STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 15701 Based on surveyor observation, interview, and record review it was determined that the facility staff failed to: 1) protect and value resident's private space by failing to knock and request permission before entering a resident's room, and 2) ensure a urine collection bag had a privacy cover and was out of sight of the public. This was evident but not limited to 1 of 7 residents (Resident #57) reviewed on the 1 [NAME] Unit and 1 (#83) of 4 residents reviewed for urinary catheters during the annual survey. The findings include: 1) An interview was conducted with Resident #57 in the resident's room with the door closed on 8/3/22. At 1:41 PM a couple of knocks were heard and without any acknowledgement from resident #57 an employee entered the room. The employee did not excuse herself, interrupted the interview and proceed to place supplies into a dresser drawer. Upon the employee's exit from the room, resident #57 identified the employee (Staff # 75) from central supply. Resident #57 commented and implied that the staff entering the room unannounced is routine. The unit manager (staff # 48) was informed at 2:48 PM on 8/3/22 of the central supply person entering the closed-door room unannounced. 44484 2) On 7/25/22 at 12:08 PM observation was made of Resident #83 lying in bed. A urinary drainage collection bag was observed hanging behind a dignity bag on the frame of the right side of the bed. On 7/26/22 at 10:03 AM observation was made of Resident #83 lying in bed. Resident #83's urinary collection bag, containing urine, was visible from the doorway on the left side of the bed. The urinary collection bag was not in a dignity bag. A urinary drainage bag collects urine through a tube that is inside the bladder. On 7/26/22 at 2:08 PM an interview was conducted with Geriatric Nursing Assistant (GNA) #34. GNA #34 was asked to describe her process in care related to the drainage bag. GNA #34 stated, I make sure the dignity bag is never touching floor. GNA #34 was shown the urinary collection bag and that there was no dignity bag present. GNA #34 confirmed the finding. (continued on next page)

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 - Few	On 7/30/22 at 2:00 PM a review of Resident #83's August 2022 physician's orders revealed an order, ensure leg strap in place, drainage bag is covered with privacy bag and placed below bladder level. The Director of Nursing was informed of the finding on 8/9/22 at 11:20 AM.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 15701 Based on a review of complaint MD00177146, medical record review, observations, and interviews with the resident, and facility staff, it was determined that the facility 1) failed to optimize the living environment for a resident with a request to add weather-stripping to the bottom of the resident's bedroom door and 2) failed to ensure access to the nurse call bell for residents residing in the facility. This was evident for 1 (complaint MD00177146) of 4 complaints reviewed for Resident #50 and 1 (Resident #53) of 32 residents reviewed during the initial stage of the annual survey. The findings include: 1) Review of complaint MD00177146 revealed a concern that the facility did not meet an agreed upon request to install weather stripping along the bottom of the resident's door to accommodate resident #50's request to maintain the air quality in the room. Review of resident #50's medical record on 8/2/22 revealed a social service Care Plan: quarterly resident meeting note dated 6/17/22 with the following statement: Resident request structural adjustment to the bottom of his/her door(strips) will discuss with administrator his/her request. Review of resident #50's care plans revealed an intervention written as [resident's name] preference to keep sheet at bottom of door and sign on door to keep door closed. Observation of the resident's doorway on 8/2/22 at 11:30 AM revealed an accumulation of sheets on the floor along the bottom of the resident's doorway. Upon the resident's permission to enter the room, 3 air purifiers were noted in the room. Resident #50 proceed to discuss the significant reason for the room air purifiers. Resident #50 indicated he/she has a weakened immune system and certain smells can cause allergic body responses. Resident #50 revealed reasons for the sheets on the floor along the threshold of the doorway to maintain the quality of air in the room by preventing odors from disinfectants or other foul odors from entering the room. The resident indicated his/her request for weather-stripping along the bottom of the door during his/her care meeting on 6/17/22. Resident #50 acknowledged that the weather-strip would be better that the built-up sheets on the floor. An interview with the nursing home administrator (NHA) was conducted at 3:55 PM on 8/2/22. The administrator was asked about the resident's request to have weather-stripping attached to the bottom of the door. The administrator indicated that due to the width and thickness of the door, weather-stripping was not found. The NHA was asked if the resident was informed that weather-stripping was not found to meet the measurements of the doorway. The NHA responded I believe so. The surveyor implied that two smaller width weather-strips may need to be modified to work as a barrier across the approximate 1-inch gap between the floor and the door. Resident #50 was re-interviewed on 8/10/22 at 11:50 AM. The resident was asked if he/she was informed of any reason for a delay in obtaining the requested weather stripping to the bottom of the door. The resident responded that he/she has not been informed of any reasons for a delay and with complaint that his/her request was taking so long. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a survey discussion with the NHA on 8/10/22 at 3:11 PM, the NHA was informed of the regulatory concerns related to resident #50's lack of an accommodation of need. 31145 2) A call bell is a bedside button tethered to the wall in the resident's room, which directs signals to the nursing station; a call light usually indicates that the patient has a need or perceived need requiring attention from the nurse or geriatric nursing assistant (GNA) on duty. On 7/25/22 at 8:47 AM observation was made of Resident #53 lying in bed. There was no call bell near Resident #53 or near the bed. On 7/25/22 at 8:50 AM an interview was conducted with the maintenance director, Staff #11, who was in the hallway outside of Resident #53's room. Staff #11 came into Resident #53's room and said there was a plug in the wall outlet where the call bell should have been connected. Resident #53's call bell cord was attached to the next bed's call light outlet. There was a call light cord for that bed, however there was no other resident occupying that bed or in the room. Staff #11 stated that someone moved the call bell plug out of Resident #53's outlet and attached the plug to the other bed's outlet. Staff #11 removed the plug and placed the other bed's call light plug into Resident #53's connection. Staff #11 stated, I have tried to do call bell audits once a week, but I am currently working alone, and we are short staffed in the maintenance department. We are also short 1 to 2 call bells and I currently have 15 on order. On 7/25/22 at 1:30 PM a review of Resident #53's care plan revealed, at risk for falls that was initiated on 4/13/22 with the intervention, educate resident on the use of call bell and the need to ask for assistance with ambulating, transfers, and toileting and place call bell within resident's reach. On 8/9/22 at 11:20 AM the Director of Nursing was informed of the finding.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 15701 Based on facility documentation review and interview, the facility staff failed to provide evidence the facility had purchased a surety bond to assure the security of all the residents' personal funds deposited with the facility. This was evident during the investigation of facility tasks during an annual survey. The findings include: On 8/9/22 at 11:45 AM, an inquiry was made with lobby receptionist (Staff #47) as to where the business office was located. It was revealed that the facility did not have a business office and she was responsible for passing out resident funds. Upon further questioning she indicated that she receives a weekly ledger listing the individual residents' current personal funds balances for the residents that have their personal funds managed by the facility. The receptionist showed the balance dated 8/3/22 of all residents' personal funds held by the facility was $59,541.00. She was asked as the total amount of the Surety bond. She expressed that she was unaware of a Surety bond. Surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (depending on State law, either the resident or the State acting on behalf of the resident), wherein the facility and the insurance company agree to compensate the resident (or the State on behalf of the resident) for any loss of residents' funds that the facility holds, safeguards, manages, and accounts for. The surveyor requested for the receptionist to ask the Nursing Home Administrator to provide a copy of the facility's surety bond. A Certificate of Liability insurance was provided to the surveyor by 12:30 PM on 8/9/22. The document dated 7/25/22 from the surety company stating the facility had a bond for $51,000 that was effective 7/31/22 until 7/31/22. The surety bond of $51,000 failed to cover the resident's personal funds of $59,541.00. At 12:35 PM, the Nursing Home Administrator was asked if the Certificate of Liability Insurance was the correct surety bond. On 8/9/22 at 12:45 PM the administrator revealed that this was the only bond with a limit of $51,000. He was informed that the bond total did not cover the total of resident funds of $59,541.00.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on clinical record review and staff interviews, it was determined that the facility failed to ensure the resident/responsible party was offered the opportunity to develop an advanced directive for 15 (#46, #76, #17, #87, #18, #28, #67, #1, #22, #49, #61, #95, #24, #75, #307) of 16 sampled residents for advanced directives. The findings include: An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity. A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. 1) On [DATE] at 12:02 PM a chart review for Resident #46 revealed the resident was admitted to the facility in [DATE] with a past medical history that included, but was not limited to, major depressive disorder, unspecified dementia, and anxiety disorder. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was recently provided to the resident and/or the resident representative. Review of the care plan section of the paper medical record had Care Plan Conference Summary sheets with the date of the care plan conference. There were care plan elements that could be checked off as discussed with the resident/resident representative. For Advanced Directives there were 2 boxes that were checked off for the [DATE] meeting. For conference summaries dated [DATE], [DATE] and [DATE], the boxes were blank. On [DATE] a Social Services note documented, care plan meeting held with resident, daughter via telephone, AD (Advanced Directives) reviewed, no HealthCare Agent at this time. Will give daughter HC (HealthCare) form. There was no further documentation about the form. 2) On [DATE] at 10:58 AM a chart review for Resident #76 revealed the resident was admitted to the facility in February 2022 with a past medical history that included, but was not limited to, asthma, COPD, hypertension, open wound of left hip, mild protein-calorie malnutrition, and altered mental status. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was recently provided to the resident and/or the resident representative. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) On [DATE] at 7:53 AM a chart review for Resident #17 revealed the resident was admitted to the facility in [DATE] with a past medical history that included, but was not limited to, early onset Alzheimer's disease, major depressive disorder, COPD, and sleep apnea. Review of progress notes dated [DATE] documented the daughter reported that the resident did not have Advance Directives, however, stated that she (daughter) has been acting as the responsible party. There was no further information indicating that an opportunity to formulate an advance directive was recently provided to the resident and/or the resident representative. On [DATE] at 9:43 AM an interview with the Social Work Director was conducted. The Social Work Director was asked about Advanced Directives and stated, Advanced Directives is code status, treatments they want, and if they want to go to the hospital. The Social Work Director confirmed that the MOLST in the medical record was considered the Advanced Directive. The Social Work Director stated she was not asking about living wills or providing any other Advanced Directive information to residents or representatives. 4) On [DATE] at 10:04 AM a chart review for Resident #87 revealed the resident was admitted to the facility in [DATE] with a past medical history that included, but was not limited to, end stage renal disease, type 2 diabetes mellitus, hypertension, pulmonary edema, peripheral vascular disease, below the knee amputation of the right leg, and chronic pain. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was recently provided to the resident and/or the resident representative. 5) On [DATE] at 7:40 AM a chart review for Resident #18 revealed the resident was admitted to the facility in [DATE] with a past medical history that included, but was not limited to, schizophrenia, cardiomyopathy, cachexia, peripheral vascular disease, major depressive disorder, malnutrition, and dysphagia. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was recently provided to the resident and/or the resident representative. 6) On [DATE] at 12:21 PM a chart review for Resident #28 revealed the resident was admitted to the facility in [DATE] with a past medical history that included, but was not limited to, protein calorie malnutrition, covid-19, osteoporosis, cachexia, hypertension, pancreatic cancer, and major depressive disorder. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was recently provided to the resident and/or the resident representative. On [DATE] at 2:47 PM both the Social Work Director and the Director of Nursing (DON) were interviewed and were informed that surveyors were not finding documentation about Advanced Directives. Both confirmed they were not documenting, asking, or providing any further information about Advanced Directives. 43096 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7) On [DATE] at 9:00 AM, a review of Resident #67's medical record revealed that the resident was admitted to the facility in 2017 with a past medical history that included but was not limited to schizophrenia (a serious mental disorder in which people interpret reality abnormally). Further review of the medical record revealed the resident's last updated MOLST was on [DATE]. However, a review of Resident #67's care plan conference summary sheet from [DATE] to [DATE] on [DATE] at 7:29 AM revealed no information indicating that an opportunity to formulate an advance directive was provided to the resident and/or the resident representative. During an interview with a Social Worker (Staff # 74) on [DATE] at 2:47 PM, Staff #74 confirmed that the facility staff was not documenting or asking about further advanced directives. During an interview with the Director of Nursing (DON) on [DATE] at 4:00 PM, the DON was informed above concerns. 15701 8) Resident #1 was admitted to the facility on [DATE]. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident and/or the resident representative. 9) Resident #22 was admitted to the facility on [DATE]. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident's court appointed guardian. 10) Resident #49 was admitted to the facility on [DATE]. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident and/or the resident representative. 11) Resident #61 was admitted to the facility on [DATE]. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident and/or the resident representative. 42507 12) Resident (R) #95 was admitted to the facility on [DATE] with a past medical history that included osteomyelitis, sepsis, diabetes, quadriplegia, and chronic obstructive pulmonary disease. During a review of the clinical record on [DATE], a resident's MOLST (Maryland Order for Life Sustaining Treatment) was located, but there was no documented evidence that the resident was provided the opportunity or provided written information regarding the right to formulate an advanced directive. 13) R #24 was admitted to the facility on [DATE] with a past medical history that included, but not limited to cerebral infarction, hemiplegia and hemiparesis, COVID-19, major depressive disorder, osteoarthritis, cognitive communication deficit, developmental disorder of scholastic skills, and muscle weakness. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident and/or the resident representative. 14) R #75 was admitted to the facility on [DATE] with a past medical history that included, diabetes, alcohol use, peripheral vascular disease, left below knee amputation, prostate cancer, and COVID-19. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no information indicating that an opportunity to formulate an advance directive was provided to the resident and/or the resident representative. 15) R #307 was admitted to the facility on [DATE] with diagnoses that included, rheumatoid arthritis, obstructive sleep apnea, chronic obstructive pulmonary disease, COVID-19, and pain in knee. During a review of the clinical record on [DATE], a resident's MOLST was located, but there was no documented evidence that the resident was provided the opportunity or provided written information regarding the right to formulate an advanced directive. On [DATE] at 1:45 PM, in an interview with Licensed Practical Nurse (LPN # 21), s/he stated that s/he has never asked the residents about their advanced directives nor given them the opportunity to formulate one. LPN #21 stated that the doctors and the nurse practitioners discuss advanced directives with the residents. On [DATE] at 1:48 PM, in an interview with LPN #22, s/he stated that s/he has never had a conversation with any of the residents about their advanced directives. LPN #22 stated that usually advanced directives was addressed by the social worker and/or admissions. On [DATE] at 10:48 AM, review of the revised [DATE] facility Advanced Directives policy read: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Advanced Directives is defined as a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated. The policy did address the Federal Regulations for provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. On [DATE] at 2:45 PM, in a follow up interview with the DON and the SW #74, they both acknowledged that it was fair to say that the above residents did not have Advanced Directives addressed in their charts and documentation.

