at 10:30 AM a review of Resident #10's medical record was conducted and revealed that the attending physician's notes were not in the electronic medical record on the day the resident was seen. There were physician visit notes dated 1/6/22 and 4/19/22, however there were no other notes in the electronic or paper medical record. 5) On 9/20/22 at 12:51 PM a review of Resident #34's medical record was conducted and revealed that the attending physician's notes were not in the electronic medical record on the day the resident was seen. A physician's progress note with an effective date of 1/17/22 had a created date of 1/21/22. A physician's progress note with an effective date of 1/20/22 had a created date of 2/2/22. A physician's progress note with an effective date of 2/14/22 had a created date of 2/21/22. A physician's progress note with an effective date of 2/21/22 had a created date of 2/24/22. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's progress note with an effective date of 3/2/22 had a created date of 3/8/22. A physician's progress note with an effective date of 3/14/22 had a created date of 3/21/22. A physician's progress note with an effective date of 6/23/22 had a created date of 6/30/22. On 9/21/22 at 11:16 AM an interview was conducted with physician #77. Physician #77 was asked why he had not seen the resident since 6/23/22 and he looked in his tablet and stated that he saw the resident on 7/20/22 and the nurse practitioner saw the resident on 8/28/22. Physician #77 was informed that his physician's visit was not in the medical and he said it should be and his office staff could send the note over. Physician #77 stated that the notes are entered into an electronic medical record and were sent from his office to the facility to be uploaded. On 9/21/22 at 1:43 PM the Medical Director was informed of the failure to get the physician's notes into the resident's electronic medical record. 6) On 9/22/22 at 3:43 PM a review of Resident #450's medical record was conducted and revealed that the attending physician's notes were not in the electronic medical record on the day the resident was seen. A physician's progress note with an effective date of 12/2/21 had a created date of 12/8/21. A physician's progress note with an effective date of 2/10/22 had a created date of 2/16/22. A physician's progress note with an effective date of 3/3/22 had a created date of 3/9/22. A physician's progress note with an effective date of 12/7/21, 12/23/21 and 1/4/22 was not in the medical record. Upon surveyor request on 9/28/22 at 9:54 AM, the NHA returned the request paper and documented that the Medical Director was getting the physician visit notes for the surveyor. Once the physician visit notes were received it was noted that the 3 physician's visits were printed on 9/28/22 at 11:00 AM and given to the surveyor. They were not in the medical record. On 9/28/22 at 12:30 PM the concerns were discussed with the Interim Director of Nursing.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview it was determined the physician failed to see a resident once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. This was evident for 4 (#62, #10, #102, #107) of 54 residents reviewed during the annual survey. The findings include: 1) On 9/15/22 at 9:21 AM a review of Resident #62's medical record was conducted. Resident #62 was admitted to the facility in April 2022. There were physician visits dated 4/5/22, 4/21/22, 5/17/22, and 8/31/22. The resident was not seen in June 2022 or July 2022 as there were no physician visits found in the electronic or paper medical record. 2) On 9/15/22 at 10:30 AM a review of Resident #10's medical record was conducted. Review of physician visits revealed visits dated 1/6/22 and 4/19/22. There were no other physician visit notes in the electronic or paper medical record. 3) On 9/23/22 at 7:30 AM a review of Resident #102's medical record was conducted. Resident #102 was admitted to the facility on [DATE]. There was no physician's history and physical or any type of physician's visit within the first 30 days of admission. On 9/23/22 at 12:36 PM the Nursing Home Administrator (NHA) brought information to the surveyor and confirmed there was no physician's history and physical or any type of physician's note within the first 30 days of admission. 4) On 9/26/22 at 11:15 AM a review of Resident #107's medical record was conducted. Resident #107 was admitted to the facility on [DATE]. There was no physician's history and physical or any type of physician's visit within the first 30 days of admission. On 9/26/22 at 2:54 PM the NHA gave the surveyor copies of items requested and there were no physician's visits. On 9/28/22 at 12:15 PM the concern was discussed with the Interim Director of Nursing.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on documentation review, resident, family and staff interview, observation, and review of Resident Council meeting minutes, it was determined that the facility failed to have sufficient nursing staff to meet the needs of the residents. This was evident for 9 of 22 complaints submitted to the Office of Health Care Quality (OHCQ), the regulatory agency, 10 (#30, #65, #64, #38, #20, #58, #19, #88, #44, #45) of 10 interviewable residents, 2 (#62, #34) of 3 family interviews conducted, multiple observations, 3 of 3 resident council meeting minutes reviewed and review of staffing schedules and employee time punches. This deficient practice had the potential to affect all residents. The findings include: 1) Nine out of twenty-two complaints that the Office of Health Care Quality (OHCQ) received and reviewed on this survey alleged the facility did not having sufficient nursing staff to provide essential care to the residents that resided at the facility. Complaints consisted of geriatric nursing assistants (GNAs) having 20 to 30 residents to take care of during any given shift. There were concerns that the residents were not receiving timely care and not receiving showers, that residents on the dementia unit (Homestead) were placed in double diapers. 2) Review of the Resident Census and Conditions CMS 672 form that was completed by the Interim Director of Nursing during the annual survey indicated that 82 of the 88 residents in the facility were either totally dependent on nursing staff for toileting or required the assistance of one or two nursing staff for assistance with toilet use. It was also documented that 85 of the 88 residents in the building were dependent on staff for bathing, 83 residents were totally dependent or required assistance of 1 to 2 staff for dressing, 78 residents required assistance for transferring and 58 of the 88 residents were either totally dependent or required assistance of 1 or 2 staff members for eating. There were 77 residents documented with occasional or frequent incontinence of the bladder and 70 residents documented with occasional or frequent incontinence of the bowel. 3) Resident interviews: 3a) On 9/11/22 at 8:40 AM Resident #58 was interviewed and stated, there is low staff especially on Fridays and Monday mornings. One nurse worked 3 days straight, never went home. 3b) On 9/11/22 08:56 AM an interview was conducted with Resident #65 who stated, they are short staffed. There are long wait times when you call for staff. 3c) On 9/11/22 at 9:50 AM Resident #38 stated that it takes a long time to get help. 3d) On 9/11/22 at 10:02 AM Resident #64 complained of long call bell wait times to the surveyor. Resident #64 stated, I am miserable all the time. I need something for anxiety. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3e) On 9/11/22 Resident #20 stated there was a lack of help/staffing. Medications are not given on time. The resident stated that yesterday, he/she got their 8 AM medications at 3:15 PM. Resident #20 stated that call bell wait times were 3 to 4 hours long. Resident #20 stated, I need assistance getting up. There is no staff to help me. 3f) On 9/11/22 at 11:16 AM Resident #88 stated, one woman was here for 24 hrs. Resident #88 did not know her name. Resident #88 stated, the staffing shortage is ridiculous. Resident #88 stated that he/she had not gotten his/her medications on occasion and repeated that staff were at the facility for a long time and another person was there for 18 hours. Resident #88 stated, the biggest problem is staffing. 3g) On 9/11/22 at 11:19 AM Resident #19 stated, staff do not show up for work. They come and don't do any work. We put call bells on, but they don't come. Sometimes it may take up to 4 hours. I need to go home to a different Rehab. 3h) On 9/12/22 an interview was conducted with Resident #30. Resident #30 complained, always low staff, took forever to receive care. They (staff), not doing their job, nobody cared about residents, blame game each other (staff). 3i) On 9/12/22 at 12:42 PM Resident #44 stated, they are overworked and underpaid. Not enough staff. 3j) On 9/13/22 02:30 PM Resident #45 stated, it takes staff a long time to answer my call bell. 4) Staff Interviews: 4a) On 9/13/22 at 7:40 AM an interview was conducted with Staff #18 who worked part time. When asked about staffing Staff #18 stated, when we have 2 Geriatric Nursing Assistants (GNAs) on the 11:00 PM to 7:00 AM shift it is doable. When we have 1 GNA it is hard because we have to watch Resident #62, one resident defecates on sheets and smears it all over all night long and when the aide is in there cleaning up and I have a resident out here who falls, and I need help getting them up or someone else needs something. Staff #18 stated, I also have to go on the COVID unit with 5 people and I have an IV back there. On the 3:00 PM to 11:00 PM shift we always need 2 GNAs. We have had 1. I was told to watch Resident #62. I have to be creative with Resident #62 to keep [him/her] in my sight while I do things. Staff #18 stated, there are no activities on 3-11. Sometimes when we come on duty there are 5 people up and the rest are in bed for their nap. What is the point in getting everyone else up when you have to watch Resident #62. We also have another resident that attempts to go in the pantry, so you have to watch him. 4b) On 9/13/22 at 7:50 AM Staff #14 stated, I have the COVID unit. I pass my meds over here, watch Resident #62, the door buzzer, answer the phones, and feeders. On the COVID unit they feel isolated, so you have to spend extra time over there. Activities is sporadic during the day. Staff #14 stated, it is a lot because yesterday in the corner of the dining room Resident #62 pulled his/her pants down and had a BM, there were feeders, and taking care of COVID residents who are isolated. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff #14 stated that Resident #62 was on 1:1 observation while awake due to behaviors yesterday, however the resident was sitting on the side of the bed eating breakfast and there was no one else in his room. Staff #14 stated, I am keeping an eye on [him/her] because they have not sent /anyone back to sit with [him/her], and I do not have a med aide today, so I have to pass all the meds today. 4c) On 9/13/22 at 8:24 AM an interview was conducted with Staff #17 (agency staff). Staff #17 was asked about staffing and stated, treatments don't get done, patients are not getting the proper care. The GNA's not doing rounds effectively. On my shift 11-7, the GNA's tell me about the dates on the dressings. There are 1 to 2 GNAs at night. Two is doable, but 1 GNA for 29 patients is not and that happens 3 out of 4 nights per week. On 9/13/22 at 8:39 AM an interview was conducted with Staff #88 who stated there was a common complaint that residents were desperate for a shower or therapy. They have gone through several administrators. The wait to get changed is a common complaint. 4d) On 9/13/22 at 12:00 PM Staff #26 also stated that there were no activities, nothing for the residents to do. She stated, we are short staffed, and I worked by myself 2 Sundays ago and had 18 residents. We don't have supplies and the nurses are doing 2 wings on 3-11 and 11-7. 4e) On 9/13/22 at 12:51 PM an interview was conducted with Staff #3 who stated, Yes, I have staffing concerns in the facility, lack of staff nursing, GNA's. Basic care not getting done. Getting a lot of complaints from staff and residents and I send to administration and the response is will look into it. When asked if she feels they will look into it she stated, no. She said, there is no guidance for nursing. Staff #3 stated the current interim DON was the regional nurse and was not full time. I don't know who is heading the nursing department. They do work with 1 GNA on the unit. I have not helped with bedside care, maybe meal trays. I hear call bells ringing a long time. 4f) On 9/13/22 at 2:20 PM an interview was conducted with Staff #49, the nursing scheduler. Staff #49 went through the schedule on the computer with the surveyor to show how to tell who actually worked. Staff #49 had only been at the facility for 1 month. Staff #49 stated that prior to her coming a lot of nursing supervisors left and it has been a struggle to keep the schedule full. She did confirm that a nurse worked 24 hours straight because another nurse failed to show up and she didn't have anyone to give her keys to. 4g) On 9/15/22 at 1:50 PM Staff #12 stated, I have 4 residents on the COVID unit and 6 residents on the Homestead unit. It is a lot because the 6 residents on the Homestead unit are total care and 2 residents on the COVID are total care. I still have to get to the COVID unit to do the 2 residents over there. It is hard because I have to help pass trays, watch the resident that keeps trying to stand out of the wheelchair and the one resident that keeps peeing on the floor and the man in the wheelchair keeps yelling help. We got him up today because his bottom was sore. Someone also called out over here today. 4h) On 9/16/22 at 9:15 AM a conversation was held with the Nursing Home Administrator (NHA). Staffing on the Homestead unit was discussed and the NHA was informed of all the observations the surveyor had made. The NHA stated they were meeting the 3.0 Patient Per Day hours (a state requirement for staffing levels). The surveyor informed the NHA that the federal staffing regulation was not being met because the needs of the residents were not being met. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4i) On 9/27/22 at 1:17 PM an interview was conducted with Staff #7. I have seen double diapering because day shift brought it to my attention. This was back in March 2022. Staffing was awful 3-11, 11-7 throughout. GNA's were doing double shifts. There were 1 or 2 nurses for the whole building. The schedules don't reflect that. There were times there was only had 1 aide. One night there were multiple callouts. We all came together to help for 3-11 shift. The med pass was late and routine meds were not given. Staffing is a little better because Mill Landing is closed and there are not as many on Homestead. 5) Family and Resident Responsible Party (RP) Interviews: 5a) On 9/12/22 at 10:44 AM Resident #62's RP was asked if she had any staffing concerns. The RP stated, if there is 1 person at the front desk of the Homestead unit it is a good day. If there are 2 it is shocking. There is always someone new there. [Resident #62] is never changed out of [his/her] clothes. We will know what [Resident #62] is wearing when we leave and in the same outfit when we come back. They don't bathe, encourage to brush teeth, and don't put [him/her] in pjs. My brother will when he visits. 5b) On 9/14/22 at 10:44 AM Resident #34's responsible party (RP) stated, I am very disappointed in the facility. We are attempting to get [Resident #34] moved. [Facility name] is not responsive at all. Have never scheduled a care plan meeting and [Resident #34 has been there since January. The RP stated that Resident #34 should be clean shaven. There is always food on [him/her]. 6) Observations: On 9/13/22 at 12:00 PM observation was made in the Homestead nursing unit, which housed residents with cognitive impairments that required a secure, safe unit. Resident #9 was in a wheelchair and was trying to push the doors open to the COVID unit. GNA #26 was passing lunch trays and could not answer the call bell that was going off in the COVID unit. On 9/14/22 at 12:09 PM a male resident walked into the nourishment room on the Homestead unit that was not locked. He came out at 12:12 PM. Meanwhile, Resident #9 was trying to get into the covid unit via wheelchair. The male resident drank an ensure that he got out of the nourishment room and then was looking through the food cart that was delivered on the unit and still sitting in the hallway. On 9/14/22 at 12:24 PM Resident #9 went through the double doors onto the COVID unit and in the hallway. Staff had to get the resident out of the unit. At 12:27 PM Resident #9 opened the COVID unit doors again and got in the unit, and the doors closed behind him/her. Resident #9 made it down the hallway until staff could get him/her out. There were 2 GNAs on the unit, 1 for a 1:1 for Resident #62. The nurse was walking a family member to the door and working with the physician, and the other GNA was attempting to pass lunch trays. Resident #9 was constantly moving around the unit via wheelchair by self-propelling with his/her feet. In addition, the phone was ringing while the surveyor was sitting at the nurse's station observing activity on the unit. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	While sitting at the nurse's station observing the unit, the call bell was ringing in room [ROOM NUMBER], the room of a new admission, from 12:35 PM to 12:52 PM, which was 17 minutes. Resident #9, at 12:36 PM came out of the COVID unit. The surveyor missed seeing the resident enter the unit. At 12:43 PM Resident #9 opened the COVID unit doors again but turned around. At 12:54 PM Resident #9 opened the COVID unit doors. At 12:57 PM Resident #9 was eating a roll and managed to go through the doors of the COVID unit and made it halfway down the hall. The doors were closed to resident rooms on the unit. Resident #9 was in the hallway for 2 minutes until staff got him/her out of the unit. At 12:59 PM a resident was coughing in the dining area. There were no staff in the dining area at that time. At 1:48 PM there were residents wandering on the unit. Resident #62 followed an aide into the pantry while Resident #9 was grabbing gloves off a medication cart. The phone was ringing, and a visitor wanted to be let out of the unit via the secure door. A code was needed to get off the unit, therefore staff had to open the door. The unit had just received a new admission. There were no activities at that time on the unit. On 9/14/22 at 2:03 PM Resident #9 went into another resident's room and was going through the resident's closet while the resident was yelling at Resident #9 telling him/her that he/she was rude. The nurse and the GNA were on the COVID unit at that time. The resident was yelling at Resident #9, what are you doing? Resident #9 wheeled him/herself out of the room and into room [ROOM NUMBER], #322, and across the hall. There were still no activities happening in the unit and no staff to intervene in the behaviors. On 9/15/22 from 10:10 AM until 10:41 AM (31 minutes) the call bell was ringing in room [ROOM NUMBER] in the Homestead unit. There were only 3 residents up and there were no activities. At 10:28 AM a male resident helped himself to apple juice from the drink cart. From 10:44 AM to 11:15 AM (31 minutes) the call bell was ringing in room [ROOM NUMBER]. At 10:45 AM one the of GNAs was trying to find an activity for Resident #62 because the resident kept attempting to stand from the wheelchair. On 9/15/22 at 11:48 AM on the Homestead unit the lunch trays were delivered in the food truck. There was 1 GNA on break and there were 2 call bells ringing, of which (1) was on the COVID unit. The secured doorbell was also ringing at the same time. Staff started passing lunch trays at 12:01 PM. On 9/21/22 at 12:11 PM observation was made in the Homestead unit of Resident #11 sitting on other side of dining room table adjacent to where his/her breakfast tray was still sitting on the table. Resident #11 was still in a hospital gown. The meal cart was in the unit. There were only 3 residents up. The Admissions Director was on the unit helping to pass lunch trays at 12:15 PM. The resident census was 17 and there was no one on the COVID unit since Friday 9/16/22. 18819 7) A review of the Resident Council minutes from the past three meetings (08/30/22, 08/05/22, 07/26/22) on 09/13/22 at 10:18 AM revealed continued complaints of a lack of staffing in the facility. The Resident Council documented the following unresolved issues: 08/30/22 - Poor staffing is still an issue, but it is mainly an issue on the weekends. 08/05/22 - The social worker is too busy to be involved in the resident's needs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	07/26/22 - Poor staffing is still an ongoing issue. Residents are not bathed or getting showers. Obtaining assistance from nursing assistants is still an ongoing issue. During the Resident Council meeting held on 09/13/22 at 10:18 AM, the residents complained of still not getting showers, staff will answer a resident's call light and then leave the room and never come back to assist the resident. 8) In an interview with Resident #5 on 09/11/22 at 10:40 AM, Resident #5 stated that the facility is short-staffed. During the week you may have 1 to 2 staff members between 30 residents, but on the weekends it is worse. Resident #5 stated that he/she has not received a shower in 2 months and that the administrator is not willing to listen to the residents. A review of Resident #5's medical record on 09/14/22 revealed that Resident #5 suffers from a stroke, left-sided weakness, diabetes, neuropathy, obesity, Atrial fibrillation, and a valve replacement. Resident #5 is dependent upon the facility staff for several aspects of care including transfers, bed mobility, toilet use/incontinence care, and personal hygiene. In a follow-up interview with Resident #5 on 09/23/22 at 4:10 PM, Resident #5 stated that he/she called for his nursing assistant for assistance at 10 AM this morning due to needing incontinence care. Resident #5 stated that she/he did not receive incontinence care until just before noon. Cross reference F 684 43096 9) During an investigation of complaint MD00175354, it was revealed that Resident #58 submitted concerns to OHCQ about low staffing. The submitted complaint included the resident's brief had not been changed from 1/15/22 till the evening shift on 1/16/22. On 9/23/22 at 9:00 AM, the surveyor requested a copy of the actual working staff and employee punch report from 1/15/22 to 1/17/22. At 12:30 PM on 9/23/22, the Nursing Home Administrator (NHA) brought a copy of the employee punch report and stated the facility did not have an actual nursing staff list for January 2022 . Also, she confirmed that the facility used employee punch reports for the agency nursing staff's attendance. On 9/23/22 at 12:42 PM, the NHA reported the facility census: 110 on 1/15/22, 109 on 1/16/22, and 109 on 1/17/22. On 9/23/22 at 3:30 PM, the surveyor reviewed the GNAs task report on January 2022 for Resident #58. The report included data for Resident #58's Activities of Daily Living (dressing, eating, locomotion off unit, locomotion on unit, personal hygiene, toilet use, incontinence bowel, transferring, bathing, ambulation, bed mobility, walk in room, walk in corridor, and incontinence bladder). However, there was no documentation on Resident #58's GNA task report from 1/13/22 to 1/18/22 to support the facility GNA's provided care to the resident. During an interview with the interim Director of Nursing (DON) on 9/28/22 at 1:30 PM, the surveyor discussed the low staffing issue in January 2022.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 31145 Based on review of employee files and interview, it was determined that the facility failed to put a system in place to ensure Geriatric Nursing Assistant's (GNA's) were competent with their skills sets. This was found to be evident for 3 out of 3 GNA (GNA #37, #44 and #45) employee files reviewed for competencies and skill sets. The findings include: On 9/20/22 at 9:32 AM a review of GNA employee files were conducted for GNA #37, #44 and #45. The review of employee files did not reveal documentation that indicated the GNA's had completed their competency skills and techniques to safely provide care to the residents. During an interview conducted on 9/20/220 at 11:26 AM, Staff #20, (Director of Human Resources) stated, I have not seen any yearly reviews since I have been here. I have not seen evidence of yearly evaluations or training. They did not have anything in place. On 9/20/22 at 11:38 AM an interview was conducted with the Nursing Home Administrator (NHA), the Interim Director of Nursing (DON) and Staff #7. The Interim DON stated, we do not have a Staff Developer. We had a DON and ADON and 2 managers. She stated they had a DON from June 6, 2022 to August 31, 2022 and they hired an ADON in the middle of August 2022 that only lasted for 2 weeks. She said she knew everything about what to do and then she quit. Now we have hired a new DON that is starting in 2 weeks and we are in the process for interviewing and recruiting for an ADON. The Interim DON stated, with the nursing shortage most of the GNAs are all agency. All GNAs are certified. Yearly performance reviews are supposed to be done but they are not being done. We don't have a lot of regular staff. The interim DON confirmed that competency skills and techniques were not done.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 31145 Based on review of resident medical records and interview with staff, it was determined that the facility failed to develop a plan of care that addressed the needs of a resident with dementia. This was evident for 1 (#62) of 2 residents reviewed for dementia care. The findings include: Resident #62's electronic and paper medical record was reviewed on 9/15/22 at 9:21 AM. During the review, it was found that the resident was diagnosed with unspecified dementia with behavioral disturbance, Alzheimer's disease and senile degeneration of the brain. Resident #62 was receiving medications such as Memantine, Seroquel and Depakote that were used in treating those diagnoses. The resident's care plan was reviewed for inclusion of goals and interventions that addressed the resident's needs related to his/her dementia diagnosis. No care plan topic was found that addressed dementia, and review of the interventions for other care plan topics failed to reveal interventions that addressed the needs of a dementia resident to achieve a high quality of life with meaningful relationships and engagement. Dementia is a general term used to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells. On 09/12/22 at 10:40 AM an interview was conducted with Resident #62's responsible party who stated, when I come [Resident #62] is usually sitting in a chair by the nurse's station. [Resident #62] is either in [his/her] room asleep in a chair or by the nurse's station. [Resident #62] worked [his/her] whole life and to do nothing just drives [him/her] crazy. On 9/28/22 at 12:15 PM the interim Director of Nursing confirmed the findings.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on complaint reviews, medical record review and interview, it was determined that the facility failed to provide residents with needed Social Work services to meet the resident's needs such as seeking ways to support residents' individual needs through the assessment and care planning process. This was evident for 4 (#107, #34, #5, #45) of 54 residents reviewed during the annual survey and had the potential to affect all residents. The findings include: 1) On 9/26/22 at 11:15 AM a review of complaint MD00170005 related to Resident #107 was conducted. The complaint alleged the staff lacked communication with Resident #107's responsible party and it was difficult to reach staff to coordinate the resident's plan of care. The complainant reported that the facility was short staffed, the Social worker left and the part time Social Worker didn't return calls. On 9/13/22 at 8:39 AM an interview was conducted with Staff #88 who stated, it is difficult to reach the social worker. There was a big issue trying to reach the social worker to get the ball rolling on a resident's discharge. A review of Resident #107's medical record was void of any care plan meeting notes or documentation that a care plan meeting was held. On 9/26/22 at 2:54 PM the Nursing Home Administrator (NHA) confirmed there were no care plan meeting notes and no evidence of care plan meetings held. On 9/26/22 at 4:57 PM an interview was conducted with Resident #107's responsible party (RP) who stated, there was no care plan meeting. No one was available. Further review of the medical record revealed the first social work note in the electronic medical record was dated 7/19/21 which was 2 months after admission. On 9/13/22 at 12:51 PM an interview was conducted with Staff #3, Social work Director, who stated, I am here 2 days a week. Staff #3 was asked if she was able to get all of the social service assessments done. Her response was, I try, I try to do 50%. She stated, Fridays are my care plan days here. I am here Tuesdays and Fridays. Staff #3 stated she is also providing social services at another (sister) facility. Staff #3 stated, I thought I could handle both places. When Staff #3 was asked if she attended Quality Assurance meetings she stated, I do not attend because they are not held on days that I am here. Staff #3 was asked, what kind of interaction do you have with resident to resident interactions? Staff #3 stated, I have not been involved with any of that. I would think I should be but I don't know if it is because I am not here everyday. Staff #3 was asked if she was involved in writing evaluations for care plans related to social services. Staff #3 stated, I have not been doing written evaluations of care plans. Staff #3 was asked if she discussed advance directives when residents were admitted , such as living wills or Power of Attorney. Staff #3 stated, I don't. If they ask I can. I usually do not have a discussion about Advance Directives. I don't do that, health care options. Cross Reference F578 (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff #3 stated, I try to do social histories on new admissions. Fridays are completely taken up by care plan meetings. One day I had 10, so my day is shot and that only leaves me Tuesdays. I have UR (utilization review) meetings on Tuesdays, so there are many times I don't leave here until 8 pm and there is a lot that I miss. I try to hit the important stuff. I probably miss a good portion of what I am supposed to do. 2) On 9/14/22 at 10:44 AM an interview was conducted with the guardian for Resident #34. The guardian stated he/she was very disappointed in the facility and was attempting to get Resident #34 moved to a different facility. The guardian stated the facility was, not responsive at all, has never scheduled a care plan meeting and [Resident #34] has been at the facility since January. On 9/20/22 at 12:51 PM a review of a social service progress note dated 7/27/22 at 12:40 PM, that was a late entry for 6/24/22, documented that a voicemail was received from Resident #34's guardian requesting a referral to be made to [facility name] for Resident #34. The note documented the social worker spoke to the admission director at the other facility, however she stated that the resident would need a COVID-19 booster. It was documented that they would reach out to the facility to see if they could do the resident's booster. The social service progress note dated 7/27/22 also included a late entry for date of service 6/27/22 which documented that an email was sent to the NHA regarding this transfer and needing [his/her] booster. The social service progress note dated 7/27/22 also included a late entry for date of service 7/6/22 which documented, this writer did not hear anything, she emailed the DON (Director of Nursing) [name], on 7/6/22, regarding the booster, she stated she would follow up with the ADON (Assistant Director of Nursing). On 9/20/22 at 2:42 PM the social work director, Staff #3, was interviewed about the status of the transfer to another facility. Staff #3 stated that she was not sure if Resident #34 received the booster shot. Staff #3 also stated she made a referral to another facility and was not sure of the status. She stated she did not document that she made another referral. She stated the other facility was in the same situation, that the resident needed a booster because of a bed shortage. Staff #3 stated the facility had a booster clinic in August. Staff #3 stated she did not have any further information. Further review of the medical record revealed documentation that Resident #4 received a COVID-19 booster on 8/16/22. The social worker failed to follow-up. Cross Reference F660 Discussed concerns with the Interim Director of Nursing on 9/28/22 at 12:15 PM. 18819 3) Review of complaint MD00181590 on 09/11/22 revealed an allegation that there was not a full time Social Worker in the facility. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the Resident Council interview that occurred on 09/13/2022 at 10:18 AM, the active Resident Council members complained that there was not a full time social worker in the facility and that the current social worker does nothing for the residents and will not answer resident or family member phone calls. In an interview with Resident #5 on 09/12/22 at 2:06 PM, Resident #5 stated that s/he has not attended any care plan meetings in 2022. In an interview with the facility social worker on 09/23/22 at 10:37 AM, the facility social worker stated that Resident #5 has not had a care plan meeting in the year 2022. In an interview with Resident #45 on 09/13/22 at 2:35 PM, Resident #45 stated that s/he has not had a care plan meeting in over a year. Review of Resident #45's clinical health record on 09/13/22 revealed that the last time the facility staff held a care plan meeting for Resident #45 was on 11/19/21. In an interview with the facility social worker on 09/23/22 at 10:37 AM, the facility social worker stated that s/he was still looking for any other documentation that Resident #45 had a care plan meeting in the year 2022. Cross reference F 850.