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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** 31145 Based on record review and staff interview it was determined the facility staff 1) failed to notify the physician that a medication for an elevated potassium level was unavailable and 2) failed to have a system in place to notify the physician when residents' weight loss was identified. This was evident for 1 (Resident #251) of 1 resident reviewed for an unexpected death and 3 (Resident #73, #67, #402) of 7 residents reviewed for weight loss. The findings include: 1) On 8/4/22 at 7:30 AM a review of Resident #251's medical record revealed a 12/17/21 physician's history and physical that documented the resident was admitted to the facility on [DATE] from an acute care facility for subacute rehabilitation due to deconditioning. Resident #251 had diagnoses that included, but were not limited to hypertension, chronic obstructive pulmonary disease exacerbation complicated by pneumonia, aortic stenosis, atrial fibrillation, and heart failure. A review of a 1/4/22 physician's note documented that Resident #251 was diagnosed with COVID 3 days prior and had been monitored closely and the patient today is seen significantly worse. The physician's note documented, labs were done today, which were abnormal. The physician documented the potassium level was 5.5. According to the Lab Results Report dated 1/4/22, the reference range for potassium levels was 3.5 to 5.2 mEq/L. According to the National Institute of Health (NIH), potassium is a type of electrolyte that is an electrically charged mineral that helps control fluid levels and the balance of acids and bases (pH balance) in the body. Potassium also helps control muscle and nerve activity along with other functions. If potassium levels are too high, it could affect the rate or rhythm of the heart. The 1/4/22 physician's note continued, Lab work today is being ordered stat, showed significantly elevated BUN (blood urea nitrogen) and creatinine indicating severe dehydration. The note continued, may have progression of [his/her] underlying COVID. [He/She has a history of underlying heart failure. We will repeat [his/her] stat BMP (basic metabolic profile). Following this, [his/her] potassium is elevated, will need Lokelma, could be from severe dehydration. Lokelma is a medication to treat high levels of potassium in the blood. A review of the written physician's orders sheet dated 1/4/22 had the order, give Lokelma 10 gm x 1 for hyperkalemia. The order sheet did not have a time that the order was written. Review of the electronic order in the facility's electronic medical record system documented the order was put into the system at 1534 (3:34 PM). A review of Resident #251's January 2022 Medication Administration Record (MAR) documented at 2021 (8:21 PM) that the medication was not given. A note by the nurse documented medicine not available, waiting for pharmacy to deliver. Further review of Resident #251's medical record failed to reveal documentation that the physician was notified of the unavailability of the 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 8/4/22 at 9:49 AM physician #73 was interviewed about the elevated potassium level and was asked, if you ordered medication for an elevated potassium level and the medication was not available, would you expect the nurse to call you if the medication was not available. Physician #73 stated, yes, the expectation, even if the nurse knew the value wasn't critical, should not have taken it upon herself to not let the physician know the medication was not available. The Director of Nursing was informed of the concern on 8/9/22 at 11:20 AM. 43096 2) On 7/25/22 at 1:09 PM review of Resident #73's medical record revealed the resident weighed 228.6 lb. (pounds) on 1/5/22 and on 2/4/22 weighed 214.6 lb., which was a 14 lb. loss (6.12 %) in 4 weeks. Further medical records on 7/28/22 at 8:29 AM revealed a dietitian (staff #13) wrote a progress note on 2/17/22 as the resident was to be re-weighed by nursing to confirm weight loss. A progress note written by a previous dietitian (staff #67) on 2/18/22 stated resident has refused to be weighed. However, no documentation was found of notification to the physician for Resident #73's weight loss. During an interview with staff #13 on 7/28/22 at 10:29 AM, staff # 13 stated whenever she recognized residents' weight loss, she documented it under electronic medical records and discussed it with the facility team (including the director of nursing and physician). She also stated that physician notifications were made via phone call, text, or in-person. However, no supportive documentation was submitted to the surveyor to verify notice was made to the physician. 2) On 7/28/22 at 7:57 AM a review of Resident #67's medical record revealed the resident weighed 218.6 lb on 12/6/21 and on 1/5/22 weighed 200.4 lb., which was an 18.2 lb. loss (9.8%) in 4 weeks. Further medical records on 7/28/22 at 7:57 AM revealed staff #67 wrote a progress note on 1/14/22 RD (Registered Dietitian) to request reweight. Also, a progress note dated 1/20/22 written by staff stated resident refused weight attempted x2 and continues to refuse. However, there was no documentation to support Resident #67's weight loss was reported to the physician. 3) On 8/5/22 at 8:21 AM a review of Resident #402's medical record revealed the resident weighed 116 lb. on 1/30/22 and on 2/1/22 weighed 104 lb. which was a 12 lb. loss (10.3%) in 2 days. Review of the resident's progress note dated 2/2/22 written by a dietitian showed poor PO (oral) intakes addressed; resident is receiving ensure clear TID (three times a day) to promote adequate intakes. Resident is to be re-weighed per nursing to confirm weight loss. A progress note written by the nurse dated 2/2/22 stated the resident refused to be weighed. Resident #402 was discharged to home on 2/4/22. However, there was no documentation to support Resident #402's weight loss was reported to the physician. On 8/5/22 at 1:39 PM, an interview was conducted with a Geriatric Nurse Assistant (GNA #32). She stated that residents' health status or order would check residents' body weight, and GNA checked the order, and nurses would put the number in the system (electronic medical record). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with a Licensed Practical Nurse (LPN #10) on 8/5/22 at 1:45 PM, she stated, When weight change is alerted, staff, reweigh residents' bodyweight at the time and later (same day different shift or next day) to ensure it was accursate. If the resident refused to be reweighed, they document that and report to the Director of Nursing/Assistant Director of Nursing and follow their direction: notify the provider or recheck it. An interview with the Director of Nursing (DON) was conducted on 8/5/22 at 1:52 PM. The surveyor reviewed Resident #402's weight loss with the DON. The surveyor asked the DON about a process of weight loss notice. The DON stated that to verify whether residents' measured weight is accurate, the following shift staff re-measures the weight, and the dietitian reviews it and reports it to the physicians. The DON confirmed the facility staff should report to the physician timely regarding the resident's weight loss. During an interview with the maintenance director (staff #11) on 8/8/22 at 9:40 AM, staff #11 was asked the accuracy of the scales. Staff #11 stated a medical equipment company comes to the facility regularly for inspection. The latest visit was 3/17/22 to replace the 1st-floor scale. Staff #11 also explained that if the scale had been issued, the facility staff would write their concern on the 'maintenance repair request log,' located in each unit. Staff #11 stated, I did not remember any concerns reported recently. The surveyor reviewed each unit's maintenance repair request log on 8/8/22 at 10:00 AM. There was no written concern found on the record. The above concern, weight loss, was not notified to the physician and was discussed with the Director of Nursing on 8/8/22 at 4:00 PM.

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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** 43096 Based on observation and interviews, it was determined that the facility failed to maintain a safe and clean environment as evidenced by 1) sagging ceiling tiles in resident rooms, 2) stained ceiling tiles, 3) walls in resident rooms that were in disrepair, 4) soiled linen and trash/debris on the floor and, 5) a rusted tube feeding pole. This was found to be evident throughout both floors of the facility. The findings include: 1) During the facility tours from 7/21/22 to 8/4/22, surveyors observed several resident rooms that had sagging ceiling tiles in their rooms. (Sagging ceiling tiles meant there was a space between the two attached tiles, and it looked like it was stuck down convexly.) -room [ROOM NUMBER] above bed B: the second ceiling tiles from the wall had sagging ceiling tiles. -room [ROOM NUMBER]: sagging tiles were observed above the bathroom entrance on the hallway side. -room [ROOM NUMBER]: sagging tiles were observed above the sink. -room [ROOM NUMBER]: sagging tiles were observed above bed A. The sagging tile was a second one from the wall on bed A resident ' s left side. -room [ROOM NUMBER]: sagging tiles were observed above bed B. The second ceiling tile from the wall that would be by the resident's head side. The whole length on the right side of the ceiling tile was sagging. 2) During the multiple facility tours from 7/21/22 to 8/4/22, surveyors observed several stained ceiling tiles in resident rooms. -room [ROOM NUMBER]: dark brownish stained ceiling tile was observed above the room door. -room [ROOM NUMBER]: One yellowish and one gray with black dots-stained ceiling tiles were observed above the sink. -room [ROOM NUMBER]: about the diameter of 40 cm., a circle-shaped, stained ceiling tile was observed above the sink. 3) During the multiple facility tours from 7/21/22 to 8/4/22, surveyors observed damaged walls/ceilings in the resident rooms. - room [ROOM NUMBER]: about a 3 inch gap was observed on the wall on the right side of the call bell. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- room [ROOM NUMBER]: approximately a 10 cm. long cracked ceiling tile was observed above the sink. - room [ROOM NUMBER]: about a 10 cm. by 25 cm. scrapped wallpaper was observed behind bed A. On 8/4/22 at 11:20 AM, the surveyor conducted rounding with the Nursing Home Administrator (NHA) and the facility maintenance director (Staff #11) to verify an unsafe and unsanitary environment, (sagging ceiling tiles, stained ceiling tiles, and damaged wall/ceilings). 31145 4) On 7/21/22 at 9:26 AM towels were observed on the floor underneath the sink in Resident #46's room. 5) On 7/21/22 at 11:11 AM observation was made of an empty bottle of Boost (nutritional supplement) lying on the floor behind Resident #75's bed and there was an empty bottle of Boost on the nightstand. 6) On 7/21/22 at 11:23 AM observation was made in Resident #18's room of the light behind the resident's bed. The light was flickering while the surveyors were talking to the resident. The walls by the window were splattered with brown material. The tube feeding pole had rust on the pole. LPN #10 was informed about the flickering light at that time. 7) On 7/22/22 at 10:30 AM observation was made in Resident #28's room of torn wallpaper behind the bed and crumbs around the bottom of the armoire. 8) On 7/25/22 at 8:43 AM observation was made in Resident #53's room of small miscellaneous debris on the floor in front of the armoire.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on policy and facility documentation review and interviews it was determined that the facility failed to implement their policy regarding reporting allegations of abuse, neglect, and exploitation of residents and misappropriation of resident property. This was evident for 2 (#58, #412) of 8 residents reviewed for abuse during the annual survey. The findings include: 1) On 7/29/22 at 7:50 AM a review of the Abuse, Neglect and Exploitation policy dated 7/21/21, Section V B6. reads, providing complete and thorough documentation of the investigation. Review of facility reported incident MD00178644 on 7/29/22 at 8:00 AM revealed on 6/9/22 Resident #58 alleged that there was money missing from his/her nightstand drawer. Review of the facility investigation that was provided by the Nursing Home Administrator (NHA) included (2) employee interviews and the resident interview. It was also noted on the front page of the report that law enforcement was notified. The facility documented that police were unable to substantiate missing money. However, there were no interviews of any other staff on the second floor and no interview of any residents. On 7/29/22 at 10:50 AM an interview was conducted with the NHA about the investigation. The NHA was asked if the investigation that he gave the surveyor was complete and the NHA responded, yes. The surveyor brought up that there were only 2 staff members that were interviewed, and the NHA confirmed that he did not interview anyone else, even though there were other opportunities for staff or residents to enter the room. The NHA failed to implement the abuse policy related to investigations. 2) On 7/29/22 at 7:50 AM a review of the Abuse, Neglect and Exploitation policy dated 7/21/21, Section III D. reads, the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict or neglect; and H. assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. Section IV, A. reads, the facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse and B. Possible indicators of abuse include, but are not limited to: 5. verbal abuse of a resident overheard and 8. failure to provide care needs. Review of complaint MD00169788 on 8/6/22 at 2:00 PM revealed Resident #412 reported that [he/she] asked if someone could transport [him/her] back to [his/her] room once therapy was finished. Resident #412 reported that the staff person said, you'll be alright. Resident #412 stated, how do you know how I feel? Resident #412 stated the staff person said, I hope you get ten of your toes cut off. Resident #412 stated, I felt some kind of way about what she said. Resident #412 stated, her comment affected me emotionally because she expressed how she felt about me. Resident #412 stated, I felt she was insensitive because I am currently dealing with possible amputations. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/22 at 11:40 AM an interview was conducted with Staff #45 (director of Rehabilitation). Staff #45 stated that Resident #412 was inappropriate with one of the rehab techs previously and the resident asked that tech to take the resident to his/her room. Staff #45 stated, the tech was uncomfortable doing that. Staff #45 stated a physical therapy assistant (PTA) stepped in and said, you can take yourself. She said jokingly, why don't you cut if off. He/she was subconscious about it. Staff #45 stated, I explained that while it was inappropriate, she said it was a joke and didn't mean it. I'm not condoning what she said, it was wrong. I did report it to the Nursing Home Administrator (NHA), and he did an investigation. We all had to write statements about everything. On 8/8/22 at 1:49 PM a review of employee statements obtained from the Nursing Home Administrator (NHA) for the incident that happened on 7/23/21 with Resident #412 revealed a written statement from PTA #46 that documented, The rehab tech stated to myself and [name], [he/she] makes me uncomfortable; I don't like [him/her], I don't want to be around [him/her]. The statement continued, attempted to grope me yesterday. Once the resident's occupational therapy session was completed, he/she looked at the rehab tech and stated, my foot hurts, I can't wheel myself. Knowing the information, the tech had provided previously, I stated, I think you'll be fine since both legs were on leg rests and he/she was using his/her arms to propel his/her wheelchair and had done so throughout the entire day without incident. Resident proceeded to get increasingly irate shouting, you think I'll be ok? You think? How dare you think you know how I feel. I just finished a workout, and my shoulders could be hurting, you don't know. At this point I said, well then if you can't use your arms and legs anymore, they can just cut them off and get rid of them, sarcastically since the resident could in fact propel him/herself around the facility at will. Since I was aware of how the resident was behaving towards our rehab tech, I did not want the resident to have access to her in a situation where he/she could continue to take advantage and make her uncomfortable. On 8/22/22 at 2:07 PM an interview was conducted with the PTA #46. PTA #46 stated that they were in the rehab gym and Resident #412 made comments towards the tech that made her uncomfortable. Resident #412 was trying to get the tech to wheel Resident #412 back to his/her room and Resident #412 was able to propel the wheelchair independently at that time. I told [him/her] [he/she] could wheel [him/herself] back because [he/she] was independent. PTA #46 stated that Resident #412 became agitated, and sarcastically I said if you are not going to use your arms and legs you might as well cut them off. I meant it not literally. Discussed with the Director of Nursing on 8/9/22 at 11:20 AM that the facility failed to implement their abuse policy.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 15701 Based on interview and medical record review it was determined the facility failed to notify the resident/resident representative in writing of a transfer/discharge of a resident or with the reason for the transfer. This was evident for 3 (#57, #61, #83) of 5 residents reviewed for hospitalization during the annual survey. The findings include: 1) Resident #57 was initially interviewed on 7/21/22 at 10:37 AM. Resident #57 revealed that he/she was transferred to the hospital on multiple occasions in the past year. A review of resident #57's medical record on 8/3/22 revealed that he/she was transferred to a hospital on the following dates and more 8/24/21, 11/24/21, 2/3/22, 3/24/22, and 7/19/22. Further review of the medical record did not reveal documentation that the resident was informed in writing related to transfers to the hospital on 8/24/21, 11/24/21, and 2/3/22. On 8/3/22 at 2:23 PM an interview was conducted with the unit manager (staff # 48). She was asked, where is the written notifications of transfer. She responded that her previous employer/facility owner kept the written notification papers in the paper chart and this facility does not do that. On 8/3/22 at 2:45 PM, the Director of Nursing (DON) was requested to provide a copy of the notice for the facility-initiated transfers on 8/24/21, 2/3/22, and 3/24/22. On 8/4/22 at 12:47 PM, interview of the DON revealed that there was not any creditable evidence related to the resident receiving notification in writing of the transfer. 2) Review of Resident #61's medical record on 7/25/22 revealed the resident was transferred to the hospital on 5/21/22 due to a change in mental status. The change of condition note that documented Resident # 61 was transferred to the hospital indicated that the resident's family was updated, however, there was no written documentation that the responsible party and/or resident was notified in writing of the hospital transfer. On 8/9/22 at 10:05 AM the DON was asked if there was any documentation to show, who was notified in writing of the facility-initiated transfer of the resident to the hospital on 5/21/22 and a copy of the written notification. The DON returned at 10:44 AM and did not provide any written notification to indicate that the resident and/or the resident's family was notified in writing of the resident transfer to the hospital. 31145 3) On 7/26/22 at 2:23 PM a review of Resident #83's electronic and paper medical record revealed Resident #83 was transferred to the hospital on 5/29/22 and 6/3/22 for a change in medical condition. Further review of Resident #83'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. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/10/22 at 12:16 PM the DON confirmed that there was no written documentation to the resident's representative regarding hospital transfer. The DON stated, it is supposed to be kept in [name of electronic system] under miscellaneous. This was a repeat citation as review of the survey results binder revealed this regulation was cited during a complaint survey that ended on 7/29/21. The corrective action that was to be taken by the facility was, RP (resident representative) will now be sent a copy of the transfer paper in writing by the admission office following the transfer. On 8/11/22 at 8:51 AM an interview was conducted with Staff #52, the Admissions Director. Staff #52 was asked if she sent out written notification to the responsible party related to transfers. Staff #52 stated, I did that in November but then was told nursing was handling that as they go out. The Nursing Home Administrator was informed on 8/11/22 at 4:15 PM.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 15701 Based on medical record review and staff interview, it was determined that the facility failed to orient, prepare, and document a resident's preparation for a transfer to the hospital. This was identified for 2 (#57, #61) of 5 residents reviewed for hospitalization during an annual certification survey. The findings include. 1) Review of Resident #57's electronic and paper medical record on 08/03/22 at 11:31 AM revealed a change in condition note dated 8/24/21 for 6:09 PM that was written as Change in Condition Note Text: Brief Synopsis of Change: Hematuria and lethargy Summary of Change in Condition: Pt was lethargic and had Hematuria. Transferred out to [hospital name] Hospital. There was no documentation as to what interventions were put into place before the transfer, what the resident was told and if the resident understood where he/she was going and why. An interview was conducted with the unit manager (staff #48) at 2:23 PM on 8/3/22. She read the change in condition note dated 8/24/21 6:09 PM (as above) and acknowledged that the note was brief. At 3:03 PM on 8/3/22 an interview was conducted with the Director of Nursing. She was asked if her staff was educated to provide sufficient orientation and preparation when there was a facility-initiated transfer to a hospital. She did not provide a response. The surveyor read the following Sufficient preparation and orientation means the facility informs the resident where he or she is going and takes steps under its control to minimize anxiety. She was asked to read the change of condition note dated 8/24/21 that indicated the resident was transferred to the hospital with documentation of preparation and orientation. 2) Review of resident #61's medical record on 7/25/22 revealed the resident was transferred to the hospital on 5/21/22 due to a change in mental status. The resident was observed shivering, was provided fluids. Vital signs were documented and a COVID test was shown to be negative. A nurse practitioner was notified and ordered for resident #61 to be transferred to an emergency room for further evaluation. The change of condition note of 5/21/22 at 2:15 PM documented 911 was called around 1:49 PM. Patient was picked up around 2:15 PM to [name of hospital] There was no documentation as to what interventions were put into place before the ambulance arrived, what the resident was told and if the resident understood where he/she was going and why. On 8/9/22 at 10:05 AM, the Director of Nursing was asked to provide a copy of the 5/21/22 change of condition note that indicated the resident was transferred to the hospital. At 10:44 AM the Director of Nursing provided the requested copy and was informed that the note did not indicate sufficient preparation and orientation for the facility initiated transfer of resident #61 to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 15701 Based on interview and medical record review it was determined the facility failed to notify the resident/resident representative in writing of the bed hold policy upon transfer of a resident to an acute care facility. This was evident for 3 (#57, #61, #83) of 5 residents reviewed for hospitalization during the annual survey. The findings include: 1) Resident #57 was initially interviewed on 7/21/22 at 10:37 AM. Resident #57 revealed that he/she was transferred to the hospital on multiple occasions in the past year. A review of resident #57's medical record on 8/3/22 revealed that he/she was transferred to a hospital on the following dates and more 8/24/21, 11/24/21, 2/3/22, 3/24/22, and 7/19/22. Further review of the medical record did not reveal copies of the bed hold policy that was to be provided to the resident at the time of each transfer. On 8/3/22 at 2:23 PM an interview was conducted with the unit manager (staff # 48). She confirmed that a copy of the bed hold policy for each transfer was not in the medical record. She added that her previous employer/facility owner kept the bed hold and written notification papers in the paper chart and this facility owner does not do that. On 8/3/22 at 2:45 PM, the Director of Nursing (DON) was requested to provide a copy of the bed hold policy with written confirmation given to resident #57 for the facility-initiated transfers on 8/24/21, 2/3/22, and 3/24/22. On 08/04/22 at 12:47 PM, an interview of the DON revealed that there was not any credible evidence related to the resident receiving written bed-hold policy notification at the time of each transfer. 2) Review of resident #61's medical record on 7/25/22 revealed the resident was transferred to the hospital on 5/21/22 due to a change in mental status. The change of condition note that documented resident # 61 was transferred to the hospital indicated that the resident's family was updated, and the resident was given a copy of the bed hold policy. Further review of resident #61's medical record revealed that the resident had a severe cognition impairment and there were physician certifications that the resident lacked capacity. On 8/9/22 at 10:05 AM the DON was asked if there was any documentation to show evidence that the resident's responsible party/guardian was provided a copy of the facility's bed hold policy at the time of the transfer. The DON returned at 10:44 AM and did not provide any evidence of the resident's responsible party receiving a written bed hold policy at the time of transfer. 31145 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 7/26/22 at 2:23 PM a review Resident #83's electronic and paper medical record revealed Resident #83 was transferred to the hospital on 5/29/22 and 6/3/22 for a change in medical condition. Further review of Resident #83's medical record documentation revealed the responsible party was notified, however, there was no written documentation that the responsible party was given a copy of the bed hold policy. On 8/10/22 at 12:16 PM the Director of Nursing (DON) confirmed that there was no written documentation to the resident's representative regarding hospital transfer. The DON stated, it is supposed to be kept in [name of electronic system] under miscellaneous. This was a repeat citation as review of the survey results binder revealed this regulation was cited during a complaint survey that ended on 7/29/21. The corrective action that was to be taken by the facility was, RP (resident representative) will now be sent a copy of the transfer paper in writing by the admission office following the transfer. On 8/11/22 at 8:51 AM an interview was conducted with Staff #52, the Admissions Director. Staff #52 was asked if she sent out written notification of the bed hold policy to the responsible party when a resident was transferred out to the hospital. Staff #52 stated, I did that in November but then was told nursing was handling that as they go out. The Nursing Home Administrator was informed on 8/11/22 at 4:15 PM.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 31145 Based on medical record review and staff interview it was determined the facility staff failed to conduct an accurate, comprehensive assessment by failing to assess a resident's mood and cognitive status on comprehensive and quarterly MDS (Minimum Data Set) assessments. This was evident for 3 (#27, #46, #28) of 38 residents reviewed 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 these individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 7/21/22 at 10:04 AM a review of Resident #31's medical record revealed a comprehensive MDS assessment with an assessment reference date (ARD) of 1/3/22 was not complete. Section C, Cognitive Patterns and Section D, Mood was not assessed. 2) On 7/27/22 at 8:04 AM a review of Resident #46's medical record revealed a comprehensive MDS assessment with an ARD of 3/22/22 was not complete. Section C, Cognitive Patterns and Section D, Mood was not assessed. 3) On 7/29/22 at 1:16 PM a review of Resident #28's medical record revealed a comprehensive MDS assessment with an ARD of 12/1/21 was not complete. Section C, Cognitive Patterns and Section D, Mood was not assessed. On 7/27/22 at 12:56 PM an interview was conducted with the MDS Coordinator who confirmed those sections of the MDS were not done. The MDS Coordinator stated, we have had issues with the Social Worker getting to do them timely. I send an email out to remind her. The Director of Nursing was informed of the concern on 8/9/22 at 11:20 AM.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. 31145 Based on medical record review and staff interview it was determined the facility staff failed to conduct a complete assessment by failing to assess a resident's cognition and mood on quarterly MDS assessments. This was evident for 5 (#4, #7, #98, #47 #28) of 38 residents reviewed during the annual survey. The findings include: 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. 1) On 7/21/22 at 12:30 PM Resident #4's medical record was reviewed and revealed an incomplete quarterly MDS. Review of the quarterly MDS with an Assessment Reference Date (ARD) of 4/10/22, Section C, Cognitive Patterns, Brief Interview of Mental Status, was not done, however Section C0700, Staff Assessment for Mental Status was done. Per the RAI Manual (Resident Assessment Instrument), If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard no information code (a dash -) entered in the resident interview items. Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted but was not done. 2) On 7/21/22 at 12:40 PM Resident #7's medical record was reviewed and revealed an incomplete quarterly MDS. Review of the quarterly MDS with an ARD of 4/19/22, Section C, Cognitive Patterns and Section D, Mood was not assessed. 3) On 7/21/22 at 12:50 PM Resident #98's medical record was reviewed and revealed an incomplete quarterly MDS. Review of the quarterly MDS with an ARD of 6/28/22, Section C, Cognitive Patterns and Section D, Mood was not assessed. 4) On 7/26/22 at 10:53 AM a review of Resident #47's medical record revealed a quarterly MDS assessment with an ARD of 5/30/22 was not complete. Section C, Cognitive Patterns and Section D, Mood was not assessed. 5) On 7/29/22 at 1:16 PM Resident #28's medical record was reviewed and revealed an incomplete quarterly MDS. Review of the quarterly MDS with an ARD of 5/12/22, Section C, Cognitive Patterns and Section D, Mood was not assessed. On 7/27/22 at 12:56 PM an interview was conducted with the MDS Coordinator who confirmed those sections of the MDS were not done. The MDS Coordinator stated, we have had issues with the Social Worker getting to do them timely. I send an email out to remind her. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing was informed of the findings on 8/9/22 at 11:20 AM.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **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 ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 10 (#53, #87, #57, #58, #80, #208, #251, #28, #67, #311,) of 38 residents reviewed 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 7/27/22 at 10:30 AM a record review of Resident #53's quarterly MDS with an assessment reference date (ARD) of 6/6/22, Section N, Medications, documented that the resident received an anti-coagulant for 7 days during the lookback period. Review of Resident #53's July 2022 Medication Administration Record (MAR) documented that Resident #53 received the medication Plavix (Clopidogrel Bisulfate) every day for DVT (deep vein thrombosis) prophylaxis. According to the FDA (Food and Drug Administration) Clopidogrel is an antiplatelet medicine used to prevent blood clots in patients who have had a heart attack, stroke, or problems with the circulation in the arms and legs. It works by helping to keep the platelets in the blood from sticking together and forming clots that can occur with certain medical conditions. According to CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Interview) Manual, under medications received, it was documented, Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. 2) On 7/27/22 at 11:00 AM a record review of Resident #87's quarterly MDS with an ARD of 6/28/22, Section N, Medications, documented the resident received an anti-coagulant for 1 day during the 7-day lookback period. Review of Resident #87's June 2022 MAR documented that Resident #87 received the medication Plavix (Clopidogrel Bisulfate) every day related to acute embolism and thrombosis of unspecified deep veins of the right lower extremity. The MDS should not have been coded for an anticoagulant. On 7/27/22 at 12:56 PM an interview was conducted with the MDS Coordinator regarding coding of an anticoagulant on the MDS. The MDS Coordinator stated, I was not aware that you didn't code Plavix as an anticoagulant. She confirmed both errors. On 7/28/22 at 8:24 AM the MDS coding errors were discussed with the Director of Nursing (DON). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 8/3/22 at 12:55 PM a review of Resident #57's July 2022 and April 2022 revealed Resident #57 received the medication Bumex, a diuretic, every day for hypertension. According to NIH (National Institute of Health), diuretics are a medication used in the management and treatment of edematous and other non-edematous disease conditions. Review of Resident #57's quarterly MDS with an ARD of 7/12/22 and 4/11/22, Section N, Medications, failed to capture the use of the diuretic. This concern was discussed with the Director of Nursing (DON) on 8/3/22 at 2:22 PM 4) On 7/28/22 at 7:47 AM a review of Resident #58's medical record revealed Resident #58 was previously admitted to the facility following a motor vehicle accident and was discharged home on 5/12/22, however had a fall and was readmitted to the facility from an acute care facility on 5/20/22. Review of the 5/20/22 Fall's risk assessment documented 1 to 2 falls within last 6 months. Review of the admit/readmit screener dated 5/20/22 documented, reason for admission as per client or family/caregiver was fall. Review of the admission MDS with an ARD of 6/1/22, Section 1700, Fall history on admission/entry or reentry, A. did the resident have a fall any time in the last month prior to admission/entry or reentry? was coded 0 which failed to capture the fall between the time the resident was discharged on [DATE] and readmitted to the facility on [DATE]. 5) On 7/29/22 at 7:43 AM a review of Resident #80's June 2022 MAR documented Resident #80 received the medication Tramadol every day for pain. According to the FDA Tramadol is a specific type of narcotic medicine called an opioid that is approved to treat moderate to moderately severe pain in adults. Review of Resident #80's quarterly MDS assessment with an ARD of 6/17/22, Section N, failed to capture the use of opioid medication for the 7-day lookback period. 6) On 8/1/22 at 9:00 AM a review of Resident #208's medical record revealed a wandering/elopement assessment dated [DATE] that Resident #208 had a history of wandering and was observed to wander aimlessly within the home or off the grounds. A 3/3/21 at 12:31 PM nurse's note documented, resident is alert and confused. Continues to wander through unit. A 3/1/21 at 6:14 AM nurse's note documented, resident awake and confused, needed closer monitoring. Resident wander all night and continue to need redirection and orientation. A 2/28/21 at 23:42 (11:42 PM) nurse's note documented, resident is alert and confused. Continues to wander around unit looking for [his/her] sister. Staff continues to reorient resident back to [his/her] unit. Review of Resident #208's MDS with an ARD of ARD 3/4/21, Section E0900 and impact in Section E1000 failed to capture wandering. On 4/21/21 at 6:45 a nurse's note documented, new admit, alert and oriented x 1 with confusion. no noted distress, resident wandered during the night from room to room redirected several time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #208's MDS with an ARD of ARD 4/21/21, Section E0900 and impact in Section E1000 failed to capture wandering. Continued review of Resident #208's medical record revealed March 2022 and April 2022 MARs which documented Resident #208 received the medication Clopidogrel every day. Review of Resident #208's MDS with an ARD of 3/4/21 and 4/21/21 coded that Resident received an anticoagulant. Review of Resident #208's March 2021 and April 2021 MAR documented the resident received Clopidogrel. Per the CMS RAI Manual, Clopidogrel is an antiplatelet drug and should not be coded as an anticoagulant. 7) On 8/4/22 at 7:30 AM a review of Resident #251's December 2021 MAR documented the resident received the medication Clopidogrel Bisulfate Tablet every day. Review of Resident #251's admission MDS with an ARD of 12/21/21, Section N, Medications, documented Resident #251 received an anticoagulant. This was incorrect as Clopidogrel is not to be coded as an anticoagulant per the RAI Manual. 8) On 8/4/22 at 12:15 PM a review of Resident #28's medical record revealed a 5/9/22 at 11:51AM progress note that documented that Resident #28 complained that when he/she ate that the upper teeth that broke was sharp and hurt his/her gum. The Nurse Practitioner ordered a dental consult. Review of Resident #28's quarterly MDS with an ARD of 5/12/22, Section L 0200F, Mouth or facial pain, discomfort, or difficulty with chewing, failed to capture the resident's mouth pain. All MDS concerns were discussed with the DON on 8/9/22 at 11:20 AM. 43096 9) On 7/29/22 at 8:38 AM, a review of Resident #67's medical record revealed that the resident has resided at the facility for several years. Resident #67's psychiatry notes dated 7/17/19 indicated the resident had paranoid delusion (a symptom of Psychosis: it involves irrational thoughts and fears that one is being persecuted). However, Resident #67's MDS assessment section E. Behavior E100. B. Delusion has been coded no since 9/18/2019. 8/1/22 2:52 PM during an interview with the Director of Nursing (DON) reviewed Resident #67's medical record together and informed MDS coding was inaccurate. 42507 10) On 8/9/22 at 9:00 AM, review of Resident #311's MDS with an ARD of 4/6/21 was completed: Section J1800, any falls since admission, was coded, no. Under Section J1900, number of falls since admission or prior assessment: Nothing was checked under this section. This was inaccurate as the resident fell on [DATE] and 4/6/2021 while in the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under section M1040, other ulcers, wounds and skin problems, Z was checked for None of the above were present. This was inaccurate as the resident had a right hip skin tear noted on the admission skin sheet dated 4/1/2021. On 8/9/22 at 9:25 AM, review of progress notes revealed nurses change in condition notes dated 4/5/21 at 10:45 Resident was found on the floor lying beside her/his bed. On 4/6/21 at 21:34, change in condition notes documented altered mental status, concurrent falls without injury. On 8/9/22 at 11:29 AM, in an interview with the Director of Nursing (DON), s/he stated that the resident fell on [DATE] and was sent to the hospital. Review on 8/9/22 at 2:10 PM of Resident #311's hospital discharge summary under wound consult dated 3/31/21 revealed Pt has IAD (Incontinence- Associated Dermatitis) of the bilateral groin and right buttocks Pt also has a right hip skin tear that was covered . Blanchable redness identified bilateral elbows and heels. On 8/10/22 at 2:38 PM, in an interview with the MDS Coordinator #40, s/he confirmed that s/he did not capture the fall and/or skin tear on Resident #311's MDS. However, MDS Coordinator #40 stated that s/he has corrected the falls section on the MDS but not the skin section. On 8/11/22 at 4:15 PM, all concerns were addressed with the Administrator and the Director of Nursing prior and during the survey exit conference.

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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 medical record review and staff interview, it was determined the facility failed to provide the resident or resident representative with a summary of their baseline care plan on admission and failed to accurately assess the resident. This was evident for 6 (#58, #208, #251, #416, #307, #89) of 38 residents reviewed during the annual survey. The findings include: A baseline care plan must be prepared for all residents within 48 hours of a resident's admission. Its purpose is to provide the minimum healthcare information necessary to properly care for a resident until a comprehensive care plan can be completed for the resident. The baseline care plan, along with a copy of their medications, is to be given to the resident and/or resident representative and details a variety of components of the care that the facility intends to provide to that resident. This allows residents and their representatives to be more informed about the care that they receive. 1) On 7/28/22 at 7:47 AM a review of Resident #58's electronic and paper medical record revealed the resident was admitted to the facility on [DATE]. Review of Resident #58's 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. Further review of Resident #58's baseline care plan, Section H, Safety Risks, documented that Resident #58 did not have a history of falls. Review of the 5/20/22 Fall's risk assessment documented 1 to 2 falls within the last 6 months. Review of the admit/readmit screener dated 5/20/22 documented, reason for admission as per client or family/caregiver was fall. 2) On 8/1/22 at 9:00 AM a review of Resident #208's electronic and paper medical record revealed Resident #208 was admitted to the facility on [DATE]. Review of Resident #208's 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/resident representative or a signature that the resident received a copy of the care plan or medication list. In Section D of the baseline care plan under Medications, it was documented that the current medication list provided to resident/representative was no and medication list reconciled with resident/representative was no. Additionally, Section 6, Social Services Section was not completed. The Director of Nursing (DON) confirmed on 8/1/22 at 4:20 PM that she did not see any documentation of signatures or evidence that the baseline care plan was given to the resident or resident representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 8/4/22 at 7:30 AM a review of Resident #251's electronic and paper medical record revealed Resident #251 was admitted to the facility on [DATE]. Review of Resident #251's 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/resident representative or a signature that the resident received a copy of the care plan or medication list. In Section D of the baseline care plan under Medications, it was documented that the current medication list provided to resident/representative was no and medication list reconciled with resident/representative was no. On 8/4/22 at 2:35 PM and interview was conducted with the Social Work Director and the DON. The DON confirmed that she doesn't give baseline care plans while her and the Assistant Director of Nursing (ADON) cover the units when there is no unit manager. 4) On 8/6/22 at 3:12 PM a review of Resident #416's electronic and paper medical record revealed Resident #416 was admitted to the facility on [DATE]. Review of Resident #416's 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/resident representative or a signature that the resident received a copy of the care plan or medication list. In Section D of the baseline care plan under Medications, there was no information documented if the resident self-administered medications, if the current medication list was provided to the resident or representative or if the medication list was reconciled with the resident or representative. 42507 5) The Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinary tool that allows many facets of the resident's care (cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain, and medications to name a few) to be addressed. The MDS assessment is part of a broader RAI (Resident Assessment Instrument) process. The RAI process ties the assessment and care plan to the delivery of care to meet the needs of the resident. Resident #307's medical records reviewed on 7/29/22 at 1:40 PM, revealed the resident was admitted to the facility on [DATE]. Review of admission MDS dated [DATE] revealed a BIMS (brief interview for mental status) score of 12. Residents with a BIMS score of 8-12 are considered mildly impaired and those with a BIMS score of 13-15 were considered cognitively intact. On 7/29/22 at 2:20 PM, review of progress notes revealed the following documentation by social services on 7/19/22 at 1:08 PM: Note Text: Care Plan: Initial IDT met at bedside with resident and daughter via telephone to review current status and goals of care. On 8/1/22 at 8:40 AM, Resident # 307's Care Plan was reviewed. During the review surveyor noted a care plan initiated on 7/8/22 and revised on 7/11/22. There was no documentation in the resident's records that the facility staff had provided them and/or their representative with a written summary of the baseline care plan by completion of the comprehensive care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/2/22 at 12:45 PM, in an interview with Licensed Practical Nurse (LPN #26), s/he stated that on admission, residents and/or their family members were involved in developing the baseline care plan. When asked if they provided the resident and/or their representative with a written summary of the baseline care plan, LPN #26 stated I ask the resident if they want a written summary of the baseline care plan, if they say yes, then I give it to them. On 8/2/22 at 12:52 PM, an interview was completed with LPN #37. LPN #37 stated that s/he has admitted residents to the facility and developed baseline care plan with their participation. However, LPN #37 stated that s/he has never given nor asked any of the residents/family members if they wanted a written summary of the baseline care plan. On 8/4/22 at 8:55 AM, a follow up interview was completed with Resident #307. The resident was asked if they participated in developing their care plan on admission, s/he stated that s/he did and that her/his son was called as well. However, Resident #307 stated s/he did not remember getting any written summary of the baseline care plan. 6) Resident #89's medical records reviewed on 8/2/22 at 8:47 AM, revealed the resident was originally admitted to the facility in June 2022. Review of admission MDS dated [DATE] revealed resident had a BIMS score of 12. On 8/3/22 at 10:36 AM, review of progress notes revealed the following documentation by social services on 7/5/2022 at 5:23 PM: Note Text: CARE PLAN: Initial Nursing, Rehab, Dietician, Activities, SS at bedside with resident. Resident was updated regarding overall care status. Resident is pleased with [his/her]care and [his/her] diet. Resident plans to return home after rehab with HHC services. On 8/3/22 at 11:47 AM, Resident# 89's Care Plan was reviewed. During the review surveyor noted a care plan initiated on 7/6/22 and revised on 7/6/22. However, there was no documentation in the medical records that the summary of the baseline care plan was given to the resident and/or resident representative by completion of the comprehensive care plan. On 8/4/22 at 9:10 AM, a follow up interview was completed with Resident #89 in his/her room. When asked if the facility staff provided them and/or their representative a written summary of the baseline care plan, Resident #89 stated that no one gave him/her a written summary of the baseline care plan. On 8/4/22 at 2:35 PM, an interview was conducted with the Social Worker (SW #74) and the Director of Nursing (DON). Regarding baseline care plan and the giving of the written summary of the care plan to newly admitted residents, SW #74 stated that the admitting nurse and the nurse managers did the baseline care plans. SW #74 further stated that s/he has not given any resident a written summary of the baseline care plan. The DON confirmed that the unit managers were supposed to review and give out the written summary of the baseline care plan to the newly admitted residents. When asked if s/he gave any out, the DON said no.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 record reviews, observation, and staff interview, it was determined that the facility failed to develop and implement comprehensive person centered care that were resident specific with measurable objectives and goals. This was evident for 17 (#46, #58, #80, #208, #84, #251, #17, #76, #53, #401, #307, #95, #89, #311, #1, #49, #152) of 38 residents reviewed during the annual survey, however affected all residents as only samples were provided in this citation. 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 7/27/22 at 8:04 AM Resident #46's medical record was reviewed and revealed a diagnosis of unspecified dementia. Review of Resident #46's care plan, has mood problem r/t Disease process cognitive decline will have improved mood state (Specify: happier, calmer appearance, no s/sx of depression, anxiety or sadness) through the review date was not specific to Resident #46. The care plan did not specify the mood state and the goal was not measurable. Review of Resident #46's care plan, has a behavior problem r/t manipulative behavior with staff regarding medication, had the intervention resident will have no evidence of behavior problems of manipulation by review date. The goal was not measurable. 2) On 7/28/22 at 7:47 AM Resident #58's medical record was reviewed and revealed Resident #58 was admitted to the facility on [DATE] following a motor vehicle accident with multiple fractures. Review of Resident #58's care plan, uses antidepressant medication r/t (related to) depression, had the goal, will be free from discomfort or adverse reactions r/t antidepressant therapy. The goal was not measurable and the care plan was not specific to Resident #58 as the interventions were, give antidepressant medication, monitor/document/report signs and symptoms and psych consult. The care plan, is on an anticoagulant, had the goal, will not develop any complications r/t anticoagulant use had 3 interventions to, administer medication as ordered, monitor for fall risk, monitor for s/s of bruising or bleeding. Resident #58 was not on an anticoagulant medication. These concerns were discussed with the Director of Nursing (DON) on 7/29/22 at 1:42 PM. 3) On 7/29/22 at 7:43 AM a review of Resident #80's medical record revealed a physician's order for Metoprolol 25 mg 1/2 tablet every 12 hours at 8 AM and 8 PM. The order stated to hold the medication if SBP (systolic blood pressure) is less than 110 or HR (heart rate). The top number of the blood pressure refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. The bottom number refers to the blood pressure when the heart muscle is between beats. This is called diastolic pressure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #80's July 2022 Medication Administration Record (MAR) revealed that blood pressures or heart rate were not being documented at 8 AM and 8 PM when the medication was signed off as given. The MAR was only initialed that the blood pressure medication was given. Review of the vital sign section of the medical record for blood pressures and heart rate revealed no consistency in times when the blood pressure was taken and that would correlate when the medication was given. There were some days where the blood pressures were taken in the vicinity of 8 AM or 8 PM and there were days when there was no blood pressure documented near those time frames. On 7/12/22 at 16:21 (4:21 PM) the blood pressure was documented as 107/63 in the vital sign section and documented on the MAR that it was given. The SBP of 107 was outside of parameters. On 7/8/22 at 16:39 (4:39 PM) the blood pressure was documented as 107/67 in the vital sign section, which was below the SBP parameter, and signed off as given on the MAR. Review of Resident #80's care plan, potential for alteration in perfusion r/t hypertension, had the goal, will remain free from s/sx of hypertension through the review date. The goal was not measurable. The intervention on the care plan, obtain blood pressure readings per medication orders. Take blood pressure readings under the same conditions each time was not followed. 4) Review of Resident #208's medical record on 8/1/22 at 9:00 AM revealed Resident #208 was readmitted to the facility on [DATE] and was assessed to be an elopement risk. Resident #208 eloped from the facility on 5/10/21. Review of Resident #208's care plan, elopement risk/wandered AEB (as evidenced by) disoriented to place. Resident wanders aimlessly, dementia, that was initiated on 5/1/21, had 2 interventions, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book and wander alert: left ankle. The care plan was not comprehensive for a resident who was exit seeking. The goal on the care plan, safety will be maintained through the review was not measurable. Cross Reference F689 5) Review of Resident #84's medical record on 8/2/22 at 9:00 revealed Resident #84 was admitted to the facility in October 2019 with diagnoses that included but were not limited to, generalized anxiety disorder, major depressive disorder, and schizophrenia. Review of Resident #84's care plan revealed on 10/20/21 a care plan was initiated that stated, is an elopement risk/wandered AEB (as evidenced by) history of attempts to leave facility unattended. There were 3 interventions on the care plan, assess for fall risk, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, knitting, coloring, and wander alert guard in place (to wheelchair). The care plan was not comprehensive and resident centered. 6) Review of Resident #251's medical record on 8/4/22 at 7:30 AM revealed Resident #251 was admitted to the facility in December 2021 with diagnoses including, but not limited to acute and chronic respiratory failure, hypertension, heart failure and chronic atrial fibrillation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #251's care plan, has hypotension r/t medication use, had the goal, will maintain b/p within acceptable range as determined by MD through date. The goal was not measurable as it did not stated the the b/p range should be. Further review of the care plan revealed 1 intervention, monitor vital signs as ordered and record. Report significant abnormalities to MD. The care plan was not resident centered for Resident #251. 7) Facility staff failed to follow the care plan: On 7/22/22 at 2:10 PM Resident #17's medical record was reviewed and revealed Resident #17 was admitted to the facility in December 2018 with diagnoses including but not limited to early onset Alzheimer's disease. Review of progress notes documented that Resident #17 had falls on 12/23/21, 2/10/22, 4/12/22, and 5/11/22 without injury. On 7/25/22 at 11:42 AM observation was made of Resident #17 in bed. Resident #17 was not wearing hipsters. On 7/25/22 at 3:08 PM Resident #17 was observed again in his/her room without hipsters. An interview of GNA #66, a GNA from a staffing agency, was conducted and she was asked if Resident #17 was wearing hipsters. GNA #66 stated, I didn't know [he/she] wore them. I didn't see anything in the room. Review of Resident #17's care plan, had an actual fall with no injury r/t poor balance and poor communication/comprehension, had the intervention, apply hipsters at all times, which was initiated on 8/20/21. 8a) Review of Resident #76's medical record on 7/29/22 at 8:00 AM revealed Resident #76's started receiving Hospice services in April 2022 due to decline in health. Review of Resident #76's care plan actual skin impairment to skin integrity r/t pressure present on admission, left hip had the goal, will have no complications r/t (specify skin injury type) of the (left hip, right malleolus) through the review date. The goal was not patient centered and was not measurable. The interventions, apply treatment as ordered, conduct weekly body audit, follow facility protocols for treatment of injury, and monitor/document was not resident centered and comprehensive for someone with a stage 3 to 4 pressure ulcer. 8b) On 7/21/22 at 11:03 AM Resident #76 was observed lying in bed wearing a nasal cannula. Observation of the concentrator revealed the oxygen (O2) was being administered to Resident #76 at 4 L (liters) per minute. 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 from the oxygen concentrator. Review of care plans for Resident #76 revealed a COPD (Chronic Obstructive Pulmonary Disease) with a goal, will display optimal breathing pattern daily through the review date. The goal was not measurable. There was nothing on the care plan about administering oxygen. Further review of Resident #76's care plans failed to reveal a care plan for oxygen therapy. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9) Review of Resident #53's medical record on 8/5/22 at 2:00 PM revealed the resident was admitted to the facility in April 2022 with diagnoses that included major depressive disorder and hemiplegia and hemiparesis following a nontraumatic subarachnoid hemorrhage affecting right non-dominant side. Review of Resident #53's care plan, hemiplegia/hemiparesis r/t chronic subdural hemorrhage had the goal, will maintain optimal status and quality of life within limitations imposed by hemiplegia/hemiparesis (specify) through review date. The goal was not measurable. The care plan, will be free from injury related limited mobility through next review had the interventions, staff will assist resident with mobility through facility as resident allows, and staff will provide assistance with repositioning as ordered. Interventions on the care plan and the ADL (activities of daily living) care plan did not include the palm guard that the resident was to wear. All care plan concerns were discussed with the Director of Nursing on 8/9/22 at 11:20 AM. 43096 10) During an interview with Resident #401's responsible party (RP) via phone on 7/26/22 at 10:26 AM, the RP stated Resident #401 had a fall incident caused by his/her hip pain. A review of Resident #401's care plan on 7/26/22 at 11:40 AM revealed the resident's care plan related to pain initiated on 4/1/20 as [Resident #401] had chronic pain related to a history of left hip intertrochanteric fracture. The only intervention included administer analgesia acetaminophen 650 mg PO (oral) every 6 hours PRN (as needed) as per orders. Give 1/2 hour before treatment or care, initiated on 4/1/20. An interview was conducted with a unit manager UM #48 on 7/28/22 at 9:00 AM. The surveyor asked UM #48 for Resident #401's pain management. UM #48 answered that since the resident's family requested minimized narcotic pain medications, he/she had prescribed lidocaine cream and Tylenol for pain. On 8/1/22 at 9:00 AM, the surveyor reviewed Resident #401's care plan with UM #48 and asked UM #48 if the care plan interventions were resident-center or measurable. UM #48 said, no, our (the facility's) care plan is weak. On 8/1/22 at 10:17 AM, UM #48 submitted a new progress note written dated 8/1/22 at 9:35 AM by herself, which included the facility staff discussing with Resident #401's RP about the resident's pain management. UM #48 stated, I'm also working on fixing the care plan. She confirmed that before the surveyor alerted this concern, the care plan was not measurable and resident-center. 42507 11) The Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinary tool that allows many facets of the resident's care (cognition, behavior, mobility, activities of daily living, accidents, activities, weight, pain, and medications to name a few) to be addressed. The MDS assessment is part of a broader RAI (Resident Assessment Instrument) process. The RAI process ties the assessment and care plan to the delivery of care to meet the needs of the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident (R) #307 was observed lying in bed on 7/22/22 at 8:10 AM. An oxygen concentrator (a machine that concentrates oxygen from the air) was on the right side of the resident's bed. The resident was wearing a nasal cannula (oxygen tube with nose prongs) that was connected to the concentrator. R #307 stated s/he used oxygen at 2L via nasal cannula continuously for COPD (chronic obstructive pulmonary disease). During a review of R #307's medical record conducted on 8/1/22 at 8:12 AM, surveyor noted an active physician order dated 7/22/22 for: Continuous 2L/min oxygen nasal cannula every shift for O2 therapy. Change nasal cannula tubing once a week, every night shift every Friday. On 8/1/22 at 8:40 AM, R # 307's Care Plan was reviewed. During the review surveyor noted a care plan initiated on 7/8/22 and revised on 7/11/22 with a target date of 10/5/22 that revealed a care plan focus entitled, Impaired respiratory status risk related to COPD, cough, sarcoidosis, OSA (obstructive sleep apnea). The goal was for the resident to have adequate tissue perfusion and no sign/symptom of respiratory distress. The care plan interventions included provide oxygen as ordered. However, the care plan did not specify the amount of oxygen and/or instruct that the tubing be changed once a week as indicated in the physician's order and Treatment Administration Record (TAR). Furthermore, further review of the resident's care plan failed to reveal any additional care plan topic related to the use of oxygen. 