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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. 31145 Based on medical record review and interview with staff, it was determined the facility failed to timely provide medication to meet the needs of the residents. This was evident for 1 (#450) of 6 residents reviewed for medications and 1(#44) of 9 residents reviewed for pain management during the annual survey. The findings include: 1) Review of the medical record for Resident #450 on 8/4/2022 at 7:30 AM revealed the resident was admitted to the facility in the beginning of December 2021 from an acute care hospital with diagnoses that included, but were not limited to, type 2 diabetes mellitus, non-pressure chronic ulcer of the right lower leg, sepsis and endometrial cancer. Review of Resident #450's December 2021 physician's orders revealed the order for the diabetes medication Jardiance 25 mg. to be taken every day. Review of Resident #450's Medication Administration Record (MAR) for December 2021 documented the Jardiance was not available to be administered on 12/19, 12/20, 12/21 and 12/22/21. Review of Resident #450's MAR for January 2022 documented the Jardiance was not available to be administered on 1/5, 1/6, 1/7, 1/8, and 1/9/22. Review of a 1/4/22 physician's visit documented the plan was to start Resident #450 back on his/her home dose of Ozempic. (Ozempic is an injection medication used to help control high blood sugar for people with type 2 diabetes). Will be started back on Megestrol for appetite stimulant given history of cancer as recommended by oncologist. (Megestrol is similar to a natural substance made by the body called progesterone. It treats breast cancer and endometrial cancer by affecting female hormones involved in cancer growth). The physician also wrote to continue the Jardiance treatment. Continued review of Resident #450's MAR for January 2022 documented the Megestrol was not available on 1/5, 1/6, 1/7, 1/8, 1/9, and 1/10/22. The Ozempic, which was only to be given on Fridays, was not available on 1/7, 1/14, 1/21, and 1/28/22. The medication Semglee 80 units every day was not available on 1/15/22, and not signed off on 1/21/22 and 1/29/22. Semglee is a prescription long-acting man-made-insulin used to control high blood sugar in adults and children with type 1 diabetes and in adults with type 2 diabetes. The notations were either pending delivery or on order. On 9/28/22 at 5:00 PM a discussion was held with the Interim Director of Nursing (DON) related to medication availability. The Interim DON stated, we had noticed when a new resident was admitted the ordering of the medication was being delayed until the next morning. We educated the staff to contact the pharmacy and order stat (immediately). Based on the midnight census, the facility staff need to order the medication. The DON also stated the pharmacy had an issue delivering medications due to some bad weather. 18819 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) A review of complaint MD00183095 on 09/11/22 revealed an allegation that Resident #44 did not receive medications for pain and anxiety for several days. During an interview with Resident #44 on 09/12/22 at 12:54 PM, Resident #44 stated the facility often runs out or doesn't have his/her medications, including Xanax and Tramadol. Xanax is used to treat anxiety and panic disorders. Tramadol is used to relieve moderate to moderately severe pain, including pain after surgery. The extended-release capsules or tablets are used for chronic ongoing pain. A review of Resident #44's September 2022 Medication Administration Record (MAR) on 09/15/22 revealed that the nursing staff documented that the medication Tramadol was not available to administer on the following days: 09/11/22, 09/12/22, 09/13/22, and 09/14/22. The nursing staff documented that the medication Xanax was not available to administer on the following days: 09/11/22 and 09/12/22. In an interview with the facility pharmacy manager on 09/15/22 at 2:05 PM, the pharmacy manager stated that the pharmacy will only dispense a 29-day supply of each medication and then the physician needs to send another C-II form authorizing more of the medications. Resident #44's Tramadol was last ordered on 08/14/22 and Resident #44's Xanax was last ordered on 08/17/22.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 18819 Based on review of medical records and interview with staff it was determined that the facility failed to 1) have an effective system in place to ensure that drug regimen reviews were done for all residents at least monthly and 2) develop policies and procedures related Medication Regimen Review to include time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This was evident for 6 (#5, #6, #20, #64, #450, #63) out of 10 residents reviewed for medications during the annual survey. The findings include: Medication Regimen Review (MRR) or Drug Regimen Review is a thorough monthly evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. 1) A review of Resident #5's medical record on 09/12/22 failed to reveal any monthly pharmacy review and recommendation evaluations in the medical record or the electronic medical record. The surveyor was unable to determine whether monthly pharmacy medication consultation reviews were being done. Resident #5 was currently prescribed the following medications: Warfarin, Sertraline, and Metoprolol Succinate. 2) A review of Resident #6's medical record on 09/14/22 failed to reveal any monthly pharmacy review and recommendation evaluations in the medical record or the electronic medical record. The surveyor was unable to determine whether monthly pharmacy medication consultation reviews were being done. Resident #6 was currently prescribed the following medications: Depakote, Risperdal, and Clonazepam. In an interview with the facility Interim Director of Nurses (DON) on 09/14/22 at 1:25 PM, the interim DON stated that there were no monthly pharmacy consult notes in any of the residents charts or electronic medical records. In an interview with the facility Administrator on 09/15/22 at 09:01 AM , the facility Administrator confirmed that there were no monthly pharmacy consult reports in any resident chart. The facility Administrator went on to state that none of the current staff printout the monthly pharmacy consult reports and place them in the residents charts, not for any resident. 3) A review of Resident #20's medical record on 09/27/22 failed to reveal any monthly pharmacy review and recommendation evaluations in the medical record or the electronic medical record. The surveyor was unable to determine whether monthly pharmacy medication consultation reviews were being done. Resident #20 is currently prescribed the following medications: Warfarin, Sertraline, Clonazepam, Buspirone, and Remeron. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident #20's charge nurse #31 on 09/27/22 at 10:47 AM, Nurse #31 stated that she/he was unable to locate and monthly pharmacy consultation notes in Resident #20's medical record or electronic medical record. 4) A review of Resident #64's medical record on 09/27/22 failed to reveal any monthly pharmacy review and recommendation evaluations in the medical record or the electronic medical record. The surveyor was unable to determine whether monthly pharmacy medication consultation reviews were being done. Resident #5 was currently prescribed the following medications: Lexapro, Potassium Chloride, Tramadol, and Metoprolol Tartrate. In an interview with Resident #64's charge nurse #31 on 09/27/22 at 10:47 AM, Nurse #31 stated that she/he was unable to locate and monthly pharmacy consultation notes in Resident #64's medical record or electronic medical record. 31145 5) Review of the medical record for Resident #450 on 9/22/2022 at 3:43 PM revealed the resident was admitted to the facility in the beginning of December 2021 from an acute care hospital with diagnoses that included, but were not limited to, type 2 diabetes mellitus, non-pressure chronic ulcer of the right lower leg, sepsis and endometrial cancer. Further review of the electronic and paper medical record failed to produce documentation that the pharmacist had performed a monthly medication review of Resident #450's medications. On 9/15/22 at 9:12 AM an interview was conducted with the NHA regarding pharmacy reviews. She stated there was no process in place related to the staff reviewing and following up on pharmacy reviews. She stated, I have a nurse going through the stack of papers now to see if any were addressed. In addition, when asked for the pharmacy review policy she said she was waiting for pharmacy to send it over. When asked if they had a policy at the facility that they were going by she stated, not that I can find. 15701 6) On 9/14/22, a copy of the facility's MRR policy was requested from the Nursing Home Administrator (NHA). Interview of the NHA on 9/15/22 at 9:12 AM revealed that she could not find a facility MRR policy. The NHA provided a policy from the pharmacy that delivers medication to the facility, that was titled Addressing Pharmacy Recommendations. Review of the pharmacy's policy on 9/15/22 did not include time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. During an interview with the NHA on 9/20/22 at 1:45 PM, it was reviewed that the facility failed to have an MMR policy. 43096 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) On 9/19/22 at 10:54 AM, a review of Resident #63's medical record revealed that the consultant pharmacist reviewed the resident's drug regimen every month and documented them under the facility's electronic medical record (PCC) since the resident's admission. Further review of the Monthly Drug Regimen revealed that the consultant pharmacist documented on the form, No irregularities present: Yes, Please see the note. However, the surveyor could not find any written note from the consultant pharmacist on Resident #63's PCC or paper chart on 9/19/22 at 10:50 AM. During an interview with the Nursing Home Administrator (NHA) on 9/19/22 at 11:00 AM, the NHA confirmed that the facility did not have a consultant pharmacist's note about residents' Monthly Drug Regiment Review.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview it was determined the facility failed to 1) perform laboratory blood testing as ordered by the discharge physician and 2) have quality laboratory supplies for resident diagnostic testing. This was evident for 1 (Resident #97) of 9 residents reviewed for quality of care and 1 of 2 medication rooms observed during the annual survey. This had the potential to affect all residents. The findings include. A doctor analyzes the laboratory blood test to see if results fall within the normal range. The doctor may also compare the results to results from previous tests. Laboratory tests are often part of a routine checkup to look for changes in patient health. They also help doctors diagnose medical conditions, plan, or evaluate treatments, and monitor diseases. 1) On [DATE] at 9:07 AM a review of Resident #97's medical record was conducted. Resident #97 was admitted to the facility on [DATE] with a medical history that included, but was not limited to, end stage renal disease that required hemodialysis and sepsis secondary to a right leg lower extremity ulcer that required to be treated with the medication Vancomycin via IV (Intravenous) which means within a vein. This allows the medicine or fluid to enter the bloodstream right away. Review of the discharge summary from the acute care facility dated [DATE] documented, please check CBC, BMP, CRP and Vanco trough level on [DATE]. A CBC, which is a complete blood count, also known as a full blood count, is a set of medical laboratory tests that provide information about the cells in a person's blood. The CBC indicates the counts of white blood cells, red blood cells and platelets, the concentration of hemoglobin, and the hematocrit. A BMP is a basic metabolic panel that measures eight different substances in the blood. It provides important information about the body's chemical balance and metabolism. A BMP includes tests for the following: glucose, a type of sugar and the body's main source of energy. Calcium, which is essential for proper functioning of nerves, muscles, and heart. Sodium, potassium, carbon dioxide, and chloride. These are electrolytes, electrically charged minerals that help control the amount of fluids and the balance of acids and bases in the body and BUN (blood urea nitrogen) and creatinine, waste products removed from the blood by the kidneys. A CRP test is a c-reactive protein test that measures the level of c-reactive protein (CRP) in a sample of blood. CRP is a protein that the liver makes. A Vanco trough is a test to measure the level of Vancomycin, which is an antibiotic drug used to treat serious, life-threatening infections by gram-positive bacteria that are resistant to less-toxic agents. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Peak and trough levels are particularly useful for therapeutic drug monitoring, which is the process of measuring drug concentrations at intervals to ensure a consistent concentration of a medication remains in an individual. Further review of the medical record failed to produce blood tests results for [DATE]. On [DATE] at 11:35 AM the Nursing Home Administrator stated that no labs were found. 44484 2) On [DATE] at 7:28 AM observation was made of the medication room located on the Mill Landing Way nursing unit. On the shelf in the medication room were 95 blood collection tubes with an expiration date of [DATE], Lot #1158585. On [DATE] 8:45 AM an interview was conducted with registered nurse (RN) #4 who verified the expired blood collection tubes. On [DATE] at 11:35 AM Staff #5 was asked if staff performed blood draws on residents in the facility. Staff #5 stated on Monday, Wednesdays, and Friday's and the not critical labs, we will call our laboratory to come and perform the blood draws. Staff #5 was asked about the blood collection tubes in the medication room and if they were used by staff for blood collection. Staff #5 stated We may have to draw it, if it is critical. The Administrator was made aware of surveyor concerns prior to survey exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on interview and medical record review, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner. This was evident for 1 (#62) of 4 residents reviewed for dental services. The findings include: On 9/12/22 at 10:45 AM an interview was conducted with Resident #62's responsible party (RP) who stated she has been requesting Resident #62 to be seen by dental since admissions because his/her dentures did not fit right. On 9/15/22 at 7:23 AM a review was conducted of Resident #62' medical record. Resident #62 was admitted to the facility in April 2022 with diagnoses that included, but were not limited to, Alzheimer's disease, senile degeneration of the brain, and unspecified dementia with behavioral disturbance. A 4/4/22 nursing admission assessment documented that Resident #62 had a full set of dentures. A 6/3/22 communication with family note documented, eats well even without [his/her] dentures. A 9/9/22 at 14:37 (2:37 PM) nursing progress note documented, Daughter in to visit during lunch time. Daughter asked for resident to be seen by a dentist due to [his/her] dentures not fitting well and resident unable to eat [his/her] lunch with them in. [name] is aware and gave order for resident to have a dental consult done. A 9/9/22 physician's note documented, daughter is in for a visit today and has requested patient see a dentist. For the daughter her [father/mother] has told her the reason [he/she's] not eating the food in the facility is related to pain caused from [his/her] dentures. She reports they're not fitting [him/her] well and rubbing and causing intense pain especially with food. Per staff patient has been in [his/her] baseline with no issues or concerns. Further review of the medical record revealed, as of 9/28/22 at 11:00 AM, Resident #62 had not had a dental consult. On 9/28/22 at 12:15 PM the dental concern was discussed with the Interim Director of Nursing.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 18819 Based on complaint, and resident and staff interviews, it was determined that the facility failed to develop, prepare, and distribute menus that reflect a resident's nutritional wishes. This was evident for all residents in the facility reviewed during the annual survey. The findings include: In an interview with Resident #23 on 09/11/22 at 10:06 AM, Resident #23 stated that he/she does not receive diabetic beverages to drink (unsweetened drinks). Resident #23 stated there was no other choice of beverages for resident's who are diabetic, except water and unsweetened tea. All of the beverages coming from the kitchen were some forms of juice that had sugar added. In an interview with Resident #5 on 09/11/22 at 10:40 AM, Resident #5 stated that he/she does not receive daily meal menus. Resident #5 also stated that you get whatever the kitchen sends out. Residents do not have any choice of meals. In an interview with the facility dietician on 09/23/22 at 11:35 AM, the dietician confirmed that the facility kitchen does not serve sugar free beverages for the residents that have diabetes, and that the kitchen only has water and unsweetened tea to serve diabetic residents. The facility dietician also confirmed that the residents do not receive daily meal menus due to the fact that the facility has a lack of activity staff.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pines Nursing and Rehab	610 Dutchman's Lane Easton, MD 21601