12) Review of Resident (R) #95 's medical records on 7/26/22 at 1:42 PM revealed the resident was admitted to the facility on [DATE] with diagnoses that included CVA, Quadriplegia, Osteomyelitis, Pulmonary embolism, Diabetes, Chronic Obstructive Pulmonary Disease, Neurogenic bladder, Sepsis. During further review of the resident's medical record on 7/26/22 at 2:53 PM, surveyor noted an active physician order dated 6/22/22 for: Foley Catheter to CD: __16__F for a diagnosis of: Neurogenic bladder every shift, Foley catheter care Q shift every shift, Monitor Foley Catheter site, and document. every shift, and orders for Acetaminophen Tablet 325 MG, give 2 tablets orally every 4 hours as needed for mild pain 1-3 as needed for temperature above 100/or pain. Not To Exceed 4gm/24 hours from all sources, oxyCODONE HCl Oral Tablet 5 MG (Oxycodone HCl), give 1 tablet by mouth every 12 hours as needed for pain dated 7/17/2022, and Lidocaine Pain Relief 4% Patch, Apply to LOWER LUMBAR topically in the morning for pain lower lumbar dated 6/23/2022. There was no order to Evaluate and Document presence of pain each shift every shift in the active orders. R#95's care plan was reviewed on 7/27/22 at 10:05 AM. During the review surveyor noted a care plan initiated on 12/18/20 with revision on 7/1/22 that revealed a care plan that was not comprehensive and/or with person-centered interventions for Foley catheter care and/or pain: 1) The care plan focus for Resident #95 uses foley catheter due to neuromuscular dysfunction of bladder/BPH had three interventions: Catheter care every shift, Empty foley catheter every shift, and Report any abnormalities to MD/NP. The interventions did not address when and how often the foley catheter and/or drainage bag should be changed, monitoring of output, monitoring of Foley catheter site, monitoring for signs/symptoms of infection/UTI (Urinary tract infection), pain, discomfort, bleeding, and/or dislodgement of the catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of R#95's care plan on 7/27/22 at 10:15 AM, revealed a care plan focus of at risk for pain due to diagnosis/immobility and Foley trauma. However, the interventions did not include monitoring for pain, assessment for signs/symptoms of pain and/or utilization of non-pharmaceutical interventions for pain relief as resident allows such as re-positioning, decrease environmental stimuli and activity diversion. R#95's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of July 2022 was reviewed on 7/27/22 at 11:30 AM. During the MAR review, surveyor noted that the resident had utilization of the as-needed pain medication (Morphine Sulfate 15 mg, 0.5 tablet by mouth every 6 hours as needed for moderate pain) from 6/22/2022 through 7/8/2022 and scheduled Morphine sulfate 15 mg, 0.5 tablet by mouth every 6 hours for chronic pain from 7/8/2022 through 7/14/2022. This was in addition to the scheduled Lidocaine pain relief 4% patch that was being applied to the resident's lower back. Apart from when staff gave pain medication, there was no documentation of staff evaluating/assessing the resident for the presence of pain anywhere else on the MAR and/or TAR. In an interview on 7/28/22 at 2:15 PM, with Licensed Practical Nurses, LPN #21, and LPN #22, both nurses confirmed that R #95 did not have an order for pain evaluation and staff did not have daily pain assessments documented. Per LPN #22, the pain evaluation needed to be in the orders for it to transfer to the TAR. S/he further stated that R #95 might have gone out and upon return to the facility, staff failed to put it in. Regarding Foley catheter care, LPN #22 did not know how often the resident's Foley catheter needed to be changed and confirmed that there was no order to that effect in the resident's chart. On 8/1/22 at 2:15 PM, the Director of Nursing (DON) was made aware of no order to evaluate and document presence of pain, and care plan interventions lacking pain assessment, and no non-pharmaceutical interventions for pain. The DON was also made aware that the resident's orders and care plan did not have resident-centered interventions for Foley catheter care. The DON stated she was going to follow up. 13) Medical record review was conducted for Resident (R) #89 on 8/2/22 at 8:47 AM. R #89 was originally admitted to the facility in June 2022 with diagnoses that included: Crohn's disease, chronic kidney disease, kidney stones, unspecified hydronephrosis, benign prostatic hyperplasia, colostomy, displacement of nephrostomy catheter. During further review of the resident's medical record on 8/2/22 at 2:31 PM, surveyor noted an active physician order dated 7/23/22 for: Sodium Chloride Flush Intravenous Solution 0.9 % (Sodium Chloride Flush) Use 10 ml via irrigation every 12 hours as needed for MAINTAIN NEPHROSTOMY PATENCY (Flush LL Nephrostomy Tube with 10 ML 0f NSS BID, PRN), Encourage PO Fluids 300 ML Q 4 hours while awake for elevate BUN every 4 hours, Cleanse LLQ Nephrostomy site with soap and water, pat dry, apply split gauze daily. every day shift, and Nephrostomy Tube: Document output every shift. every shift. Review of progress notes on 8/3/22 at 10:36 AM, revealed admission notes on 6/30/22 that indicated R #89 arrived at the facility with a left side nephrostomy tube in place. A change in condition notes dated 7/22/2022 at 3:37 PM revealed Nephrostomy tube became dislodged, and R #89 was transferred to the hospital for it to be replaced. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the progress notes revealed documentation by nursing on 7/24/22 at 10:49 PM indicating that the resident was back in the facility with a new nephrostomy tube that was intact and patent. On 8/3/22 at 11:47 AM, R # 89's Care Plan was reviewed. During the review surveyor noted a care plan initiated on 7/6/22 and revised on 7/6/22 with a target date of 9/28/22 that revealed a care plan focus entitled Resident has a nephrostomy tube. The goal was that the resident will be free from infection through the review date. The care plan interventions included Empty nephrostomy tube every shift, monitor for sign/symptom of infection, UTI, monitor nephrostomy site. However, the care plan was not comprehensive and interventions not resident centered. There were no interventions to address cleansing of the nephrostomy site/dressing change, need for increased fluid intake, tube irrigation (as indicated in the physician's order, MAR, and TAR), monitoring for skin breakdown, and/or physical management of tubing and collection bag to prevent infection or dislodgement. On 8/4/22 at 2:35 PM, in an interview with the Social Worker (SW #74), s/he stated that baseline care plans were developed by the admitting nurse and nurse managers. Regarding care plan revisions, SW #74 stated the nurse managers revised the care plans when there was a change in resident condition. On 8/4/2022 at 2:45 PM, in an interview with the Director of Nursing (DON), and in the presence of SW #74, s/he was made aware that Resident #89's care plan interventions were not resident centered, and the care plan was not revised to reflect dislodgement of nephrostomy tube. Regarding care plan revision and update, the DON stated that the nurse/unit managers were responsible for updating the care plans, but the 2 [NAME] unit did not have a nurse manager. So, s/he was now responsible for revising and updating residents' care plans. During this interview, both the DON and SW #74 stated that the expectation was for care plans to be updated/revised quarterly and when there's significant change in condition. 14) Medical record review on 8/9/22 revealed Resident (R) # 311 was admitted to the facility in April 2021 with diagnoses that included Altered mental status, hemiplegia and hemiparesis, cerebrovascular disease, liver transplant, dehydration, asthma. On 8/9/22 at 9:25 AM, review of the progress notes revealed nurses change in condition notes dated 4/5/21 at 10:45 Resident was found on the floor lying beside her/his bed. On 4/6/21 at 21:34, change in condition notes documented altered mental status, concurrent falls without injury. R # 311's Care Plan was reviewed on 8/9/22 at 11:20 AM. During the review, surveyor noted a care plan initiated on 4/1/21, revision on 4/7/21, and cancelled on 4/7/21 that revealed a care plan focus entitled resident is at risk for falls. Resident is newly admitted with ADL deficit. The goal was that the resident will have no major injury from falls by the next review 6/30/21. However, the care plan topic had been developed with only two interventions: Assist with ADLs as needed and Place call bell within resident's reach. The care plan was not comprehensive and interventions not resident centered. There were no interventions addressing resident education or cueing, evaluate for fall risk per, keep bed in low position, physical therapy/occupational therapy screen, eval and treat as indicated, or other interventions designed to address the resident's risk of and actual fall. All concerns were addressed with the Administrator and the Director of Nursing prior and during the survey exit on 8/11/2022 at 4:15 PM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	15701 15) Resident #1's medical record was reviewed on 7/26/22 for dental concerns. Review of the care plan section revealed a care plan focus area initiated on 5/24/19 written as: [name of resident] has no teeth. The goal was written as to be able to eat and drink free of pain. Interventions include provide oral hygiene, Provide supplies for self-oral hygiene and Report any abnormal impairments to licensed personnel. There have not been any changes since the initiation of focus care area except for a change in the goal target date. On 7/27/22 at 12:30 PM Resident #1 was interviewed and observed. Resident #1 was noted to have teeth. Resident #1 was observed to be missing upper front teeth but had bilateral upper back teeth and did have some missing lower teeth. An interview was conducted with the Unit manager Staff #48 on 7/28/22 at 11:42 AM. She was asked if resident #1 had teeth, and she responded that she does not know as she indicated that she does not provide resident #1's daily care. She confirmed the care plan was written that the resident has no teeth. The care plan was not person centered as the plan of care was not accurate. 16) Resident #49's medical record was reviewed for activity participation on 7/28/22. The last documented Activity participation note was dated 1/26/22. The note revealed that the resident was not an active participant in activities, but the resident likes 1 to 1 visits from activities, the resident also likes snacks and watching television and also video chats. The medical record revealed that the resident has a severe cognition impairment. Review of the resident's care plans revealed two care plans were written for activities. One of the care plans was written as [name of resident] has a psychosocial well-being problem (potential) r/t Recent Admission. This plan of care was initiated on 11/1/19 with a stated goal of [name of resident] will have no indications of psychosocial well-being problem through review. The goal was not resident centered and was not measurable as it did not quantify indications of psychosocial well-being problem. This plan of care was related to the resident's admission to the facility on [DATE]. The interventions for resident #49 were not person-centered as the interventions for this cognitive impaired individual were written as Allow [name of resident] time to ask questions and to verbalize feelings perceptions, and fears related to Coronavirus and Monitor/document resident's usual response to problems: Internal - how individual makes own changes, External - expects others to control problems or leaves to fate, or luck. On 8/4/22 at 11:15 AM an interview was conducted with the activity's director (Staff #43) and an activities assistant (staff #44). The goals and interventions were reviewed with the activities staff and there was a response that they were unaware of the activities care plan in question. The staff were shown that the interventions were the responsibility of social work and activities staff as documented on the plan of care. 17) Resident #152's medical record was reviewed on 7/27/22. The resident was originally admitted to the facility on [DATE] and was readmitted to the facility on [DATE]. The resident had diagnosis that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia, chronic kidney diseases stage 4, and was assessed on 7/8/22 to have severe cognitive impairment. The resident had repeatedly been observed in bed and not in any activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A plan of care with activities interventions was initiated on 3/21/20 written as At risk for psychosocial communication and coping R/T emerging infectious disease (Covid-19) The stated goal of Resident will display positive results from new interruption of social interaction was not measurable or quantitative. The care plan was not person centered as evidence by the interventions documented for this plan of care, such as alternate smoking schedules, Offer pen & Paper to write letters or assist with phone calls to family and friends, Program that educates and demonstrates hand washing/hand sanitizer make it fun, Sunporch activity programs- games, and Identify feelings of isolation. Note risk factors esp. Very social residents and report mood and/or behavioral changes r/t changes in routines, and consults SS, psych, prn On 8/4/22 at 11:15 AM an interview was conducted with the activity's director (Staff #43) and an activities assistant (staff #44). The care plan was reviewed with the staff and the two staff indicated that the resident does not smoke. When the sunporch activities were reviewed the activities director, indicated that the facility has a courtyard but not a sun porch. They indicated that when the resident was admitted to the facility he/she was able to participate in activities. Upon review of the goals and interventions the staff acknowledged that the care plan was not accurate and it was not person centered.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 43096 Based on a review of resident medical records and interviews with facility staff, it was determined that the facility failed to 1) hold care plan meetings of the interdisciplinary team for residents at the time of the quarterly revision of their care plan and 2) review and revise resident care plans after each assessment or as resident care needs became apparent or changed over time. This was evident for 2 (#67, #401) of 4 residents reviewed for care plan meetings and 7 (#46, #84, #1, #27, 49, 152, #89) of 38 residents reviewed during the annual survey, however affected all residents on units that did not have a unit manager. The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). 1) The surveyor reviewed Resident #67's medical record on 7/28/22 at 12:07 PM. The review revealed that Resident #67 had quarterly Minimum Data Set (MDS) assessments completed on 9/2/21, 12/21/21, 3/10/22, and 6/10/22. Further review revealed that care plan meetings were held on 8/25/21, 12/1/21, and 3/2/22. The details of care plan meetings were written by a unit manager or social worker in the resident's electronic medical record under the progress note. However, there was no evidence in the medical record that a care plan meeting had been held with the resident and the interdisciplinary team in June 2022. The surveyor interviewed the Director of Social Services (Staff #74) on 8/3/22 at 2:20 PM. During the interview, Staff #74 stated that she was responsible for scheduling and arranging care plan meetings and social worker or attending nurse (unit manager or Director of Nursing) would document care plan meetings. 2) The surveyor reviewed Resident #401's medical record on 7/28/22 at 2:21 PM. The review revealed that Resident #401 had quarterly and annually MDS assessments completed on 2/19/21,5/22/21, 8/12/21, 10/12/21, 11/5/21, 1/12/21, 4/14/22, and 7/15/22. A review of written progress notes by Staff #74 revealed that Resident #401's care plan meetings were held on 1/29/21 and 11/10/21. However, there was no evidence in the medical record that care plan meetings had been held with the resident and the interdisciplinary team around 2/19/21, 5/22/21, 8/12/21, 10/12/21, 1/21/22, 4/14/22, and 7/15/22. During an interview with the Director of Nursing (DON) on 8/8/22 at 4:00 PM, the surveyor informed the DON that there was no evidence that a care plan meeting was held around 6/10/22 for Resident #67. As of the time of exit on 8/11/22, no additional information had been provided regarding these concerns. 31145 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) On 7/21/22 at 9:15 AM Resident #46 was interviewed and stated he/she goes down to activities all the time and enjoys the activities. On 7/27/22 at 8:04 AM Resident #46's medical record was reviewed and revealed a diagnosis of unspecified dementia. Review of Resident #46's impaired cognitive function/dementia or impaired thought processes r/t difficulty making decisions had the goal, will be able to communicate basic needs on a daily basis through the review date. The care plan was initiated on 9/9/20. There were no evaluations found in the medical record and the care plan had not had any additional interventions since 9/9/20. Review of Resident #46's dependent on staff for social stimulation at this time related to: cognitive impairment and poor decision making was initiated on 8/31/19. The care plan had 4 interventions: a) arrange 1:1 contacts during disruption of social interaction, b) engage in group activities of interest, c) familiarize resident with nursing home environment and activity programs on a regular basis and d) visit 3x's/week to develop or sustain contact using conversation. There was no evidence found in the medical record that the care plan was evaluated and new interventions were put in place since 2019. The care plan was not updated to reflect Resident #46's interests. Review of Resident #46's annual MDS with an assessment reference date (ARD) of 3/22/22, Section F preferences for routine and activities; answered somewhat important for all the questions related to activities. Resident #46's care plan, has a behavior problem r/t manipulative behavior with staff regarding medication, had the goal, will have no evidence of behavior problems of manipulation by review date. There were no evaluations found documented if the care plan worked and if the resident still had manipulative behaviors. 4) Review of Resident #84's medical record on 8/2/22 at 9:00 AM revealed a care plan, is an elopement risk/wanderer AEB history of attempts to leave facility unattended. The goal was, will not leave facility unattended through the review date. There were no evaluations found in the medical record that indicated whether or not the care plan was effective or if the resident had any increased wandering or attempts to elope. On 8/9/22 at 11:20 AM discussed with the Director of Nursing who stated that the units that have unit managers usually do the evaluations and the units that currently do not have a unit manager are not having the evaluations done. 15701 5) Resident #1's medical record was reviewed on 7/26/22 for dental concerns. Review of the care plan section revealed a care plan focus area initiated on 5/24/19 written as: [name of resident] has no teeth The goal was written as to be able to eat and drink free of pain. Interventions include provide oral hygiene, Provide supplies for self-oral hygiene and Report any abnormal impairments to licensed personnel. There have not been any changes since the initiation of focus care area except for a change in the goal target date. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/27/22 at 12:30 PM Resident #1 was interviewed and observed. Resident #1 was noted to have teeth. Resident #1 was observed to be missing upper front teeth but had bilateral upper back teeth and did have some missing lower teeth. An interview was conducted with the Unit manager Staff #48 on 7/28/22. She was asked if resident #1 has teeth, and she responded that she does not know as she indicated that she does not provide resident #1's daily care. She confirmed the care plan was written that the resident has no teeth. The care plan was not person centered as the plan of care was not accurate. Recent quarterly MDS assessments were dated 4/5/22 and 7/6/22. Further review of the medical record did not reveal any care plan evaluations for July 2022. The last documented quarterly care plan meeting was held on 5/11/22. There was not any documentation found that this dental care plan was reassessed for the effectiveness of the interventions and revised as the inaccurate focus of the care plan remained since initiation of the care plan on 5/24/21. 6) Since the initiation of the survey on 7/21/22 the Resident #27 has been observed daily in bed. Resident #27 care plan was reviewed on 8/1/11 for activities. Resident #27's activity care plan focus was written as [name of resident] is dependent on staff for social stimulation related to cognitive impairment and hearing deficit. This care plan was initiated on 4/27/18. There were three goals written for this plan of care all goals were initiated on 4/27/18. On 8/4/22 at 11:15 AM an interview was conducted with the activity's director (Staff #43) and an activities assistant (staff #44). The goals for the resident's activities care plan were reviewed with the staff. The 1st goal was written as Identify at least two activities that [name of resident] would like to participate in. and the 2nd goal written as [name of resident will participate in at least 3, 1:1 activities per week during this period of social distancing. The two staff were asked if they have identified two activities and was that documented however there was no response if they had identified at least 2 activities. The surveyor reviewed that the resident's activity care plan has remained unchanged for over 4 years. The two activities staff were asked if they evaluate their care plans. The response was no. The activities director indicated that when she writes activity notes she only document the types of activities each resident has participated. The 3rd goal was not a goal of the resident but more as an intervention for the staff as this was written as Staff will approach from the front and speak clearly and loud enough for [Resident Name] to hear them. This goal had a target date of 10/9/22. 7) Resident #49's medical record was reviewed for activity participation on 07/28/22. The last documented Activity participation note was dated 1/26/22. The note revealed that the resident was not an active participant in activities, but the resident likes 1 to 1 visits from activities, the resident also likes snacks and watching television and also video chats. Review of the resident's care plans revealed two care plans were written for activities. One of the care plans was initiated on 8/1/19 as [name of resident] is dependent on staff for socialization related to: not wanting to get OOB and social distancing practices. There was two goals for the focus care area indicating the resident will participate in 1 to 1 activities of interest with staff at least 2 times per week and the resident will verbalize enjoyment of one activity after participation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Evaluations and revision of the activities care plans after assessments were not found in the record. On 8/4/22 at 11:15 AM an interview was conducted with the activity's director (Staff #43) and an activities assistant (staff #44). When asked the activities director indicated that she does not evaluate the activities care plans. 8) Resident #152's medical record was reviewed on 7/27/22. The resident was originally admitted to the facility on [DATE]. The resident had diagnosis that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant Side, dysphagia, chronic kidney diseases stage 4, and was assessed on 7/8/22 to have severe cognitive impairment. The resident had repeatedly been observed in bed and not in any activities. 42507 A nephrostomy tube is a catheter or tube that is surgically inserted into the kidney to drain urine from the body. The drained urine is collected in a small bag located outside the body. 9) Medical record review was conducted for Resident #89 on 8/2/2022 at 8:47 AM. Resident #89 was originally admitted to the facility in June 2022 with diagnoses that included: Crohn's disease, chronic kidney disease, kidney stones, unspecified hydronephrosis, benign prostatic hyperplasia, colostomy, displacement of nephrostomy catheter. Review of progress notes on 8/3/2022 at 10:36 AM, revealed admission notes on 6/30/2022 that indicated the resident arrived at the facility with a left side nephrostomy tube in place. A change in condition notes dated 7/22/2022 at 3:37 PM revealed the following summary: Nephrostomy tube became dislodged. CRNP (Certified Registered Nurse Practitioner) made aware. Order to send resident to hospital to be replaced. Further review of the progress notes revealed documentation by nursing on 7/24/2022 at 10:49 PM indicating that the resident was back in the facility with a new nephrostomy tube that was intact and patent. On 8/03/22 at 11:47 AM, review of Resident #89's care plan identified that the care plan interventions were not resident centered. Care plan was not revised to reflect dislodged nephrostomy tube. On 8/03/22 at 1:06 PM, review of hospital discharge summary dated 7/23/2022 revealed the Resident was seen in the hospital for a dislodged nephrostomy tube that was replaced. On 8/04/22 at 8:40 AM, in a follow up interview with Licensed Practical Nurse (LPN #21), s/he stated that Physical Therapist got the resident out of bed to chair and when the Geriatric Nursing Assistant (GNA) was assisting the resident back to bed, the nephrostomy tube fell out. LPN #21 further stated that the GNA was immediately re-educated on how to monitor the nephrostomy tube during transfers. On 8/4/2022 at 2:35 PM, in an interview with the Social Worker (SW #74), s/he stated that baseline care plans were developed by the admitting nurse and nurse managers. Regarding care plan revisions, SW #74 stated the nurse managers revised the care plans when there was a change in resident condition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/04/22 at 2:45 PM, in an interview with the Director of Nursing (DON), with SW #74 present, s/he was made aware that Resident #89's care plan interventions were not resident centered, and the care plan was not revised to reflect dislodgement of nephrostomy tube. Regarding care plan revision and update, the DON stated that the nurse/unit managers were responsible for updating the care plans, but the 2 [NAME] unit did not have a nurse manager. So, s/he was now responsible for revising and updating residents' care plans. During this interview, both the DON and SW #74 stated that the expectation was for care plans to be updated/revised quarterly and when there's significant change in condition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 15701 Based on observation, medical record review, and staff interview, it was determined the facility failed to follow a physician's ordered treatment. This was evident for 1 (Resident#61) of 1 resident reviewed for non-pressure skin condition. The findings include. Review of resident #61's medical record on 7/26/22 revealed that the resident had multiple chronic vascular bilateral lower extremity wounds. Review of the physician order's revealed that there was multiple treatment wound orders prescribed for daily dressing changes with various treatments to each wound. On 8/4/22 at 9:14 AM, an agency Licensed Practical Nurse (LPN) staff #86, was observed to provide wound care and replace the wound dressing to the multiple areas on resident #61's feet and legs. Upon completion of the observed wound treatments, resident #61's medical record was reviewed to reconcile the physician orders to the observed wound care. Based on the medical record review it was discovered that the nurse staff #86 failed to provide the prescribed treatment ordered as Wound location: right medial plantar great toe cleanse with Dakin, apply Medi-honey and dressing everyday shift for wound care. Review of the Treatment Administration Record (TAR) on 8/4/22 at 2:50 PM revealed that the nurse had signed off on the record as completed. Staff #86 was interviewed at 2:55 PM on 8/4/22. She confirmed that she had not provided the treatment as ordered and acknowledged that she had sign off on the order. The Director of Nursing was informed of the nurse's omission at 3:24 PM on 8/4/22.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31145 Based on observation, interview, and record review it was determined the facility failed to ensure that residents with limited range of motion received the appropriate treatment and services to prevent further decline in range of motion. This was evident for 3 (#17, #53, #55) of 6 residents reviewed for positioning and mobility during the annual survey. The findings include: 1) On 7/25/22 at 12:00 PM an observation was made of Resident #17 sitting in a chair with a right palm protector in place. On 7/26/22 at 10:08 AM a second observation was made of Resident #17 lying in bed without anything in the right hand. Resident #17's right hand was in a fist. On 7/25/22 at 12:00 PM Resident #17's daughter was interviewed and stated that Resident #17's hands were not always like they are now. On 7/27/22 at 1:24 PM Resident #17's medical record was reviewed. Resident #17 was admitted to the facility in December 2018 with diagnoses including but not limited to early onset Alzheimer's disease. Review of physician's orders revealed an order for, Right palm protector continuous wear, that was ordered on 8/21/21. Palm Protectors provide support and protection to prevent finger contractures and skin breakdown in the palm. Review of Resident #17's medical record revealed a care plan, has limited physical mobility r/t (related to) contractures of bilateral hands. The interventions consisted of, left hand carrot splint, provide gentle range of motion as tolerated with daily care, and provide supportive care, assistance with mobility as needed. There was nothing in the care plan about the continuous wear of the right palm protector. On 8/9/22 at 10:50 AM Resident #17 was observed with nothing in the right hand. On 8/10/22 at 11:59 AM an interview was conducted with Staff #56 (occupational therapist) who stated Resident #17, keeps both hands fisted. Staff #56 stated that they began with a carrot in September 2020 because of fisting in the left hand. Staff #56 stated in August 2021 speech therapy was no longer feeding the resident, so they attempted finger foods and a palm protector for the right hand. In October 2021 Resident #17 was referred to therapy again for a fall evaluation and, I discontinued the carrot due to a wound in the right hand and he/she was to continue with a palm protector for the left hand. 2) On 7/25/22 at 10:59 AM Resident #53's medical record was reviewed. Resident #53 was admitted to the facility in April 2022 with diagnoses including but not limited to hemiplegia and hemiparesis following a nontraumatic subarachnoid hemorrhage affecting the right non-dominant side, major depressive disorder, and fibromyalgia. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to [NAME] Hopkins Hospital, A subarachnoid hemorrhage means there is bleeding in the space that surrounds the brain. Most often, it occurs when a weak area in a blood vessel (aneurysm) on the surface of the brain bursts and leaks. The blood then builds up around the brain and inside the skull increasing pressure on the brain. This can cause brain cell damage, life-long complications, and disabilities. Hemiparesis is a mild or partial weakness or loss of strength on one side of the body. Hemiplegia is a severe or complete loss of strength or paralysis on one side of the body. Review of Resident #53's July 2022 physician's orders revealed an order for Resident #53 to wear a left palm guard from 8:00 AM to 8:00 PM daily. On 7/25/22 at 12:10 PM observation was made of Resident #53 sitting in the first-floor activity room with no palm guard present in the left hand. Review of Resident #53's July 2022 Treatment Administration Record (TAR) documented the palm guard was signed off as being worn. On 7/28/22 at 2:09 PM observation was made of Resident #53 in the main hallway across from the information desk on the first floor. Resident #53 was not wearing the left palm protector. Review of Resident #53's July 2022 TAR documented the palm guard was signed off as being worn. Review of Resident #53's care plans failed to address the palm guard. Review of Resident #53's hemiplegia/hemiparesis care plan documented the intervention, range of motion (active or passive) with am/pm care daily. There was nothing about putting a palm guard on the left hand. 3) On 7/21/22 at 9:54 AM observation was made of Resident #55 lying in bed. Resident #55's left arm appeared contracted. An interview was conducted with Resident #55 who stated he/she was paralyzed on the left side of the body. Resident #55 was asked if staff performed range of motion (ROM) and Resident #55 said, no. Resident #55 stated. I'm supposed to have range of motion, but I can't remember the last time staff did it. On 8/1/22 at 1:37 PM Resident #55's medical record was reviewed. Resident #55 was admitted to the facility in May 2017 with diagnoses that included but were not limited to a cerebral infarction (stroke) affecting the left dominant side and nontraumatic intracerebral hemorrhage. Review of July 2022 and August 2022 physician's orders revealed there were no orders for range of motion. Continued review of Resident #55's medical record revealed a physical therapy screen dated 8/5/22 that documented that Resident #55 was not a candidate for skilled restorative PT program and was functioning at baseline. On 8/8/22 at 10:23 AM an interview was conducted with Staff #53, physical therapist (PT). Staff #53 was asked why Resident #55 was evaluated since he/she was admitted in May 2017. Staff #53 stated that when a resident is sent out to the hospital and returns, they are assessed for baseline and nursing checks their ROM. Staff #53 stated Resident #55 was not on a program due to being at baseline, and the resident prefers his ROM in bed, not in PT, but with the Geriatric Nursing Assistant (GNA.) Staff #53 stated he had an in-service form that was completed for Resident #55. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/8/22 at 10:32 AM Staff #53 gave the surveyor an in-service form dated 3/4/22 that stated, FMP (Functional Maintenance Program) to maintain LE (lower extremity) strength and range of motion. Hip bridging as tolerated x 3 sets, left lower extremity range of motion exercise knee to chests (sic) as tolerated x 3 sets. The form was signed by Licensed Practical Nurse (LPN) #37. On 8/11/22 at 8:15 AM an interview with GNA #34 revealed she did ROM for the resident's left arm when she was assigned to the resident. She stated she was assigned to the resident about 1 week out of the month. GNA #34 stated she was an agency GNA and not an employee of the facility. On 8/11/22 at 8:19 AM an interview was conducted with Resident #55. Resident #55 was asked if the staff were performing ROM on his/her arms and legs. Resident #55 stated, some of the aides sometimes do ROM, but usually I have to ask. Range of motion is they tell me to grab the bed rail and pull myself in bed. The right arm they move but not the left arm. On 8/11/22 at 8:22 AM an interview was conducted with GNA #38, and she was asked about performing ROM with Resident #55. GNA #38 stated she did ROM with the right arm. She stated that if she touched the left arm the resident would scream that it hurt. When asked if she did ROM on the resident's legs, she replied that she didn't do the legs because nobody ever said anything about his/her legs. On 8/11/22 at 10:14 AM Staff #53 was interviewed about the FMP program and the in-service form. Staff #53 stated, with the education I gave, it was to be done every day and as many times as the patient could tolerate. I gave it to the nurse who was on that side of the unit (agency nurse #37). The moves I put in there are fairly simple, easy to perform, and I wouldn't think there was any risk of them doing it wrong so there was no follow-up on my part. That is what we usually do to endorse exercises. When there is less staff, I don't want them to have a long list of exercises to do with a resident and then end up with aides not wanting to do it. On 8/11/22 at 11:00 AM an interview was conducted with agency LPN #37. LPN #37 stated, training with the resident, I was not the unit manager. I do charge nurse. If I work the floor that is what it usually is. I don't recall any in-service from PT. PT usually works with the resident. When asked if she did the FMP program exercises with the resident, she said, No, I have not done that with the resident. It would be for the unit. LPN #37 stated that when she signed the in-service form, she thought it meant that rehab went around the unit and did it with everyone. LPN #37 stated, I have not done ROM with the resident. LPN #37 continued, I would normally not do range of motion with anyone, bedbound or limited. I do supervise GNAs, turn and reposition, checking for ice cups, watching linen. Assisting with care if they need it. LPN #37 stated she did not mention the FMP program to any of the GNAs on the unit and did not pass the information to anyone else. The FMP program exercises were not written on any plans, treatment administration records, or GNA task assignments. This is a repeat deficiency as F 688 was cited on the 7/29/21 complaint survey. Preventive measures that were supposed to be put into place was a log tool that was created for monitoring residents ordered splinting devices to ensure monitor placement and Unit managers were to visualize splints monthly.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of medical records and facility investigation documentation, interviews and observations it was determined the facility failed to have an effective system in place to prevent residents with cognitive impairment from leaving the facility without appropriate supervision. More specifically, the facility failed to: 1.) Provide adequate supervision to prevent a resident with known wandering and exit seeking behaviors from exiting the facility unsupervised on 5/10/21, 2.) Ensure all staff check the functionality of the wander guard bracelets for residents currently in the facility with a bracelet in place that have exit seeking behavior; 3.) have an elopement risk binder on all nursing units and educate all staff on the location and purpose of the elopement risk binder and 4.) educate all staff, including agency staff to monitor their surroundings when entering and exiting the facility. These actions resulted in the finding of an Immediate Jeopardy which was identified on 8/2/22 at 9:40 AM. This deficient practice was evident for 2 of 2 residents (Resident #208, #84) reviewed for elopement/wandering during the annual survey. Additionally, the facility staff failed to ensure residents received protective devices that were intended to protect the resident from injury due to a fall. This was evident for 1 of 6 residents (Resident #17) reviewed for accidents during the annual survey. The findings include: According to the Centers for Medicare and Medicaid Services (CMS), an Elopement occurs when a resident leaves the premises or a safe area without authorization. A resident who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle. The resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement. BIMS stands for Brief Interview for Mental Status. It is a screening tool used to assist with identifying a resident's current cognition and to help determine if any interventions need to occur. There is a series of questions that are asked to the resident. These questions have a score value attached to them. The total score of all the questions ranges from 0-15. The numeric value falls into one of three cognitive categories: Intact which is 13 to 15 points, Moderate which is 8 to 12 points or Severe cognitive impairment which is 0 to 7 points. 1) A review of Resident #208's medical record on 8/1/22 at 9:00 AM revealed the resident was first admitted to the facility in February 2021 from an acute care facility with the primary diagnosis as stroke. An elopement evaluation dated 2/26/21 documented Resident #208 was a high risk for elopement as the resident was ambulatory, could communicate, had a history of wandering, and had wandered aimlessly within the building. A 2/26/21 admission note documented Resident #208 was alert to self and required reorientation frequently. Resident #208 was deemed a high fall risk due to the ability to get out of bed and wander. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A 2/28/21 at 23:42 (11:42 PM) nurse's note documented Resident #208 was alert and confused and continued to wander around the unit looking for his/her sister. A nursing note on 3/1/21 at 6:14 AM documented Resident #208 wandered all night and continued to need redirection and orientation. Resident #208 was discharged home with his/her spouse in the end of March 2021. On 8/1/22 continued review of Resident #208's medical record revealed Resident #208 was readmitted to the facility towards the end of April 2021. The hospital discharge summary documented that the resident was brought by ambulance to the emergency room after being found wandering outside with no shoes. The documentation noted the resident was confused and attempted to wander around the emergency room . The facility Elopement Risk Evaluation dated 4/20/21 identified Resident #208 as high risk for elopement as the resident was ambulatory, had a history of wandering, medical diagnosis of dementia/cognitive impairment, and has wandered aimlessly within the house and off the grounds. 