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on resident interviews, and observations of the kitchen services with the testing of a food tray, it was determined that the facility failed to serve food at a preferable/palatable temperature. Food complaints and concerns were identified for 09 (#16, #19, #20, #23, #44, #58, #75, #87, #141) of 24 residents selected in the final sample and a failed test tray was identified on the unit that was served last. This had the potential to affect all residents. The findings included: Upon initiation of the survey on 9/11/22 random food complaints from residents included: Interview of Resident #58 at 8:28 AM was asked about the food and responded, the milk tastes sour, some days the food is cold and somedays it's hot. At 10:05 AM Resident #43 stated the food is terrible; not enough food to eat. At 10:06 AM Resident #23 indicated the food, is fair some days it's bad. At 10:45 AM Resident #16 indicated food is bad and Resident #75 indicated the meals were bad and not hot with cold eggs and toast. At 11:15 AM, during an interview with Resident #19, revealed food is served cold and the portions are small. Introduction interviews continued on 9/12/22. Resident #141 was interviewed at 9:20 AM with indication, the food is served cold. Resident # 20 responded at 11:44 AM, Food is poor. Resident #44 at 12:46 PM revealed, I do not like the food, brittle to eat, over salted, hard to chew, not nourishing. Review of the resident council meeting minutes for a meeting held on 7/26/22 revealed old business concerns of poor food quality (primarily lack of consistent schedule and food temperature. The minutes did not reveal an administrative response to the poor food quality concern. On 9/13/22 at 10:00 AM an interview with 4 resident council members revealed, food quality had not improved. On 9/23/22 at 7:15 AM breakfast meal service observations were initiated in the kitchen. Per a handwritten note that was posted near the kitchen tray line indicated, the breakfast tray line was to begin at 7:20 AM. At 7:30 AM dietary staff began to take and record food temperatures and had to place some pans of food back into a steamer/oven to raise the temperature of the food. The tray line began at 7:40 AM. Review of the breakfast menu revealed 2 ounces (oz) of scrambled egg, 2 oz. turkey sausage patty, 1 slice of toast, and cereal of choice. The bread did not look toasted as the bread was white. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A [NAME] brand thermometer was calibrated in an ice water bath at 8:05 AM. A test tray was requested to the Certified Dietary Manger (staff #61) and was placed on the food cart at 8:20 AM. The cart arrived on the Chesapeake unit at 8:25 AM. Initially only one nursing assistant passed out food trays. It was noted that a separate, open aired cart had an assortment of juices in clear plastic pitchers without any ice and insulated carafes of coffee with plastic coffee mugs and plastic juice cups. The orange juice appeared to have settled and some staff assisting with the delivery of breakfast and beverage would try to swirl the pitcher prior to pouring. The surveyor waited until the last resident tray was delivered prior to temperature check of the test tray. The test tray was removed from the cart at 9:11 AM. The meal was tested with the dietary manager (staff #61). The scrambled egg temperature was 100 degrees Fahrenheit (F.), turkey sausage was 98 degrees F., and the requested cup of apple juice was tempted at 60 degrees and a cup of coffee was checked to be 82 degrees. The eggs and sausage were tasted and were cold on the palate. The dietary manager acknowledged that the white piece of bread did not look like toast. At 9:15 AM Resident #43 was eating breakfast at the table closest to the nursing station and was asked about his/her breakfast. Resident #43 stated it was not good, it was cold, but the girls can heat it up if I ask. Resident #43 indicated that he/she did not want it heated as the food would be rubbery after heating in the microwave. Additionally, Resident #87 was also eating breakfast and indicated his/her breakfast was cold, including the coffee. 18819 A review of complaint MD00177291 on 09/11/22 at 7 AM, revealed an allegation that the morning breakfast meals were cold and not palatable. In an interview with Resident #20 on 09/11/22 at 9:50 AM, Resident #20 stated that the food quality was poor. In an interview with Resident #23 on 09/11/22 at 10:06 AM, Resident #23 stated that the food was fair and that there are good and bad days. Resident #23 stated that facility does not serve enough different types of sugar free beverages for residents that have diabetes. In an interview with Resident #44 at 09/12/22 at 12:46 PM, Resident #44 stated that he/she does not like the food. Resident #44 went on to say that the food is to brittle to eat, over salted, hard to chew, and not nourishing. In an interview with the facility Resident Council on 09/13/22 at 10:18 AM, the residents complained that they do not receive water/pitchers of ice water at the bedside unless you ask for it. The residents also complained that they have not been given a list of foods and beverages available to them on a 24/7 basis. A review of 3 previous Resident Council minutes, 08/30/22, 08/05/22, and 07/26/22, revealed that resident food complaints were a common monthly issue. In a breakfast test tray observation on 09/23/22 at 9:09 AM, the breakfast meal was determined to be cold and did not hold temperature.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 18819 Based on complaint, and resident and staff interviews, it was determined that the facility failed to prepare and serve a resident's nutritional wishes and plan of care. This was evident for all residents that can eat and drink in the facility and suffer from diabetes. The findings include: In an interview with Resident #23 on 09/11/22 at 10:06 AM, Resident #23 complained that he/she does not receive diabetic beverages to drink (unsweetened drinks). Resident #23 stated there was no other choice of beverages for resident's who are diabetic, except water and unsweetened tea. All of the beverages coming from the kitchen were some forms of juice that had sugar added. In an interview with the facility dietician on 09/23/22 at 11:35 AM, the dietician confirmed that the facility kitchen does not serve sugar free beverages for the residents that have diabetes, and that the kitchen only has water and unsweetened tea to serve diabetic residents.

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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. 18819 Based on observation, interviews of facility staff, and documentation review, it was determined that food service employees failed to ensure that sanitary practices were followed, equipment was maintained, and safe food handling practices were followed to reduce the risk of foodborne illness. This deficient practice had the potential to affect all residents. This was evident during the initial tour of the facility kitchen and nourishment rooms while conducting the annual survey. The findings include: 1) On 09/11/22 at 7:30 AM a tour of the facility's main kitchen was conducted with the facility's Assistant Food Service Manager (Staff #58). Upon entering the kitchen, observations of the kitchen floor revealed free standing water that covered the kitchen entrance and was observed leaking under the door of the storage room located near the front door. The kitchen floor lacked signage notifying staff and vendors that the floor was wet. No staff members were actively attempting to dry the floor or wipe up the water. In an interview with Staff #58 on 09/11/22 at 7:35 AM, Staff #58 stated that 2 of the kitchen sinks were currently clogged and backup onto the kitchen floor if the water was allowed to run into the drain. Observations of the general kitchen ice machine revealed a heavy buildup of dirt and mold on the ice machine lid. The ice machine was functioning and making ice cubes. Observations of the large kitchen refrigerator revealed 12 sandwiches that lacked a date when they were created, 4 pitchers of what appeared to be juice also lacked a date they were created, and 6 bowls of pudding were observed on a tray that also lacked a date when they were created. A wheelchair armrest was also observed under one of the kitchen sinks. A wheelchair was not observed in the kitchen area. In an interview with the facility assistant maintenance director staff #11 on 09/11/22 at 8:50 AM, staff #11 stated that she/he was aware that 2 of the kitchen sink drains were clogged. Staff #11 stated that the local plumbing vendor was coming back on Monday to fix the 2 kitchen sink drains. Staff #11 stated that there was also a water leak behind the 3 compartment sink in the dish room. Staff #11 also stated that the plumbing vendor was here last week to fix the clogged kitchen grease trap. Staff #11 stated that the facility has a monthly plumbing contract that services the building. The assistant maintenance director #11 stated that she/he reports to the facility administrator. In an interview with the facility administrator on 09/11/22 at 9:05 AM, the facility administrator confirmed that he/she was the facility person who authorizes repair work in the facility. The facility administrator stated that he/she was not aware of a problem with a grease trap or an issue with flooding in the kitchen. The facility administrator also stated that the Local Health Department was not currently aware of an issue in the facility kitchen, nor has he/she seen any flooding in the kitchen. The facility administrator stated that he/she saw some water on the floor and confirmed the facility dish washer system was functioning. 15701 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) An environmental kitchen food service inspection was conducted in the facility's kitchen on 09/16/22 at 2:15 PM. The lunchtime dishwashing service was concluding at the time of the observation. The certified dietary manager (staff #61) was asked to restart the dishwashing machine and run trays through the machine. Observations of the temperature gauge for the hot water wash temperature remained at 140 degrees Fahrenheit (F.) as she placed multiple trays to run through the machine. A sign on the wall above the dishwashing machine indicated the minimum hot water wash temp was 160 degrees F. and the minimum rinse temperature was 180 degrees. The signage was very concise, instructing staff to inform a manager if the minimum hot water temperatures were not archived. During the observation, the wash water temperature did not rise above 140 degrees F. The Dietary Manager revealed that the repair vendor for the dishwashing machine (Ecolab) was at the facility earlier in the day to service the dishwasher. The certified dietary manager was asked to show the dishwashing machine temperature logs. The log was kept in her office. The log shown was a daily sheet for all temperatures titled Food temp logs, 3 Comp sink, and Walk-in Temps. There was a place to record dishwasher temperatures for the water temperature of the wash and sanitize for Breakfast, Lunch, and Dinner. The wash temperature for the breakfast service was documented as 180 and the Sanitize(rinse) level was 189. There was not any documentation for the wash and rinse temperatures for the lunchtime service. A review of the log for 9/15/22 showed that the wash and sanitize water temperatures for breakfast were both 140 degrees F. The lunchtime hot water temperatures were both documented as 140 degrees F. There was not any documentation for the dinner time wash and sanitize water temperatures. A review of the log for 9/14/22 did not reveal any dishwashing machine water temperatures for all three mealtimes. The dietary manager made copies of the documents per request. The facility failed to ensure that minimum dishwashing water temperatures were maintained for proper sanitation of the dishware. 31145 3) On 9/13/22 at 12:01 PM observation was made in the pantry/nourishment room of the Homestead unit of the ice machine. The ice machine was empty. Staff #26 was in the nourishment room at the time and the, the ice machine is broke and we have to leave the unit to go to the kitchen to get ice and bring it back to the unit. The machine has been broken for a while. It was also noted that the front of the refrigerator in the nourishment room was rusted.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 31145 Based on interview, observation and record review, it was determined that the facility administration failed to provide effective oversight activities for the facility to ensure that resources were used effectively in order to meet the health and safety needs of each resident and identify and correct inappropriate care processes/standards, as evidenced by failing to 1) ensure that the facility had sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, and ensure the nursing staff had training which included dementia training and yearly in-service training; 2) ensure the food served to residents was palatable and served at the correct temperatures, 3) ensure there was an ongoing program to support residents in their choice of activities along with having an activities director to lead the program, and 4) ensure that the facility had a qualified social worker who was available to meet the individual needs of the residents. This was evident during the annual survey and had the potential to affect all residents. The findings include: 1) Facility administration failed to ensure there was enough staff available to ensure that the residents that were currently residing in the facility had their needs met daily. Surveyors entered the facility unannounced on Sunday, 9/11/22 at 7:00 AM. During the screening process at the beginning of the survey 10 of 10 residents that were interviewed complained about lack of nursing staff. Two of 3 family interviews conducted revealed staffing concerns, and review of 3 of 3 resident council meeting minutes revealed staffing concerns. Some of the concerns expressed by residents were long wait times once the call bell was activated and that it took a long time to get help. Some resident complaints stated wait times could be 3 to 4 hours long. Resident complaints included not receiving medications on time and taking forever to receive care. There were several complaints from residents stating that the call bells were not working, and in some cases hand call bells were given to residents. On 9/13/22 at 8:39 AM an interview was conducted with Staff #88 who stated, call bells have been an issue since July. People act like they don't know the call bells are broken. In an interview with the facility assistant maintenance man, Staff #11 on 09/11/22 at 8:50 AM, Staff #11 stated that there were many call bell units that were broken in resident rooms. Staff #11 stated that he does not have parts to fix all the broken call bell units and that the call bells break every day. Staff #11 stated that he will use call bell unit parts from other resident rooms that are not occupied. Staff #11 stated that the facility administrator is aware of the broken resident rooms call bell issue and that there was no current plan or contract to fix the call bell system at this time that he was aware of. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff at the facility verbalized staffing concerns stating that basic care was not being done. Staff stated that resident behaviors on the Homestead unit were time consuming and when they had to deal with the increased behaviors with limited staff, it was hard. In addition, the staff on the Homestead unit also were responsible for the residents on the COVID-19 unit. Staff stated that since those residents were on isolation, when staff went on that unit it took longer due to isolation precautions and the residents wanted someone to talk to since they were in isolation. Staff stated that treatments were not being done and the residents were not getting the proper care. Staff stated that 1 GNA for 29 patients was not doable and, that happens 3 out of 4 nights per week. A common complaint was that residents were desperate for a shower or therapy. Staff stated the facility has gone through several administrators and had a staff walkout a couple of months ago that was in the paper. The wait to get changed is a common complaint. Staff #3 stated she received a lot of complaints from staff and residents and that the Nursing Home Administrator was informed, and the response was, will look into it. When asked if she feels they will look into it, she stated, no. On 9/16/22 at 9:15 AM a conversation was held with the Nursing Home Administrator (NHA). Staffing on the Homestead unit was discussed and the NHA was informed of all the observations the surveyor had made. The NHA stated they were meeting the 3.0 PPD hours. The surveyor informed the NHA that the federal staffing regulation was not being met because the needs of the residents were not being met. The 3.0 PPD hours was a minimum standard for the state requirement, not the federal requirement. Cross Reference F725 2) The facility failed to ensure nursing staff competencies, yearly training, and new employee orientation were being done. On 9/20/22 at 11:26 AM an interview was conducted with Staff #20, Director of Human Resources, and the Business Office Manager. Staff #20 stated, I have not seen any yearly reviews since I have been here. I have not seen any evidence of yearly evaluations. They did not have anything in place. Staff #20 was asked about in-service training and she stated, only for new hires is there abuse training. Right now, there is nothing for existing staff on yearly training related to abuse and dementia management. Staff #20 stated, Corporate should have a training program. Different modules for abuse training throughout the year. I have not set it up yet. I just did my yearly set-up at [name of sister facility]. It is in modules, and I know how I want to set it up. They did not have anything in place here. On 9/20/22 at 11:38 AM an interview was conducted with the Nursing Home Administrator (NHA), Interim Director of Nursing (DON), and Staff #7. They said, we do not have a Staff Developer. They stated the process of training and competencies, never evolved because the ADON was only at the facility for a week. We do not have any competencies on nurses and GNAs. The Interim DON stated, yearly performance reviews are supposed to be done. We don't have a lot of regular staff. I have not tracked making sure everyone is getting the 12 hours of training. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/28/22 at 5:30 PM, during a quality assurance interview, the interim DON and Medical Director stated, training has not been discussed in QA. The DON stated, I identified the lack of training and new employee orientation. As of 9/28/22 nothing had been put in place to correct the deficient practice. Cross Reference F943 and F947 3) Concerns were expressed to the surveyors from residents that the food was served cold and was not good. The interim DON and MD stated that they did QA the food and, it is much better than what it was, but it isn't where it should be. The MD stated that the previous Nursing Home Administrator (NHA) brought in test trays every week to sample. The previous NHA has not been at the facility since May 31, 2022. There has not been any more documented follow up related to the food. Review of the resident council meeting minutes for a meeting held on 7/26/22 revealed old business concerns of poor food quality (primarily lack of consistent schedule and food temperature). The minutes did not reveal an administrative response to the poor food quality concern. On 9/13/22 at 10:00 AM an interview with 4 resident council members revealed, food quality had not improved. Facility administration knew about the food quality and failed to develop an action plan to address the concerns. Cross Reference F804 4) The facility failed to have an activities program that was directed by a qualified professional. On 9/16/22 at 9:30 AM Staff #27, (activities assistant) was interviewed and stated she had been employed at the facility since June 2022. There was no activity director at that time. On 9/13/22 at 12:51 PM an interview was conducted with Staff #3 who stated the facility was without an activity's director. Staff #3 stated the activities director had left and the replacement just left 2 weeks ago. He was trying to do things with them, doing crafts and movies. The issue was being given money to do things with the residents. There is no budget. Now there are only 2 activity aides here. Several observations were made on the Homestead (dementia) unit. No activities occurred on the unit and was corroborated by staff. Administration was aware of the lack of activities, however an action plan was not in place. Cross Reference F679, F680 and F725 5) Facility administration failed to provide needed social work: During the Resident Council interview that occurred on 09/13/2022 at 10:18 AM, the active Resident Council members complained that there was not a fulltime social worker in the facility and that the current social worker did nothing for the residents and did not answer resident or family member phone calls. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of facility records and interview with staff, it was determined the facility failed to conduct and document an accurate/current facility-wide assessment that was up to date. This was evident during the review of the sufficient and competent nurse staffing task of the annual survey and the extended survey. This had the potential to affect all residents within the facility. The findings include: A facility-wide assessment is conducted to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The assessment is to include the care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population. A copy of the Facility Assessment was provided at the initiation of the survey. The Date of the assessment or Update was Change of Leadership 9/20/21. Date assessment reviewed with QAA/QAPI (Quality Assessment and Assurance/ Quality Assurance and Performance Improvement committee) was documented 10/2021. On 9/28/22 at 5:30 PM an interview was conducted with the QA Director, which was the Interim Director of Nursing and the Medical Director. The Medical Director stated, it was reviewed at least 2 years ago. I brought a copy from the other facility, and I told administration to please prepare and send to me and we would review as a group. When I came back a month later, [name of previous NHA] showed me the most updated plan. I think I would have recalled that it was reviewed. There was a discussion about a plan. I would remember if it was reviewed. It was not reviewed last year. Review of the Facility Assessment (FA) revealed out of the 17 people that completed the assessment, only 2 remained at the facility along with the governing body. On page 5 of the assessment there was nothing about possible elopements from the facility or the use of a secured unit and wander guards for elopement risk residents. On page 6 of the assessment under infectious diseases, it did not list COVID-19. On page 7 of the assessment under special treatments and conditions, there was nothing about the quarantine of new admissions for COVID-19 surveillance and anyone with symptoms along with the need for constant screening and testing for COVID-19. The special treatments and conditions documented on pages 7 and 8 was compared to the Resident Census and Conditions that was provided to the surveyors upon admission to the facility on [DATE]. There was an increase in oxygen therapy, IV medications, injections, dialysis, ostomy care and isolation or quarantine for active infectious disease. Assistance with activities of daily living (ADL) had increased in all categories such as dressing, bathing, transfer, eating, toileting, and mobility. Continued review of the Facility Assessment revealed the staffing plan was documented on page 12. The staffing plan did not mention Certified Medicine Aides (CMA) which the facility currently used. The staffing plan did not mention the overwhelming use of agency staff. The staffing plan documented a need for 1 RN supervisor for evenings and nights 7 days a week and for an Assistant Director of Nursing (ADON) and (3) Unit managers. The facility was currently without those staff. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On page 13 of the Facility Assessment the plan documented, describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time. Consider if and how the degree of fluctuation in the census and acuity levels impact staffing needs. The facility documented (1) full time DON - currently had an interim DON, (1) ADON - currently did not have, (3) unit managers - currently did not have. For other departments in the facility the plan documented, recreation department has (3) FT (full time) staff to coordinate programs, activities and entertainment. The recreation department did not have (3) FT staff. (Cross reference F679 and F680). On page 14 of the Facility Assessment the plan documented under staff training/education and competencies, Additional training in 2020 is ongoing for CDC, CMS and MDDH guidelines regarding COVID. This was not up to date. The facility documented the staff training/education and competencies that were necessary to provide the level and types of support and care needed for the resident population, however, the facility was not doing staff competencies, yearly evaluations, or the minimum of 12 hours of geriatric nursing assistant (GNA) education required per year. The facility assessment did not address the high quantity of agency staff that were utilized daily and the components to provide education/training and/or competencies for all the agency/contractual staffing. The facility did not have a staff developer. Cross Reference F726, F730, F741, F943, F947

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 15701 Based on medical record review, interviews and observations it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. Furthermore, the facility failed to assure the completeness, and accuracy of documentation related to the use of Healthcare Virtual Assistant Transcription Support services. This was evidenced by review of resident's medical records with multiple examples of incomplete documentation initiated by HVAs and documentation of staff performing assessments and documented progress notes at times the staff were not in the facility. This practice was evident for 13 (#141, #45, #49, #69, #97, #93, #103, #34, #10, #291, #97, #38, #99) of 54 residents reviewed. The findings include: 1) Review of electronic medical records revealed documentation by Healthcare Virtual Assistants (HVA). The nursing home administrator (NHA) and the director of nursing (DON) provided explanations to the survey team as the role of the HVAs and how the facility staff utilize the assistance of the HVAs. Healthcare Virtual Assistant Transcription Support Services Guidelines were provided to the survey team with an implemented dated of 3/4/22 and a reviewed/revised dated of 4/1/22. The service contract indicated that the service began in November 2021 and the Corporate Chief Nursing Officer stated that the service started in November 2021. The facility failed to assure the completeness, and accuracy of documentation related to the use of Healthcare Virtual Assistant Transcription Support services. Resident #141's medical record was reviewed repeatedly during the survey. Resident #141 was admitted to the facility on [DATE]. Review of Resident #141's medical record on 9/22/22 at 10:10 AM revealed a Peak COVID-19 Evaluation dated 9/21/22, time stamped for 18:42 (6:42 PM) and a Lock Date 9/21/22 20:18 (8:18 PM). The assessment was created by a HVA (staff #78). The nurse who completed the assessment worked day shift 7 AM to 3:30 PM on 9/21/22. An interview was conducted with the nurse (Staff #7) at 10:19 AM on 9/22/22. She stated that she was not at the facility at the times recorded on the assessment. She indicated that when she was locking the assessments for the resident under her care on 9/21/22 she noticed the time discrepancy. She stated that she added a time next to her name. She confirmed that this evaluation/assessment for Resident #141 did not have a time by her name, and she was not in the facility at the times recorded on the assessment form. Review of the electronic medical record for Resident #141 on 9/26/22, under the Assessment tab, revealed 6, In Progress assessments dated 9/6/22. The assessments were titled Peak Braden, Peak Fall Risk Evaluation, Peak Lift Transfer Evaluation, Peak Side Rail Evaluation, Peak Elopement Risk Assessment, and Peak Baseline Care Plans. The screen view indicated the 6 assessments were Created by and Revised by a HVA (staff #78). Review of each assessment shown to have incomplete documented assessment data. Other In Progress in completed assessments that were Created by and revised by a HVA included: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Peak COVID-19 Evaluation dated 9/7/22 Peak PDPM/Skilled Nursing Evaluation, 2 evaluations dated 9/10/22 Peak PDPM/Skilled Nursing Evaluation dated 9/11/22 Peak PDPM/Skilled Nursing Evaluation dated 9/13/22 Continued random review of assessments revealed documented completion of assessments by a nurse that was not in the facility for the Effective Date of the assessments. Review of Peak COVID-19 Evaluation with an effective date of 9/11/22 was Created by a HVA and was signed by a registered nurse (staff #92) on 9/23/22. COVID-19 Evaluation with an effective date of 9/14/22 was Created by a HVA and was signed by a registered nurse (staff #92) on 9/22/22. A Peak PDPM/Skilled Nursing Evaluation with an Effective Date of 9/14/22 was created by an HVA and signed by staff #92 on 9/23/22 and a Peak PDPM/Skilled Nursing Evaluation with an Effective Date of 9/21/22 was created by an HVA and signed by staff #92 on 9/23/22. It was also noted that a Daily Nursing Charting note was created on the progress note section of the electronic medical record for each of the PDPM/Skilled Nursing Evaluations. Copies were requested and received of the identified Peak Evaluations and progress notes. On 9/26/22 at 1:00 PM the interim DON was asked about the identity of Staff #92. She revealed, staff #92 was a DON at another Peak facility. A phone interview was conducted with the DON of the other Peak facility on 9/28/22 at 2:38 PM. She stated that she did not perform any of the assessments. She indicated that she had locked the assessments and the name of the nurse was on the document. She was informed that the printed documents were shown to be signed by her without any additional names on each of the documents. The printed documentation did not indicate that the document was locked. The concern was expressed to her, that her signature on the document was a false representation of an evaluation that was not performed on the resident. On 9/28/22 at 6:15 PM, the medical director and the interim DON were shown the copies of the Evaluations that were signed by a nurse that did not perform the assessment, and the assessment documented at a time when the nurse was not in the facility. 