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 8/1/22 a review of Resident #208's admission Minimum Data Set (MDS) assessment, with an assessment reference date of 4/21/21, coded that Resident #208 had a BIMS score of 1 under Section C, cognition. Section E, wandering, coded wandering has not occurred and answered no to intrude on privacy of others. This was inaccurate according to a nursing progress note dated 4/21/21 at 6:45 AM which documented Resident #208 wandered during the night from room to room and had to be redirected several times. On 8/1/22 a review of Resident #208's care plan, elopement risk/wandered AEB (as evidenced by) disoriented to place. Resident wanders aimlessly, dementia, that was initiated on 5/1/21, had 2 interventions, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book and wander alert: left ankle. On 8/1/22 a review of facility-reported incident MD00167212 revealed that on 5/10/21 at 6:58 AM, Resident #208 was last seen while the nurse was administering medications. Police brought Resident #208 back to the facility at about 8:30 AM on 5/10/21. Resident #208 was found two doors down from the facility by the police officer. The facility's investigation determined the wander guard system was working. Review of a written statement from the RN night shift supervisor #24, documented that around 6:50 AM Resident #208 was sitting in the lobby and attempting to push the front door but was redirected, was receptive and went back upstairs to the unit. Resident #208 was again observed to be in the lobby, but Staff #24 was checking incoming staff in and outgoing staff out and did not see when Resident #208 exited the front doors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a 5/10/21 written statement from Geriatric Nursing Assistant (GNA) #27 documented that Resident #208 was up all-night walking all over the second floor. At 6:45 AM GNA #27 noticed the resident was not around, so she started asking if anyone had seen the resident. GNA #27 went downstairs and one of the GNA's saw the resident and told him/her to go back upstairs. GNA #27 documented that she said, why didn't someone bring him/her back upstairs. GNA #27 documented that she started to go outside, and the police showed up and asked if the resident lived at the facility. The police brought Resident #208 back in the building. A review of nursing notes dated 5/10/21 at 7:50 AM, Patient [Resident #208] alert and oriented x 1, awake during this shift, walking around the nursing station. Patient [Resident #208] received his/her medication at 6:58. The note continued, GNA notified me around 7:04 that she can't find [Resident #208] in his/her room or walking around the hallway on the second floor. Supervisor notified and Elopement code was called. Patient [Resident #208] was brought back safely by the police officer. On 8/1/22 at 8:46 AM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated Resident #208 was sitting at the front door and got in-between 2 people and got out, unfortunately. The door did not alarm. In the panel, the alarm volume setting was on low, and we immediately raised the volume to high and that was the problem. The NHA was asked why it was on the low setting and his response was he did not know. The NHA stated the wander guard bracelet was working. The NHA stated it was change of shift and that was part of the issue because it was louder in the lobby. The NHA was asked to provide the surveyors with a copy of the investigation along with any other documents to support the facility's actions. Review of the medical record on 8/1/22 at 9:00 AM revealed a 4/28/22 at 6:44 AM nurse's note which documented, resident did not sleep throughout the night, resident made several attempts to exit but redirected. The note stated, resident kept saying I want to go home to my mother. A 5/1/21 at 6:27 AM nurse's note documented that Resident #208 did not sleep all night, wandered around, and was redirected several times. A 5/1/21 at 7:58 AM note documented, persistent to leave facility this am. was stated by night staff resident has been awake all night, was given prn melatonin, no change. Resident stated my daddy is going to pick me up, I have to leave. CRNP updated, supervisor aware of resident's increased wandering. The resident is being closely monitored at this time. residents' wander guard is in place of the left ankle. A 5/4/21 at 6:02 AM note documented, Resident did not sleep through the night, wandering from unit to another, several attempts made to situate resident. Noncompliance. A 5/4/21 at 1:13 PM social services discharge planning note documented that nursing, rehab, activities, and social work discussed with the family via telephone Resident #208's advanced dementia, wandering risk and safe environment options. It was the recommendation of the team that the resident be in a long-term setting with a dementia unit, with one-to-one supervision. A 5/6/21 at 8:23 PM nurse's note stated, Resident wandering around in the Lobby area, attempting to open the doors. Staff continues to redirect and take back upstairs. Wander guard remains in place on [his/her] left ankle. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A 5/7/21 at 7:19 AM nurse's note documented that the resident wandered all night, was redirected several times but kept wandering up and down the building and only slept for 2 hours. On 8/1/22 at 7:41 AM Police Officer #28 was interviewed and stated, the resident was walking down the street from the facility and fortunately I was sitting at the end of the street. [He/she] was not dressed appropriately to be walking down the street. [He/she] was wearing PJs, socks, and no shoes. Not appropriate for being outside. He stated, it took me a while to figure out who [he/she] was. [He/She] said [he/she] was going home to [spouse]. Police Officer #28 stated he looked through the resident's belongings, which was some type of satchel. He said he took the resident back to the facility. On 8/1/22 at 7:52 AM during an interview with the night shift supervisor, Staff #24, two resident pictures were observed on the bulletin board at the front desk. Staff #24 confirmed the pictures were of the two residents in the building that were currently elopement risks. Staff #24 was able to produce an elopement binder with the two resident's information. Staff #24 stated, there is always someone at the front desk until 8 PM. There is a camera at the front desk and at the 1 west nurse's station. The front door is alarmed and needs a code to get out for it to open. The wander guard will sound even if the door is open to let someone in. The Maintenance Director was interviewed on 8/1/22 at 9:09 AM. The Maintenance Director stated, all exit doors are checked every day, Monday through Friday. On 8/1/22 at 10:31 AM the NHA provided the surveyor with the education that followed the elopement. The employee signature sheet for Clinical Policy - Elopement described the elopement procedure. The policy documented the facility will assess residents for elopement risk by completing the Elopement Risk Assessment on admission, annually and with changes in condition that may interfere with resident's mental status. Residents identified as at risk, will have an updated care plan with appropriate interventions. The education failed to address shift change and the opportunity for residents to slip past staff. A review of the elopement policy that was given to the surveyor on 8/1/22 at 11:32 AM documented, alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. On 8/1/22 at 3:46 PM LPN #29 was asked if anyone on his unit (1 West) had a wander guard bracelet. LPN #29 stated, just about everyone wears a wander guard. RN #30 (agency nurse) was standing next to LPN #29 and stated, I know nothing. I would direct you to the unit manager or Director of Nursing. On 8/1/22 at 3:50 PM LPN #31 was asked if she knew who on her unit was an elopement risk. LPN #31 stated, this is my first day. LPN #31 was asked if she was oriented to the unit and she stated, it depends on if it is a [corporate name] facility. LPN #31 stated she was not oriented here, just told her schedule. LPN #31 was asked if there was an elopement binder on the unit and her reply was, I have not seen one. On 8/2/22 at 7:28 AM the surveyor asked LPN #26, who was on the second floor, 2 East unit, if there was an elopement binder for the unit. LPN #26 looked all through the nurse's station along with 2 other nurses and stated, we used to have one, but I can't find it. When asked if there was anyone on the unit that was an elopement risk she stated, I don't think so. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/2/22 at 7:31 AM GNA #32 (agency) was on the second-floor west wing unit and was asked if any of her residents were an elopement risk. GNA #32 stated, I don't think so. GNA #32 stated, if anyone wears a wander guard it will go off if they try to leave. GNA #32 was asked if she was educated prior to her shift about elopement and she stated, no. On 8/2/22 at 7:33 AM LPN #33 (night shift) was asked if he checked the wander guard for Resident #84. Resident #84 is 1 of 2 residents in the facility that was an elopement risk. LPN #33 stated, I occasionally check it. He/she has physical limitations. I don't need to check it because [his/her] room is right next to the nurse's station. On 8/2/22 at 7:36 AM Resident #84's medical record was reviewed and revealed a physician's order, use wander guard universal tester to check that wander guard bracelet is functioning. Replace bracelet if not working properly. Document replacement under progress note tab in [name of electronic medical record]. Every night shift for elopement precaution. Order date 5/4/22 at 1402. Review of Resident #84's Treatment Administration Record (TAR) for August 2022 revealed LPN #33's initials and checkmark that he checked the bracelet on night shift of 8/1/22. On 8/2/22 at 7:41 AM, with a second surveyor, another interview with LPN #33 was conducted. LPN #33 was asked if he checked Resident #84's wander guard bracelet for function and he said, no. The surveyor asked LPN #33 to open Resident #84's TAR and the surveyor pointed out that he signed off that the wander guard check was done. LPN #33 stated, there is the alarm over there by the door. The surveyor read the order to LPN #33 and pointed out that he signed off that he checked the resident's wander guard functionality. LPN #33 confirmed that he did not check the wander guard even though he signed off on the TAR that he did check it. At that time the surveyor asked LPN #33 to go into Resident #84's to confirm placement of the wander guard. Resident #84 was not wearing the wander guard. It was placed on the wheelchair due to the resident's refusal to wear it. On 8/2/22 at 7:43 AM it was also confirmed by LPN #10 that there was no elopement binder on the 2 [NAME] nursing unit. On 8/2/22 at 7:54 AM the Director of Nursing (DON) was informed of the conversation with LPN #33. The DON was also asked about elopement binders on the units, and she stated there was an elopement binder at the front desk and in the conference room where the supervisors were located. The DON also stated that information should be exchanged in report between shifts. From 7/22/22 until 8/2/22, the surveyors would arrive at the facility at approximately 7:00 AM and observe shift change from night to days. There were always several staff standing in the lobby in front of the check-in window, either getting their temperature checked and screened for COVID-19 symptoms or agency staff checking in or out with the night shift supervisor. It was observed that when there were staff standing in front of the screening window and the night shift supervisor was looking down at paperwork or a phone, the night shift supervisor could not see who or what was going on at the front door. Staff would hold the door open for the next person to walk in or out. Because of these findings, an Immediate Jeopardy was identified on 8/2/22 at 9:40 AM. A final plan to remove the Immediate Jeopardy was submitted to the surveyors on 8/2/22 at 4:30 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/3/22 at 3:40 PM the NHA came to the surveyors and stated, I did some digging and found more education and information from the elopement in 2021. The NHA presented a binder of all education and everything the facility had put into place. This binder was not provided to the surveyors on 8/2/22 and was not an option to review before the Immediate Jeopardy was identified. Education sign-in sheets that were provided to surveyors on 8/3/22 at 3:40 PM for the elopement on 5/10/21 were compared to the current staffing roster that was provided to surveyors on entrance to the facility on [DATE]. It was noted that (2) requests had been made for a complete staffing list for May 2021 on 8/4/22 and 8/5/22 at 9:30 AM and as of 3:30 PM on 8/5/22 the list was not provided. There were 31 staff names with a date of hire prior to 5/10/21 that were not educated that were on the current staffing roster. Additionally, the Wandering and Elopements Policy that was given to the surveyors from the time of the initial elopement did not match the policy that the staff were educated on 5/10/21. The policy that staff were educated on 5/10/21, had a date issued 11/15 on the lower left-hand corner of the page. The policy described the elopement procedure. The policy the facility provided to the surveyors in the binder on 8/3/22 had an April 2019 date in the lower left-hand corner of the page. On 8/11/22 at 11:14 AM the nursing staffing scheduler was interviewed and stated, the staff on most days and shifts are agency. She stated, on weekends the numbers can go up to 75% agency. On a given day more than half of our staff is agency. She stated, we have a book on the unit for agency staff that has information on how to handle situations, policies, and procedures. On the weekends it is a lot of agency staff, but we make sure there is a supervisor for every shift. The facility submitted a plan for removal of the Immediate Jeopardy on 8/2/22 at 12:58 PM that was not accepted. The facility submitted a second plan on 8/2/22 at 2:34 PM that was not accepted. On 8/2/22 at 4:30 PM the facility submitted a third plan of removal that was accepted on 8/2/22 at 5:00 PM. After determination of Immediate Jeopardy concerns, an extended survey was conducted. The Immediate Jeopardy was removed on 8/5/22 at 3:40 PM after validation that the plan had been implemented. After removal of the immediacy, the deficient practice continued with a scope and severity of E with potential for more than minimal harm for the remaining residents. The facility's removal plan included the following provisions: The elopement and wandering policy was reviewed and revised. All residents in the building were reassessed for elopement risk and if they were deemed a risk, interventions were put into place. Audits of MDS assessments to ensure the care plan reflected the needs/concerns identified. All staff and new hires received education on wandering, elopement, and resident safety. A Quality Assurance Performance Improvement (QAPI) Project was implemented to review and interpret all audit findings. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility placed Pink Elopement Binders on each nursing unit at the nurse ' s station, in the conference room and at the front desk. The binders will be checked at the beginning of each shift and as changes occur. Completion of the task will be signed off on a signature sheet. Signs were placed on the door to alert staff and family members not to allow anyone to exit the facility without approval from licensed staff. Employees were made aware to monitor their surroundings when entering and exiting the facility and monitor that residents at risk for elopement do not exit the facility. Education that employees must respond to alarms as soon as possible, in a timely manner to prevent elopement. Employees have read and received a copy of the elopement policy. A process was put in place for agency staff to be educated on elopement prevention prior to taking an assignment. 2) Facility staff failed to ensure Resident #17 received protective devices that were intended to protect the resident from injury due to a fall. On 7/22/22 at 2:10 PM Resident #17's medical record was reviewed and revealed Resident #17 was admitted to the facility in December 2018 with diagnoses including but not limited to early onset Alzheimer's disease. Review of progress notes documented that Resident #17 had falls on 12/23/21, 2/10/22, 4/12/22, and 5/11/22 without injury. Review of progress notes documented on 5/18/22 at 13:58 (1:58) PM that hipsters were provided on 5/17/22. Hipsters are briefs that have impact absorbing pads over the critical hip area that are designed to minimize potential damage, including hip fractures that can occur from a fall. Review of Resident #17's care plan, had an actual fall with no injury r/t poor balance and poor communication/comprehension, had the intervention, apply hipsters at all times, which was initiated on 8/20/21. On 7/25/22 at 11:42 AM observation was made of Resident #17 in bed. Resident #17 was not wearing hipsters. On 7/25/22 at 3:08 PM Resident #17 was observed again in his/her room without hipsters. An interview of GNA #66, a GNA from a staffing agency, was conducted and she was asked if Resident #17 was wearing hipsters. GNA #66 stated, I didn't know [he/she] wore them. I didn't see anything in the room. The DON was informed on 8/9/22 at 11:20 AM.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42507 Based on observation, medical record review, and interview, it was determined the facility 1) failed to properly date label oxygen tubing when changed, 2) failed to follow physician's orders for the administration of oxygen, and 3) failed to develop and implement a person centered comprehensive care plan with resident centered goals for respiratory care to include oxygen therapy. This was evident for 2 (#307 and #76) of 3 residents reviewed for respiratory care during the annual survey. The findings include: On 7/22/22 at 8:10 AM, the surveyor observed Resident #307 lying in bed. An oxygen concentrator (a machine that concentrates oxygen from the air) was on the right side of the resident's bed. The resident was wearing a nasal cannula (oxygen tube with nose prongs) that was connected to the concentrator. The tubing was not date labeled to indicate when it was last changed. When asked, the resident was unable to recall when it was last changed. During a review of Resident #307's medical record conducted on 8/1/22 at 8:12 AM, surveyor noted an active physician order dated 7/22/22 for: Continuous 2L/min oxygen nasal cannula every shift for O2 therapy. Change nasal cannula tubing once a week, every night shift every Friday. On 8/1/22 at 9:20 AM, review of Treatment Administration Record (TAR) for July and August 2022 revealed the tubing was changed on 7/29/22, however, the tubing had no date label. A Plan of Care was developed for Resident #307 for impaired respiratory status risk. The interventions included but were not limited to: Provide oxygen as ordered. The goal was for the resident to have adequate tissue perfusion and no sign/symptom of respiratory distress. The plan of care did not specify the amount of oxygen and/or instruct that the tubing be changed once a week as indicated in the physician's order and TAR. Another observation was made of Resident #307 on 8/1/22 at 9:35 AM. The Resident was lying in bed and receiving oxygen by nasal cannula from the oxygen concentrator. No date label was on the oxygen tubing at that time. In an interview with the resident, s/he stated that the tubing was changed last week but s/he could not remember the date. In an interview with the Director of Nursing (DON) on 8/1/22 at 2:15 PM, s/he was made aware of surveyor's observations. The DON stated that she was going to follow up. 31145 2) On 7/21/22 at 11:03 AM Resident #76 was observed lying in bed wearing a nasal cannula. Observation of the tubing failed to reveal the date when the tubing was changed as it was not labeled. Observation of the concentrator revealed the oxygen (O2) was being administered to Resident #76 at 4 L (liters) per minute. There was a humidifier bottle sitting on the nightstand and not attached to the concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/22 at 12:05 PM observation was made of Resident #76 lying in bed with O2 tubing lying on the bed. The oxygen concentrator was running at 4 liters per minute. On 7/26/22 at 10:04 AM observation was made of Resident #76 lying in bed with O2 N/C in place under the nostrils. The O2 was set at 4 L. On 7/28/22 at 3:06 PM and on 7/29/22 at 9:26 AM observation was made of Resident #76's oxygen concentrator set at 3L per minute. On 7/28/22 at 1:00 PM a review of Resident #76's medical record revealed Resident #76 was admitted to the facility in February 2022 with diagnoses that included asthma, COPD, and hypertension. A July 2022 physician's order stated, oxygen therapy, continuous 2 liters of oxygen by nasal cannula as needed for asthma. The oxygen order was originally written on 3/16/22. There was no order for when to change the oxygen tubing. Review of Resident #76's July 2022 Medication Administration Record (MAR) revealed the order for continuous 2 liters of 0xygen by nasal cannula as needed for asthma. The MAR did not have documentation from the nurses that oxygen was being administered at any time. Additionally, Resident #76 was receiving either 3 liters or 4 liters of oxygen when the physician's order stated to administer 2 liters of oxygen. Review of Resident #76's care plans revealed a care plan for COPD that was initiated on 2/2/22 and revised on 7/5/22. There were 3 interventions on the care plan that included, Encourage small frequent feedings instead of large meals. Give supplements if needed to maintain adequate nutrition. Encourage good fluid intake, Monitor for s/sx of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB at rest, Cyanosis, Somnolence, and Monitor/document/report to MD PRN any s/sx of respiratory infection: Fever, Chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing. The care plan did not include oxygen therapy. The facility failed to develop a care plan related to oxygen therapy. There was no documentation of the response to oxygen therapy. On 7/29/22 at 9:26 AM an interview was conducted with Registered Nurse #24, who was an agency nurse that was filling in for the unit manager and night supervisor. RN #24 was asked to explain the process for residents with oxygen therapy. RN #24 stated, O2 vital signs are recorded every shift on the TAR (Treatment Administration Record) and any O2 saturations under 90, as the nurse I will assess the resident and then provide interventions and notify the M.D. RN #24 was then asked to follow surveyors into Resident #76's room. RN #24 was asked, how many liters of oxygen is the resident receiving. RN #24 stated 3 liters. RN #24 was asked how many liters Resident #76 should be receiving. RN #24 checked the physician's orders and stated 2 liters. RN #24 was then asked what the procedure was for changing the oxygen tubing and RN #24 stated, that is in the orders section. While reviewing the medical record RN stated, there are no orders for changing the O2 tubing. RN #24 was observed going back into Resident #76's room to change the O2 setting to 2L. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing was informed of the concerns on 8/9/22 at 11:20 AM.