2) Resident #141's medical record was reviewed on 9/16/22. Review of the Certified Registered Nurse Practitioner wound consultant (staff #62) note was electronically signed on 9/15/22 at 1:56 PM and revealed inaccurate/false documentation in the note. The note was written after she assessed Resident #141's wounds. The nurse practitioners note stated, Wound rounds completed and reconciled with wound nurse today. All questions and concerns answered for staff and patient as applicable. The nurse practitioner was interviewed on 9/22/22 at 9:44 AM. She was asked who the wound nurse was that she reconciled with as documented in her note. She acknowledged that the facility does not have a wound nurse, further replied that the bulk of her notes were prepopulated, and she did not know how to change the prepopulated data. On 9/23/22 review of the Nurse practitioner's note, that was electronically signed on 09/22/2022 1:43 PM revealed the same inaccurate information referencing wound rounds was, reconciled with the wound nurse today. The facility did not have a wound nurse on 9/22/22. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	18819 3) On 09/15/22 at 3:10 PM a review was conducted of Resident #45's electronic medical record. During the review, while looking for information regarding the Resident's responsible party, it was noted that a different Resident's activity care plan had been entered into Resident #45's care plan. The other resident's activity care plan indicated it was created on 08/18/2021. 31145 4) On 9/15/22 at 11:02 AM a review of Resident #49's medical record was conducted. Resident #49 was admitted to Hospice on 8/27/21. There were Hospice visit notes in the paper medical record up to 7/7/22. There were no recent visits documented. RN #14 confirmed the findings and stated they are usually pretty good at getting their notes in the record. 5) On 9/14/22 at 10:15 AM a review of Resident of Resident #69's medical record was conducted. Resident #117's laboratory results of a Hemoglobin A1C dated 1/6/20 was found in the Advanced Directives section of Resident #69's electronic medical record. Hemoglobin A1C or HbA1c test is a simple blood test that measures the average blood sugar levels in the blood over the past 3 months. The interim DON was informed on 9/14/22 at 10:24 AM. 6) On 9/26/22 at 9:07 AM the medical record of Resident #97 was reviewed. Resident #118's signed death certificate dated 5/6/22 was in the front of Resident #97's closed paper medical record. Resident #97 was discharged from the facility on 3/2/21. 7) On 9/23/22 at 11:11 AM the medical record of Resident #93 was reviewed. Review of the progress note section of the electronic medical record revealed a care conference note for a date of service of 7/1/22 that was not written and put into the electronic medical record until 7/27/22 at 10:48 AM. Resident #93 was discharged from the facility on 7/11/22. On 9/23/22 at 11:02 AM the social work director was asked why the note was entered 26 days after the meeting. The social worker stated, I could not get the note into the system timely due to the volume of work. 8) On 9/23/22 at 8:00 AM the medical record of Resident #103 was reviewed. Review of the 1/25/22 nursing admission assessment documented the resident had a foley catheter. A foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. A 1/26/22 bowel and bladder assessment documented, Indwelling catheter, Does the resident have an indwelling catheter? YES; If the resident has an indwelling catheter is there a plan for removal? No. Bladder status was documented as yes, has an indwelling catheter. A 1/27/22 physician's H&P (history and physical) did not mention about GU (genitourinary) status. Review of hospital notes dated 1/24/22 documented urinary catheter was inserted 1/24/22 at 23:56 (11:56 PM). Indication: immobilization required (trauma/surgery). Review of the entire medical record failed to indicate if Resident #103 had a foley catheter or had urinary incontinence. There was no physician's order for a foley catheter. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	GNA (geriatric nursing assistant) documentation documented bladder incontinence even though documentation was spotty and not thorough. Review of GNA documentation for January 2022 from 1/25/22 to 1/31/22, all 3 shifts (day, evening, night) revealed there were only 3 times that there was documentation. On 1/26, 1/27 and 1/31 evening shift. All of the other days and shifts were blank. For February 2022 for 2/1/22 to 2/4/22 there were blanks on day shift 2/1, 2/2, 2/3, evening shift 2/4 and night shift 2/1/22. On 9/27/22 at 11:06 AM with the Interim DON, a discussion was held regarding the lack of accurate documentation related to the foley catheter and the resident's urinary continence status. 9a) On 9/20/22 at 4:20 PM observation was made of Resident #34 and his/her room. There was a television on a table that was flipped over on its face/screen. On top of the back of the television was a French fry and a pair of ted stockings. TED (Thrombo-Embolus Deterrent) stockings are also known as compression stockings, anti-embolism stockings, or support hose. They help reduce the risk of developing a deep vein thrombosis (DVT) or blood clot and help reduce the risk of swelling (edema). On 9/21/22 at 7:39 AM observation was made of the TED stockings lying on top of the television. Further observations on 9/21/22 at 12:09 PM revealed the TED stockings were still on top of the television. At 12:53 PM on 9/21/22 the resident was observed out of bed wearing gray slipper socks without TED stockings. Review of physician's orders for Resident #34 documented, Support hose. On in the morning and remove at bedtime. The order was written on 1/18/22. Review of Resident #34's Treatment Administration Record (TAR) for September 2022 documented on 9/20/22 and 9/21/22 that Resident #34 wore TED stockings. This was inaccurate documentation. On 9/21/22 at 5:00 PM the NHA toured with the surveyor and observed Resident #34. The NHA was asked to note what the resident was wearing on his/her feet. Resident #34 was wearing gray slipper socks and not TED stockings. At that time the NHA was informed that the past 2 days the TEDS were signed off as worn, when they were not worn. 9b) Review of physician's orders for Resident #34 revealed the order, pt. to utilize [NAME] cup during meals daily as tolerated and staff assist with all meals. The physician's order was written on 1/28/22. The [NAME] Cup is a lightweight, easy-to-grip adapted drinking cup designed to prevent spills. On 9/21/22 at 9:20 AM observation was made of Resident #34 in bed with the tray table in front of him/her with a breakfast tray on top. There was a regular plastic cup on the tray with no lid. The plastic cup was sideways and empty. Review of Resident #34's TAR documented that the nurse signed off on 9/21/22 that Resident #34 utilized a [NAME] Cup at breakfast (8:00 AM) and lunch (12:00 PM) which was inaccurate. 10) On 9/21/22 at 8:05 AM the medical record of Resident #10 was reviewed and revealed on Friday, 9/16/22, Resident #10 was transferred to the hospital for a change in medical condition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of assessments for Resident #10 revealed a COVID-19 assessment was conducted on Sunday, 9/18/22 even though Resident #10 was admitted to the hospital and not in the facility. Further review of Resident #10's medical record revealed the Change in Condition/Concurrent review dated 9/16/22 was incomplete. 11) On 9/26/22 at 2:00 PM a review of Resident #291's medical record was conducted. Resident #291 was admitted to the facility in August 2021 with diagnoses including, but not limited to, dependence on renal dialysis, diverticulitis of intestine and chronic atrial fibrillation. Review of a discharge planning tool that was initiated 9/2/21 at 16:09 (4:09 PM), documented that Resident #291 was going to be discharged to another facility on 9/3/21. There was no documentation in the medical record on 9/3/22 that the resident was in fact discharged , where to, with whom, and the condition of the resident upon discharge. 12) On 9/26/22 at 9:07 AM a review of Resident #97's medical record was conducted. Resident #97 was admitted to the facility on [DATE] with a medical history that included, but was not limited to, end stage renal disease that required hemodialysis, sepsis secondary to a diabetic right leg lower extremity ulcer, diabetes mellitus, COPD (Chronic Obstructive Pulmonary Disease), atrial fibrillation and Atherosclerotic heart disease. Further review of the medical record revealed the facility only created care plans for activities, safe discharge and actual fall. Resident #97 was discharged from the facility on 3/2/21, however the care plan, at risk for limited meaningful engagement due to COVID-19 restrictions was initiated on 9/26/22 and created on 1/29/21 and revised on 9/26/22 with the current NHA's name. The NHA's name was on the interventions and goal with create and revised dates of 9/26/22. The NHA's name and create and revised dates of 9/26/22 also documented on the safe discharge and actual fall care plan, even though the resident was discharged from the facility on 3/2/21. 43096 13) On 9/11/22 at 09:42 AM the surveyor observed Resident #38 had a gauze dressing with pink oozing mark on his/her left foot, and end of the gauze (at least 30 cm long) was hanging on the bed. Immediately an interview was conducted with Resident #38. The dressing change was ordered every day, but wound nurse did it twice a week. The resident also said that the current dressing was applied on last Thursday (11/8/22). The second observation for Resident #38's wound was conducted on 9/12/22 at 11:53 AM. The resident had the same dressing as on 9/11/22. Also, the surveyor found a bug flying in the resident's room. Another observation was done on 9/14/22 around 10 AM. Resident #38 had a new dressing with a handwritten date of 9/13/22. During an interview with Resident #38 on 9/15/22 at 1:53 PM, the resident said, wound nurse changed the foot dressing on 9/13/22 and this morning (9/15/22). They didn't change the dressing yesterday. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/22 at 1:56 PM a review of Resident #38's medical record revealed that the resident had an order of, Left foot near 3rd toe: Cleanse with wound cleanser onstream setting, pat dry. Apply a thin layer of medihoney f/b (foreign body) cut a piece of Calcium alginate AG and cover with DCD (dry clean dressing). Every day shift for wound care monitor daily for s/sx (sign/symptom) of pain, infection & healing - order initiated on 7/26/22, discontinued on 9/15/22. Additionally, Resident #38's Treatment Administration Record (TAR) showed the facility nurses checked off the resident's foot wound dressing was done daily from 9/8/22 to 9/15/22 (except 9/11/22). On 9/16/22 at 10:10 AM, the surveyor shared concerns regarding Resident #38's wound dressing which was not changed daily but recorded as done daily with the NHA. The NHA stated, I will talk to nurses. 14) A review of complaint MD00166828 on 9/26/22 at 10:54 AM revealed that Resident #99 was admitted to the facility on [DATE] for ambulatory dysfunction s/p (status post) fall and transferred to the hospital on February 2021. The complaint report contained that Resident #99 failed to follow the neurologist, no precautions were placed for the fall, and the facility staff did not manage the resident's pain. For more information regarding Resident #99's care, the surveyor requested a closed record for the resident on 9/26/22 at 11:00 AM. The facility staff did not provide the resident's closed record until 3:30 PM on 9/26/22. On 9/26/22 at 3:45 PM, an interview was conducted with the NHA. The surveyor asked about Resident #99's closed record. The NHA replied, we do not have Resident #99's closed record. We can't find the folder. In an interview with the interim DON on 9/28/22 at 1:30 PM, the surveyor informed the concern related to the discharged resident's closed record. The interim DON stated that some documentation was missing since the facility had re-arranged rooms several times.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. 18819 Based on written and verbal complaints, reviews of medical health records and staff interview, it was determined the facility failed to obtain a full time social worker when the certified number of beds exceeded 120 in the facility. Currently the facility was licensed for 170 certified beds. This was evident for 1 out of 1 required personnel and had the potential to affect all residents. The findings include: Review of complaint MD00181590 on 09/11/22 revealed an allegation that there was not a full time Social Worker in the facility. During the Resident Council interview that occurred on 09/13/2022 at 10:18 AM, the active Resident Council members complained that there was not a full time social worker in the facility and that the current social worker does nothing for the residents and will not answer resident or family member phone calls. In an interview with the facility social worker on 09/13/22 at 12:51 PM, the facility social worker stated that S/he is the only social worker in the facility and works twice a week on Tuesdays and Fridays. The facility social worker stated that S/he also works full time at another company facility and stated I try to complete 50% of the social history assessments on newly admitted residents. Fridays are completely taken up by care plan meetings. On Fridays, I may have up to 10 scheduled care plan meetings. This only leaves me Tuesdays to assess residents and attend utilization review meetings. There are many times I don't leave the facility until 8 PM. I try to speak with families and accomplish the important stuff like completing MDS assessments. I complete sections C, D, E, Q, and S, on Resident MDS assessments. The facility social worker also stated that S/he was not involved in resident to resident incidents but would make referrals to the facility psych services. The facility social worker also stated that S/he does not have discussions about advance directive, obtaining a powers of attorney, or creating living wills with residents unless asked by staff or residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on observation, review of resident medical records, review of facility documentation, and interview with facility staff, it was determined that the facility failed to ensure that they developed and maintained an effective infection control program. This was evidenced by 1.) failing to destroy a used COVID-19 kit in the laundry room, 2.) failing to place an order for COVID-19 care/treatment for residents with confirmed COVID-19 infection. This was evident in 1 (Resident #63, #348) of 5 Residents reviewed for the COVID-19 order, 3.) failing to have a system in place to report a positive test for COVID-19 to the local health department. This was evidenced by lack of documentation for COVID-19 line listing from January 2022 to April 2022, 4.) failing to develop a facility policy for Personal Protect Equipment (PPE) during an outbreak in the facility; 5.) failing to ensure the facility provide updated COVID-19 education to staff, 6.) failing to maintain Alcohol Base Hand Rub dispensers and supplies. This was evidenced by 9 out of 41 ABHR dispensers observed without ABHR present, 7.) failed to ensure COVID-19 screening was performed for staff and visitors to entered the facility, 8.) failed to have a system in place to ensure that each resident was evaluated daily to check for COVID-19 symptoms. This was evident for 7 (#29, #36, #38, #58, #63, #141 and #10) of 7 residents reviewed for daily COVID-19 screening, 9.) failing to assess a resident for tuberculosis evidenced by failure to document the results of a two-step tuberculin skin test within 10 days of admission to the nursing home. This was evident for 1 (Resident #141) of 1 new admissions reviewed for tuberculosis and failed to follow infection prevention and control to prevent the spread of infection. These practices had the potential to affect all residents; 10.) failing to date and/or change/discontinued resident oxygen tubing (Resident #10); 11.) failing to store personal items separately from patient items evidence by observation of staff belongings on the clean linen laundry table and in a linen closet; 12.) staff failed to appropriately wear face masks, evident for 3 staff observed during the survey (Staff #41, #93, #94); 13.) failing to date and/or discard Sterile Water used for Inhalation (Resident #78). The findings include: A COVID-19 line listing is a tool that enables a facility to track and monitor residents and staff with COVID-19. It identifies positive tested individuals' names, dates of birth, test results, symptoms, outcomes, and vaccination information. The line listing can also be used to identify outbreaks of COVID-19 in a facility. Alcohol-based hand rub (ABHR) is the preferred approach to prevent healthcare-associated infections in most routine patient encounters, except when handwashing with soap and water is advised. Inappropriate utilization of ABHR could have detrimental effects, most importantly during the coronavirus disease (COVID-19) pandemic, which includes exposure of healthcare professionals to healthcare-associated infections and the development of resistant microorganisms. (National Library of Medicine: National Center for Biotechnology Information) 1) Two surveyors observed the facility laundry room on 9/13/22 at 10:01 AM. There was a stainless stationary shelf on the left side of the folding table. The surveyors observed some curtains, linens, a gallon water bottle with 1/5 remaining water, and an opened allergy medication bottle. Also, a surveyor found a used COVID-19 test kit on the shelf. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/13/22 at 10: 05 AM, an interview was conducted with the EVS director (Staff #19) in the laundry room. The surveyor asked about the used COVID-19 test kit on the shelf. Staff #19 immediately threw it away, and he stated it had been left by a staff member who did their self-test and left the kit on the shelf. Staff #19 stated all things on the shelf were not in use and said, we will discard the shelf soon. The Interim Director of Nursing (DON) was informed of the concern on 9/28/22 at 1:30 PM. 2a) The surveyor reviewed a medical record of Resident #63 on 9/21/22 at 11:40 AM. The review of the change in condition report dated 1/10/22 written by a nursing staff member revealed that Resident #63 was diagnosed as COVID-19 positive on 1/10/22. Also, the report included a note under the interventions section, The client is on droplet precaution. Mask will be worn when leaving the room. Aseptic education was given to the client. However, no physician's order was found for Resident #63 regarding COVID-19 care. 2b) The surveyor reviewed the medical records of Resident #348 for a portion of investigating complaint MD00178201, on 9/22/22 at 4:00 PM. The record review revealed that Resident #348 was admitted to the facility in March 2022 and tested positive for COVID-19 on 5/13/22. Further review of the medical records revealed the Change in Condition form completed by nursing staff on 5/13/22 that showed Resident #348 tested positive for COVID-19 on the same day, the physician was notified, and isolation precautions were updated on 5/13/22. Also, the facility's daily COVID-19 evaluation documented the resident tested positive from 5/13/22 to 5/19/22. However, a review of Resident #348's order showed no order for COVID-19 care/treatment. 3) Review of complaint MD00176851 on 9/13/22 at 9:00 AM revealed that the facility had not reported positive COVID-19 cases to the local health department at the beginning of May 2022. On 9/13/22 at 11:00 AM, surveyor requested a copy of COVID-19 line listing from January 2022 to May 2022. The Interim (DON) submitted an electronic version of the COVID-19 line listing files dated 5/11/22, 5/13/22, 5/16/22, 5/19/22, 5/23/22, 5/26/22, 6/7/22, 6/9/22, 7/1/22, 7/7/22, 8/30/22, and 9/11/22 via email on 9/14/22 at 9:57 AM. On 9/14/22 at 10:30 AM, a review of the COVID-19 line listing dated 5/11/22 revealed that the facility had five residents test positive for COVID-19 on 4/30/22, and one resident tested positive on 5/9/22. During a phone interview with an employee at the local health department (Staff #90) on 9/15/22 at 10:07 AM, Staff #90 confirmed the previous facility ADON (Assistant Director of Nursing) called on 5/2/22 and reported the facility had 4 residents test positive for COVID-19 on 4/30/22. Staff #86 stated that even though the local health department discussed testing, infection control, staffing, and guidance to fill out the line listing, the facility had not submitted the COVID-19 line listing until the middle of May 2022. On 9/16/22 at 1:28 PM, the surveyor reviewed randomly selected residents' medical records to verify whether the facility had a COVID-19 outbreak from January 2022 till May 2022. The record review revealed a written progress note, [family member] letting know one of our staff members has tested positive for COVID-19, dated 3/11/22 under Resident #2's and #24's records. Also, further review of Resident #63's medical record revealed that the resident was diagnosed as COVID-19 positive on 1/10/22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor interviewed the Interim DON on 9/16/22 at 2:07 PM. The interim DON stated since so many DONs and ADONs stayed a short time and left, there was technical difficulty in handing over all COVID-19-related documentation, including line listing and documentation of the COVID-19 outbreak report. She confirmed that there was no documentation for the COVID-19 line listing from January 2022 to May 2022. Also, the interim DON stated that the facility did not have evidence they reported to the local health department related to the COVID-19 outbreak. The surveyor shared concerns about the facility's failure to develop a system of reporting/tracking COVID-19 to the local health department on 9/28/22 at 1:30 PM. 4) During an initial facility tour on 9/11/22 at 7:54 AM, a Geriatric Nurse Aide (GNA) #84 handed an N-95 masks to surveyors at the Wye Oak unit nurse station. GNA #84 explained to surveyors since the facility had an outbreak of COVID-19, all staff needed to wear N-95 masks. Also, GNA #84 confirmed that staff did have surgical masks when they entered the building this morning. On 9/12/22 at 7:07 AM, the surveyor observed GNA #51 wearing a surgical mask at the Mill Landing unit. During an interview with GNA #51 at the time, she stated, we had COVID-19 positive residents last week. They moved to the Homestead unit. I'm not sure they are still in this facility or not. On 9/12/22 at 7:10 AM, the surveyor observed Licensed Practice Nurse (LPN) #30 and Registered Nurse (RN) #16 had surgical masks on while at the Wye Oak nurse station. On 9/12/22 at 9:05 AM, LPN #15 was wearing a surgical mask. An interview was conducted with LPN #15 at that time. LPN #15 said, I understood there is COVID-19 resident in this building. But we have a choice to wear an N-95 or a Surgical mask. We must change the mask to N-95 when we enter the COVID-19 unit. The surveyor requested all the facility's policies for COVID-19 on 9/12/22 at 1:30 PM. The interim DON brought policies: Infection Prevention and Control Program- revised date 7/14/21, COVID-19 testing Guidelines - revised 6/9/22, Antibiotic Stewardship Program - implemented date 7/30/21, and COVID-19 vaccination - revised date 1/10/22. However, none of these policies indicated PPE use during an outbreak of COVID-19 in the facility. This concern was informed to the interim DON on 9/28/22 at 1:30 PM. 5) During an interview with the interim DON (who also had the role of Infection Control Preventionist) on 9/14/22 at 1:55 PM, the interim DON stated the basic infection control education (such as hand hygiene and PPE use) was provided to the newly hired employees during training. Also, the interim DON said the updated COVID-19 Information was sent to all staff via the message system. During the interview, the interim DON confirmed that the messaging system was not trackable. On 9/20/22 at 3:25 PM, the surveyor reviewed the facility's COVID-19 education binder, which the interim DON provided. The review of the education binder showed a training record for the COVID-19 vaccination dated 8/22/21 containing 36 staff signatures who attended. No other training records were found in the binder. At 3:50 PM on 9/20/22, the surveyor interviewed the interim DON and asked how many staff worked in August 2021. The interim DON said, I need to verify it, but more than 36. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/28/22 at 1:30 PM, the surveyor informed the interim DON regarding concerns that there was no evidence to support the facility provided updated COVID-19 education to all staff. 6) During the initial tour of the facility on 9/11/22 at 7:30 AM, the surveyor found an Alcohol Based Hand Rub (ABHR) dispenser was broken near the washroom in the Wye Oak unit and three empty ABHR dispensers on the Wye Oak Hall (between room [ROOM NUMBER]-106). Additionally, during the facility tour on 9/13/22 at 8:40 AM, the surveyor found the facility had a total of 41 ABHR dispensers placed on the wall between residents' rooms; 6 were broken, and 3 were empty. During an interview with the EVS director (Staff #19) on 9/14/22 at 8:09 AM, Staff #19 stated that the central supply team ordered the ABHR supplies, and the housekeeper refilled them. The maintenance team would fix the broken dispenser. On 9/14/22 at 11:20 AM, during an interview with GNA #5, also the general supply manager, GNA #5 stated she did not order the ABHR gels, but the EVS team did. On 9/27/22 at 11:29 AM, the surveyor shared the concerns with the interim DON regarding the ABHR issues (broken and/or empty). The DON was unable to identify the person responsible for managing the ABHR supplies but consulted the interim DON. The interim DON stated, EVS would manage the ABHR dispenser and refill. Now Staff #19 also had a maintenance director role. Every ABHR dispenser was fixed. On 9/28/22 around 9 AM, the surveyor found 2 empty ABHR dispensers in the Wye Oak 100 hallway. 7a) When the surveyor team initially entered the building for the survey on 9/11/22 at 7:00 AM, there was no announcement posted for the COVID-19 screening required for any visitors or staff at the main entrance. During the survey period from 9/11/22 to 9/12/22, no announcement was posted for the COVID-19 screening necessary in the facility. On 9/12/22 at 7:40 AM, a surveyor entered the facility without COVID-19 screening through the KIOSK (a tablet for COVID screening questions and temperature check). The surveyor pushed a bell for the door to be opened, the door was opened remotely, allowing access to the conference room without completing the COVID-19 screening. During her entry process, no one reminded or monitored surveyor for COVID-19 screening. During an interview with the interim DON on 9/13/22 at 11:17 AM, the interim DON confirmed that whoever entered the building, regardless of entering time, needed to be screened by the Kiosk. The COVID-19 screening included a temperature check and three yes-no questions: Any signs/symptoms of illness including cough, body aches, chills, fatigue, sore throat, congestion, runny nose, shortness of breath, headaches, loss of taste/smell, nausea/vomiting, diarrhea, Have you been identified as a close contact to someone with COVID-19 or had contact with someone with COVID-19 within the last 14 days, and Have you been fully vaccinated? The interim DON also explained that if anyone entered the facility off hours (8 PM-8 AM: no receptionist attending hours), a shift supervisor would open the door (directly or remotely) for visitors, and the supervisor would require the visitors to do the COVID-19 screening. The surveyor asked how the visitor would know to do COVID-19 screening if the entrance door opened remotely and no announcement was posted for the screening. The interim DON did not add any comments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7b) During an interview with the Nursing Home Administrator (NHA) on 9/15/22 at 8:39, the NHA stated that the employee punch report was the most accurate documentation to verify who worked on a certain day and time. The NHA explained that the punch report also recorded agency nursing staff's clock-in time. On 9/21/22 at 11:24 AM, the surveyor reviewed the facility's punch report and KIOSK screening report for 9/11/22, 9/12/22, and 9/15/22. On 9/11/22: a total of 34 staff names were listed on the punch report. Among the listed 34 staff, 17 staff screened for COVID-19 via the KIOSK system. On 9/12/22: a total of 40 staff names were listed on the punch report. Among the listed 40 staff, 12 staff had COVID-19 screening records in the KIOSK. On 9/15/22: a total of 37 staff names were listed on the punch report. Among the listed 37 staff, 14 staff were screened for COVID-19 via KIOSK. During an interview with the interim DON on 9/28/22 at 1:30 PM, the surveyor informed the interim DON of concerns that staff were not screened for COVID-19 when entering the facility. 8) On 8/26/22, the State of Maryland Health Secretary issued an Amended Directive and order Regarding Nursing Home Matters (No. 2022-08-26-01). The Amended Directive continues to instruct, Each nursing home resident shall be evaluated daily to check for COVID-19 by the nursing home's clinical staff. 8a) The surveyor reviewed daily COVID-19 evaluations from 9/11/22 to 9/27/22 during the ongoing survey period for randomly selected Residents (#29, #36, #38, #58, #63, and #141) on 9/28/22 at 10:00 AM. The review of records revealed that 6 out of 6 Residents' daily COVID-19 evaluations were not documented under electronic medical record (PCC). i) Resident #29's COVID-19 daily evaluation was not documented on 9/11/22 ii) Resident #36's COVID -19 daily evaluations were not documented on 9/11/22, 9/13/22, 9/14/22, 9/15/22, 9/19/22, 9/23/22, 9/25/22, and 9/27/22. iii) Resident #38's COVID-19 daily evaluations were not documented on 9/11/22, 9/13/22, 9/14/22, 9/15/22, 9/21/22, 9/23/22, and 9/25/22. iv) Resident #58's COVID-19 daily evaluations were not documented on 9/11/22, 9/13/22, 9/14/22, 9/15/22, 9/17/22, 9/18/22, 9/19/22, 9/25/22, and 9/26/22. v) Resident #63's COVID -19 daily evaluations were not documented on 9/11/22, 9/13/22, 9/14/22, 9/15/22, 9/18/22, 9/19/22, and 9/25/22. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	vi) Resident #141 was admitted to the facility on [DATE]. Resident #141's medical record was reviewed on 9/27/22 for daily COVID-19 evaluations. A Peak COVID-19 evaluation dated 9/7/22 was found not completed as it was labeled in progress by a Healthcare Virtual Assistant. The evaluation was not signed by a facility nurse to show completion of the COVID-19 evaluation. There was no documented COVID-19 evaluations on 9/15, 9/17, 9/18, 9/19, and 9/26/22 for resident #141. 15701 9) The facility failed to assess a resident for tuberculosis within 10 days of a resident's admission to the facility. Resident #141 was admitted to the facility on [DATE]. Review of Resident #141's medication administration record (MAR) on 9/20/22 revealed the resident was administered the tuberculin skin test (TST) intradermally on 9/7/22 and 9/13/22. There was no documentation of the results of both tests. The interim DON was interviewed on 9/20/22 at 4 PM. She was asked, where do the staff document the reading/results of a Tuberculin skin Test? The interim DON indicated that the results would be recorded on medication administration record. She was informed that the results of two administered tuberculin skin test were not documented in the record. 31145 10) On 9/11/22 at 9:26 AM observation was made of a portable oxygen tank on the back of the wheelchair for Resident #10. There was a nasal cannula attached to the oxygen tank. There was no date indicated on the nasal cannula as to when the nasal cannula was attached and/or changed. A nasal cannula consists of a flexible tube that is placed under the nose. The tube includes two prongs that go inside the nostrils to deliver oxygen. On 9/14/22 at 2:10 PM an interview was conducted with RN #3. RN #3 stated she did not know why the resident had oxygen. The surveyor said, even with the nasal cannula wrapped around the back of his chair. RN #3 said, don't know. On 9/15/22 at 10:30 AM a record review of the vital sign section of Resident #10's electronic medical record revealed the last time the resident used oxygen was 1/31/22, which was at least 8 months that the nasal cannula has been attached to the oxygen without being changed, as there was no date known. 11) On 9/21/22 at 8:05 AM a review of Resident #10's medical record was conducted and revealed daily COVID-19 evaluations were not done on 9/10/22, 9/9/22, 9/6/22, 8/27/22, 8/26/22, 8/20/22, 8/16/22, 8/13/22, 8/12/22, 8/6/22, 8/5/22, 8/4/22, 7/27/22, 7/25/22, 7/9/22, and 7/2/22. 11) Facility staff failed to store personal items separately from patient items: On 9/11/22 at 7:56 AM observation was made in the laundry room. There was clean laundry in a bin next to the folding table and clean laundry at the end of the table. On the clean folding table was a pocketbook, drink bottle, shaker bottle and a cell phone. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/12/22 at 8:41 AM observation was made of the linen closet at the end of the 200 hallway. There were 3 backpacks hanging on the inside of the door: 1 flowered backpack that had Puerto Rico embroidered on the front, 1 black cloth backpack and 1 orange/pink cloth backpack. 12) Facility staff failed to appropriately wear face masks: On 9/13/22 at 3:35 PM an agency GNA was in the Homestead unit with her mask below her nose. She was wearing a surgical mask under a sparkly mask. On 9/20/22 at 12:58 PM and 3:25 PM observation was made of Staff #41 come out of Nursing Home Administrator's office, walk into the hallway past a resident and back to the receptionist desk. Staff #41 was wearing a mask under her chin. On 9/23/22 at 9:07 AM observation was made in the kitchen of Staff #93 and Staff #94 wearing their masks below their chins while they were standing at the food steam table. 13) On 9/16/22 at 12:59 PM observation was made of Resident #78's nightstand. There were (2) 550 ml. bottles of Sterile Water for Inhalation. The first one was opened, one fourth used with a date opened written on the bottle in pen of 11/10/21, Reference # AS0552. The second bottle was opened with one fifth of the contents remaining. There was no date opened on the bottle. According to an email response from the manufacturer, The product is sterile saline for inhalation packaged in plastic container. Once opened, it is no longer considered sterile. There are no studies on how long it is good for after opening. Saline is mostly water. Evaporation will (slowly) change the salinity level. Different environmental conditions (temperature, humidity) have effects on evaporation. There is also potential for contamination after the container is opened. On 9/28/22 at 12:15 PM discussed all concerns with the Interim DON.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 31145 Based on observation, medical record review, and staff interview it was determined the facility failed to have a process in place to conduct regular inspections of bed frames, mattresses, and bed rails. This was evident for 1 (#34) of 8 residents reviewed for accidents during the annual survey. The findings include: On 9/21/22 at 7:39 AM observation was made of Resident #34 lying in bed with bilateral 1/2 side rails in the raised position. On 9/21/22 at 4:30 PM a medical record review was conducted for Resident #34 and revealed a recent side rail assessment had not been done. There were no physician's orders for side rails and there was not a care plan for side rail use. On 9/27/22 at 11:13 AM an interview was conducted in Resident #34's room with the Director of EVS (environmental services) and Maintenance, Staff #19, and the Regional Director of Plant Operations. Staff #19 was asked if he had a process in place to check side rails along with the beds and mattresses. Staff #19 stated he would have to check. He has only been in the position for the past 2 weeks. The surveyor showed Staff #19 the loose side rail and the Regional Director confirmed the side rail was loose and should have been reported in the TELS system (electronic system for repairs), however they have so many agency staff working at the facility and things don't get reported. Cross Reference F700 The side rails issue was discussed with the Interim Director of Nursing on 9/28/22 at 12:15 PM.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on complaint, observation, and staff interview, it was determined that the facility staff failed to maintain the resident call system in working order and within reach. This was evident for 2 of 3 nursing units observed during the annual survey. The findings include: 1) A review of complaint MD00178416 on 09/11/22 at 7:30 AM, revealed an allegation that resident call bells have been broken for months. During an initial observation of the 200-hall nursing unit on 09/11/22 at 8:15 AM, the nurse surveyor observed the following: An observation of Resident #70 on 09/11/22 at 8:30 AM, revealed a call bell wall receptacle in disrepair. An observation of Resident #6 on 09/11/22 at 8:35 AM, revealed a call bell wall receptacle in disrepair. An observation of Resident #34 on 09/11/22 at 8:56 AM, revealed a call bell wall receptacle in disrepair. Resident #34 was supplied with a handheld call bell that was located on his/her bedside table. When asked, Resident #34 was unable to demonstrate how to use the handheld call bell to call for assistance from the nursing staff, An observation of Resident #1 on 09/11/22 at 9:50 AM, revealed Resident #1's call bell lying on the floor behind Resident #1's bed. Resident #1, when asked, was unable to locate his/her call bell. In an interview with the facility assistant maintenance man, Staff #11 on 09/11/22 at 8:50 AM, Staff #11 stated that there were many call bell units that were broken in resident rooms. Staff #11 stated that he does not have parts to fix all the broken call bell units and that the call bells break every day. Staff #11 stated that he will use call bell unit parts from other resident rooms that are not occupied. Staff #11 stated that the facility administrator is aware of the broken resident rooms call bell issue and that there was no current plan or contract to fix the call bell system at this time that he was aware of. In an interview with Staff #27 on 09/12/22 at 10:17 AM, Staff #27 stated that he was instructed to pass out handheld call bells to residents on the morning of 09/11/22 when the State Survey team entered the building. During an observation and interview with Resident #5 on 09/11/22 at 10:40 AM, Resident #5 stated that his/her call bell had been broken now for four days and that the staff had supplied him/her with a cowbell to request for assistance. 31145 (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 9/13/22 at 8:39 AM an interview was conducted with Staff #88 who stated, the call bells have been an issue since July 2022 and people act like they don't know the call bells are broken. 3) Observation was made on 9/15/22 at 10:44 AM of the call bell ringing in room [ROOM NUMBER]. The call bell was audible at the nurse's station but was not lighting up outside of room [ROOM NUMBER] in the hallway. 4) Observation was made on 9/20/22 at 4:20 PM of Resident #34 lying in bed. Resident #34's call light cord was on the right side of the bed. The surveyor pushed the button on the call bell several times and and the call bell was not audible and did not illuminate. Observation was made of a hand held bell on the night stand table in front of the closet. The bell was approximately 5 ft. away from the resident. On 9/21/22 at 5:00 PM the surveyor took the Nursing Home Administrator (NHA) in Resident #34's room. The surveyor showed the NHA that the hand held call bell was on the night stand which was on the other wall that was not next to the bed. The NHA stated, I thought they fixed the call bell. The NHA tried the call bell and acknowledged that it did not work. On 9/28/22 at 5:30 PM an interview about QA (quality assurance) activities was discussed with the Medical Director and the Interim Director of Nursing (DON). They were asked if the issue with broken call bells had been brought up in the QA meetings. The Medical Director replied, the call bells not working has not been brought up in QA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215010	A. Building B. Wing	09/28/2022

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 15701 Based on staff collaborated observations of two restrooms utilized by staff and residents, a nursing station and a shower room, it was determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff as identified in 2 of 2 staff bathrooms observed and for 1 (200 hall) of 4 nursing units observed during the annual survey. The findings include. 1) An observational environmental tour of the facility was conducted on 9/28/22 with the environmental services director/maintenance director #19 beginning at 1:30 PM. Observation of the staff restroom that was shared with residents on the Chesapeake unit did not have a paper towel dispenser and the paper towels were kept on the back of the toilet. The environmental services director was informed that a hand-washing sink for the staff is required to be equipped with a goose-neck spout, with a separate soap dispenser, and a disposable paper towel dispenser. Observation of the staff restroom that was shared with the residents on the Wye Oak unit did not have a staff hand washing sink that was equipped with a goose-neck spout. 18819 2) On 09/12/22 at 10:55 AM, surveyor observation at the 200 hall nurses' station revealed a red-colored sharps container underneath the 200 hall nurses' station desk. The locked sharps container was observed sitting on the floor behind the medical record shredding container. Alongside the locked sharps container was a brand new sharps container lid. The surveyor lifted the locked sharps container onto the desk. Observations of the locked sharps container revealed what appeared to be whole, round pills and capsules throughout the container. The whole, round pills and capsules appeared to be in a retrievable condition. At this time, the facility corporate clinical nurse #32 was passing by the 200 hall nurses' station. The nurse surveyor made the corporate clinical nurse aware of the findings and the surveyor handed the locked sharps container to the corporate clinical nurse. In an interview with the facility Administrator on 09/12/22 at 11:05 AM, the facility Administrator asked the nurse surveyor questions about the discovery of the locked sharps container. The facility Administrator stated that the locked sharps container should have been placed in the soiled holding room for trash removal. During the interview, the Administrator also removed two single gallon-sized drug buster containers from the 200 hall nurses' desk and had them placed in the soiled holding room for trash removal. 3) During an observation of the 200 hall on 09/21/22 at 1:35 PM, surveyor identified malodors emitting from the 200 hall shower room. A closer observation of the 200 hall shower room revealed an approximate 5-inch hole, an uncovered shower drain on the floor of the right shower stall. The surveyor identified the malodors emitting from the uncovered shower drain.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 31145 Based on interview and documentation review, it was determined the facility failed to ensure a training program was set up and in place for their staff to be educated on abuse, neglect, exploitation, and misappropriation of resident property along with dementia management and resident abuse prevention. This was evident for current staff and had the potential to affect all residents. The findings include: On 9/20/22 at 11:26 AM an interview was conducted with Staff #20, Director of Human Resources and the Business Office Manager. Staff #20 was asked about in-service training and she stated, only for new hires is there abuse training. Right now there is nothing for existing staff on yearly training related to abuse and dementia management. Review of the packet for new hire training revealed printed papers for self study on Resident Abuse Prevention and Reporting, Resident Rights and Facility Responsibilities, Compliance and Ethics Program, and HIPAA Security. Each stapled packet had a Pre/Post Test. Staff #20 explained that a new hire would receive the packet and then have to return the post test prior to working. Staff #20 stated, Corporate should have a training program. Different modules for like abuse training throughout the year. I have not set it up yet. I just did my yearly set-up at [name of sister facility]. It is in modules, and I know how I want to set it up. They did not have anything in place here.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on documentation review and interview, it was determined the facility failed to ensure nurse aide competency training occurred no less than 12 hours per year as determined in nurse aides' performance reviews. This was evident for 3 of 3 files reviewed and had the potential to affect all residents. The findings include: A review was conducted of GNA personnel files on 9/20/22 at 9:32 AM. A review of GNA #37's personnel file revealed GNA #37 was hired on 8/4/21. A review of GNA #44's personnel file revealed GNA #44 was hired on 9/14/20. A review of GNA #45's personnel file revealed GNA #45 was hired on 4/21/20. There was no evidence that 12 hours of training occurred for the three GNA's. On 9/20/22 at 11:26 AM an interview was conducted with Staff #20, Director of Human Resources and the Business Office Manager. Staff #20 stated, I have not seen any yearly reviews since I have been here. I have not seen any evidence of yearly evaluations. They did not have anything in place. Staff #20 was asked about in-service training and she stated, only for new hires is there abuse training. Right now there is nothing for existing staff on yearly training related to abuse and dementia management. Staff #20 stated, Corporate should have a training program. Different modules for like abuse training throughout the year. I have not set it up yet. I just did my yearly set-up at [name of sister facility]. It is in modules, and I know how I want to set it up. They did not have anything in place here. On 9/20/22 at 11:38 AM an interview was conducted with the Nursing Home Administrator (NHA), Interim Director of Nursing (DON), and Staff #7. They said, we do not have a Staff Developer. We had a DON and (Assistant) DON and 2 managers. It was divided between the ADON and managers. They stated, it kind of fell apart. They said they had a DON from June 6 to August 31, 2022. They hired an ADON in the middle of August 2022 and she did not last for 2 weeks. She said she knew everything about what to do and then she quit. They stated the process of training and competencies, never evolved because the ADON was only at the facility for a week. In April [name] was here as ADON and she resigned the first week of August. We do not have any competencies on nurses and GNAs. The Interim DON stated, so far I have not had any GNAs without experience. With the nursing shortage most of them are all agency. All GNAs are certified. Yearly performance reviews are supposed to be done. We don't have a lot of regular staff. I have not tracked making sure everyone is getting the 12 hours of training.