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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. 31145 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 5 (#46, #80, #55, #67, #65,) of 38 residents reviewed during the annual survey. The findings include: 1) On 7/27/22 at 8:04 AM a record review was done for Resident #46. Review of the paper and electronic medical record revealed the last physician's note found in the medical record was from an 8/4/21 visit with an upload to the electronic medical record on 8/11/21. 2) On 7/9/22 at 9:30 AM a review of Resident #80's medical record revealed the last physician's visit that was in the medical record was dated 11/28/21 with an upload date of 12/22/21. The previous note was dated 5/18/21. There were no physician visits noted in-between those 2 notes. A physician's note dated 5/17/22 was found in the labeled other section of the electronic record that was uploaded on 6/13/22. In that note there is documentation of visits dated 12/14/21, 1/18/22, 2/8/22, 3/8/22, 4/15/22, and 5/17/22, however they were not uploaded until 6/13/22. 3) On 8/8/22 at 10:09 AM Resident #55's medical record was reviewed and revealed the last physician's visit uploaded into the medical record was dated 11/9/21. Physician visits dated 6/22/21, 7/7/21, 7/27/21, 8/24/21, 9/21/21, 10/5/21, 10/8/21, 10/12/21, 10/26/21, 11/9/21, 11/23/21, 11/28/21, 12/7/21, 12/10/21, 1/7/22, 1/18/22, 2/1/22, 2/8/22, 3/8/22, 4/8/22, 4/15/22, 5/3/22, 5/17/22, 5/31/22, 6/3/22, 6/14/22, 6/21/22, and 7/19/22 were not uploaded into the medical record until 8/2/22. An interview was conducted with the medical records staff #49 on 7/29/22 at 9:55 AM. Staff #49 stated that at first the physician was emailing the physician visits but then Staff #49 was granted access to the physician's notes system. Staff #49 stated, there are more steps to pull the notes in, especially when there are so many notes. When asked if she was behind in pulling the notes in, Staff #49 stated, I am but I did not tell anyone. Staff #49 stated she has had personal issues and was having a hard time doing her job. 43096 4) A review of Resident #67's electronic medical record on 7/29/22 at 8:38 AM revealed the last physician's visit was dated 10/26/21 with an upload date of 11/9/21. However, there was no physician's note since 10/26/21. On 8/5/22 at 2:29 PM review of Resident #67's electronic medical record revealed that the physician's medical visit notes dated 11/28/21, 12/14/21, 1/21/22, 2/22/22, 3/22/22, 4/12/22, 5/24/22, 5/31/22, and 6/21/22 were uploaded on 8/1/22. 4) On 7/29/22 at 9:00 AM a review of Resident #65's electronic medical record revealed the last physician visit was dated 5/18/21 with an upload date of 6/2/21. However, there was no physician's note since 5/18/21. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/1/22 at 2:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that residents were seen by physicians monthly, and some documentation was delayed uploading under residents' medical records. The DON was alerted of the concern that the physician's notes were not found under the residents' medical records. On 8/5/22 at 2:35 PM review of Resident #65's electronic medical record revealed that physician's notes dated 6/22/21, 7/27/21, 8/24/21, 9/21/21, 10/26/21, 11/28/21, 12/14/21, 1/21/22, 1/28/22, 2/1/22, 2/4/22, 2/22/22, 3/22/22, 4/12/22, 5/24/22, 5/31/22, and 6/21/22 were uploaded on 8/1/22.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on review of facility records and interview with staff, it was determined the facility failed 1) ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs and 2) failed to ensure all nursing staff had the specific competencies and skill sets necessary to care for residents with a Nephrostomy tube. This was evident for 2 (Staff #71 and #72) of 5 randomly selected GNAs reviewed for competency review and 2 (# 89 and #83) out of 2 residents with Nephrostomy tubes reviewed. The findings include: Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as resident Rights, person centered care, communication, basic nursing skills, basic restorative services, skin and wound care, medication management, pain management, Infection control, Identification of changes in condition, and cultural competency. 1) A meeting was held with the Human Resource (HR) Director (staff #78) at 10:00 AM on 8/10/22 to review the GNA employment files for education and yearly performance Appraisals. The HR director did not have access to employee education files but was requested to obtain staffing education and competencies documentation of the 5 randomly selected GNAs. At 1:47 PM on 8/10/22 the HR director provided 3 of 5 GNA documented clinical competencies. The competencies were titled CNA orientation Clinical Competencies. The HR director was asked to provide the additional requested competency documentation. The HR director reported at 2:25 PM on 8/10/22 that there was not documentation to support that clinical competencies were appraised for staff #71 and #72. 42507 2) A nephrostomy tube is a catheter or tube that is surgically inserted into the kidney to drain urine from the body. The drained urine is collected in a small bag located outside the body. Brief Interview for Mental Status (BIMS) is an assessment that assists staff in determining a resident's cognitive status. A score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired, and 0-7 indicates severe impairment. On 7/21/22 at 10:42 AM, in an interview with Resident #89, s/he stated that s/he had a nephrostomy tube in place and was in the hospital for a long time because of kidney stones prior to coming into the facility for rehab. Resident #89 stated the nephrostomy tube was not flushed and bag not emptied daily by staff. Medical record review was conducted for Resident #89 on 8/2/2022 at 8:47 AM. Resident #89 was originally admitted to the facility in June 2022 with diagnoses that included: Crohn's disease, chronic kidney disease, kidney stones, unspecified hydronephrosis, benign prostatic hyperplasia, colostomy, and displacement of nephrostomy catheter. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of admission MDS dated [DATE] revealed resident had a BIMS score of 12. Resident was coded as extensive assistance with one-person physical assist for bed mobility, transfers, dressing, toilet use, and personal hygiene; section H of the MDS rightly coded for appliances (nephrostomy tube). During further review of the resident's medical record on 8/2/22 at 2:31 PM, surveyor noted an active physician order dated 7/23/22 for: Sodium Chloride Flush Intravenous Solution 0.9 % (Sodium Chloride Flush) Use 10 ml via irrigation every 12 hours as needed for MAINTAIN NEPHROSTOMY PATENCY (Flush LL Nephrostomy Tube with 10 ML 0f NSS BID, PRN), Encourage PO Fluids 300 ML Q 4 hours. while awake for elevate BUN. every 4 hours, Cleanse LLQ Nephrostomy site with soap and water, pat dry, apply split gauze daily. every day shift, and Nephrostomy Tube: Document output every shift. every shift. Review of progress notes on 8/3/22 at 10:36 AM, revealed admission notes on 6/30/22 that indicated R #89 arrived at the facility with a left side nephrostomy tube in place. A change in condition note dated 7/22/22 at 3:37 PM revealed Nephrostomy tube became dislodged, and R #89 was transferred to the hospital for it to be replaced. Further review of the progress notes revealed documentation by nursing on 7/24/22 at 10:49 PM indicating that the resident was back in the facility with a new nephrostomy tube that was intact and patent. On 8/3/22 at 12:29 PM, review of Medication Administration Record and Treatment Administration Record revealed medications and treatments were administered as ordered. Daily nephrostomy site care and nephrostomy tube output every shift documented by staff. However, there was no documentation on the as needed sodium chloride flush for maintaining the patency of the nephrostomy tube, to show that staff had flushed the tube even once. On 8/4/22 at 8:40 AM, a follow up interview was completed with the resident's nurse, Licensed Practical Nurse (LPN #21). When asked if s/he was educated on hire about nephrostomy care, LPN #21 stated no but added that s/he had gotten training from her/his prior job and was very familiar with the care of residents with nephrostomy tubes. On 8/4/22 at 2:45 PM, the surveyor interviewed the Director of Nursing (DON) regarding staff training on Nephrostomy tube care. The DON stated that staff competency training was done annually and as needed. However, when asked to provide documentation on staff training on nephrostomy tube care, the DON stated that s/he could not find any in-service sheets and/or staff sign-in sheets to show training that was done. When asked if the facility had a staff educator, the DON stated there was none, she added that staff training was being done by the DON, the Assistant Director of Nursing (ADON), Unit Managers, and Supervisors. When asked about the training of Agency staff, the DON stated s/he did not have proof of their education as they were expected to be trained by their agencies. S/he further stated that the information could be pulled out of the agency website, but s/he did not have that information. When asked about the number of residents with nephrostomy tubes in the building, the DON stated she did not know but would find out. On 8/5/22 at 12:05 PM, in a follow up interview with the DON, s/he stated, the facility currently has one resident with a nephrostomy tube (Resident #89), the other resident that had a nephrostomy tube (Resident #83) no longer has it. However, the DON did not provide proof of staff education on nephrostomy tube care. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/9/22 at 2:45 PM, surveyor completed an interview with resident's Geriatric Nursing Assistant (GNA # 32). S/he stated that this was her/his first day taking care of Resident #89. When asked if s/he was given any education/instructions on nephrostomy tube care prior to her/his assignment, GNA #32 stated No. However, she stated that s/he knew how to empty the nephrostomy drainage bag because of her/his experience from working in other facilities with similar residents. On 8/10/22 at 3:05 PM, in an interview with the Assistant Director of Nursing (ADON), s/he stated that she was the facility staff developer and they have started staff training on nephrostomy tube care. However, the ADON did not provide staff sign-in sheets on training provided on nephrostomy tube care. On 8/10/22 at 3:25 PM, the ADON gave the surveyor copies of sign-in sheets for training provided to licensed staff (including agency staff) on Nephrostomy tube care and maintenance from 8/4/22 through 8/9/22. When asked if any training was provided to the Geriatric Nursing Assistants (GNAs), the ADON stated no. On 8/11/22 at 8:40 AM, an interview was completed with GNA #65, who has worked in the facility for close to [AGE] years. Regarding nephrostomy tube care training, GNA #65 stated that s/he had a formal training on 2 East about 2 years ago when they had a resident with a nephrostomy tube. GNA #65 further stated that they hardly got residents with nephrostomy tubes and the last time s/he had one, the nurse showed her/him how to empty the drainage bag. In addition, s/he stated that the nurses provided nephrostomy site care, GNAs were only allowed to empty the drainage bag. On 8/11/22 at 4:15 PM, the Administrator and Director of Nursing were made aware of surveyor's concerns prior to and during the exit meeting. No additional documentation of training or competency was provided to surveyors at the time of the exit meeting. 31145 3) On 7/26/22 at 2:23 PM a review Resident #83's medical record revealed Resident #83 was admitted to the facility in October 2017 with diagnoses that included, but were not limited to, cerebral infarction, neuromuscular dysfunction of bladder, chronic respiratory failure. Review of progress notes dated 12/8/21 documented Resident #83 was sent to the emergency room for a dislodged left nephrostomy tube. A progress note dated 5/29/22 at 6:06 AM note documented Resident #83's left nephrostomy tube was dislodged during am (morning) care. Resident #83 was transferred to the hospital. Resident #83 was readmitted to the facility on [DATE]. A 6/3/22 change in condition note documented the right nephrostomy tube was displaced and the resident was sent to the hospital. A 7/30/22 note documented Resident #83's left nephrostomy tube was dislodged and due to the resident being on Hospice, the physician decided to not replace the tube. On 8/4/22 at 2:45 PM the Director of Nursing (DON) was asked about staff education on Nephrostomy tube care. The DON stated that she could not find any in-service sheets and/or staff sign-in sheets to show that staff had the training.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 15701 Based on review of employee files and staff interview it was determined that the facility staff failed to put a system in place to ensure that Geriatric Nursing Assistants (GNA) are evaluated annually and provided appropriate re-education based on the outcome of these evaluations. This was found to be true for 5 of 5 GNA employees (Staff #68, #69, #70, #71, #72) reviewed for annual evaluations. This deficient practice has the potential to affect all the residents in the facility. The findings include: On 8/10/22, the Human Resources (HR) Director (staff #78) provided a requested list of the facility's Geriatric Nursing Assistants (GNAs) with hire dates. Out of a list of 23 GNAs, 5 employee files were selected at random. A meeting was held with HR at 10:00 AM on 8/10/22 to review the GNA employment files for education and yearly performance Appraisals. 1) Review for GNA (staff #68) with a Date of hire (DOH) 8/1/18 revealed an incomplete employee Job performance appraisal dated 8/1/21. The form showed 11 areas that each employee was evaluated with a number system from 4 = Excellent to 0 = fails to meet expectations. Only the corresponding number was circled for each area of the evaluation. The form did not have any additional comments or goals written. The scoring section was blank without an indication of a total score. The form was signed by the evaluator on 8/1/21. There was a signature of a supervisor but was not dated as to when signed. There was not an indication of the employee receiving the appraisal as it was not signed by the employee. Additionally, there was not a signature of the administrator. The HR director did not provide any indication of when a performance evaluation will be conducted for the current anniversary month. 2) Review for GNA (staff #69) with a DOH 4/24/2019 revealed that a yearly evaluation was not performed in April of 2022 (the employees' anniversary DOH). An incomplete Job performance appraisal dated by the evaluators signature for 4/1/21 was reviewed. Only 10 of the 11 evaluation areas had a number circled. The form did not have any additional comments, goals, or a total score documented. There was not any indication that the appraisal was reviewed and discussed with the employee. 3) Review for GNA (staff #70) with a DOH 2/5/2020, revealed that a yearly evaluation was not performed in February of 2022. An incomplete evaluation was dated by the evaluator for 2/1/21. Besides the circled numbers, the appraisal did not have any additional comments, goals, or a total score documented. There was not any indication that the appraisal was reviewed and discussed with the employee. 4) Review for GNA (staff#71) with a DOH 1/16/2019, revealed that a yearly evaluation was not performed for the current year January 2022. An incomplete evaluation was dated by the evaluator for 1/16/2021. This appraisal only had numbers circled for 10 of the 11 areas of employee evaluation. There were two sections with documentation under goal. There were not any other comments of total score documented. There was not any indication that the appraisal was reviewed and discussed with the employee. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) Review for GNA (staff#72) with a DOH 8/1/18, revealed an incomplete evaluation dated by the evaluator on 8/1/21. Besides the circled numbers, the appraisal did not have any additional comments, goals, or a total score documented. There was not any indication that the appraisal was reviewed and discussed with the employee. The HR director did not provide any indication of when a performance evaluation will be conducted for the current anniversary month. Review of the incomplete annual employee appraisals shown that there was not any identification or discussions related to specific in-service education recommendations based on the outcome of those reviews for each individual nurse assistant.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 15701 Based on request for historical staffing sheets the facility failed to maintain the posted daily staffing sheets for resident and public access. 3 of 3 dates for staffing sheets requested were not provided. The findings include. Upon discussion with the Director of Nursing on 8/10/22 at 8:41 AM, Federal and state staffing sheets for all three shifts for the following dates 7/23/21, 8/29/21, and 5/17/22 were requested. On 8/11/22 at 1:15 PM, The Director of Nursing revealed that she could not find the requested staffing sheets.

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Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 31145 Based on medical record review and staff interview it was determined the facility pharmacist failed to identify and report irregularities in the resident's drug regimen to the physician, facility's medical director and the director of nursing. This was evident for 1 (#80) of 7 residents reviewed for unnecessary medications. The findings include: On 7/29/22 at 7:43 AM a review was conducted of Resident #80's medical record. Review of the July 2022 physician's orders revealed the order Metoprolol 25 mg. 1/2 tablet every 12 hours at 8 AM and 8 PM. The order stated to hold the medication if SBP (systolic blood pressure) was less than 110 or HR (heart rate) less than 60. Metoprolol is a beta-blocker used to treat hypertension. The top number of the blood pressure refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. The bottom number refers to the blood pressure when the heart muscle is between beats. This is called diastolic pressure. Review of Resident #80's July 2022 Medication Administration Record (MAR) revealed that blood pressures or heart rate were not being documented at 8 AM and 8 PM when the medication was signed off as given. The MAR was only initialed that the blood pressure medication was given. Review of the vital sign section of the medical record for blood pressures and heart rate revealed no consistency in times when the blood pressure was taken and that would correlate when the medication was given. There were some days where the blood pressures were taken in the vicinity of 8 AM or 8 PM and there were days when there was no blood pressure documented near those time frames, or at all. On 7/12/22 at 16:21 (4:21 PM) the blood pressure was documented as 107/63 in the vital sign section and documented on the MAR that it was given. The SBP of 107 was outside of parameters. On 7/8/22 at 16:39 (4:39 PM) the blood pressure was documented as 107/67 in the vital sign section, which was below the SBP parameter, and signed off as given on the MAR. Review of monthly pharmacy reviews dated 7/17/22, 6/20/22, and 5/15/22 documented that no recommendations were made regarding the pharmacy reviews. The pharmacist failed to pick up that the blood pressures were not being monitored when the blood pressure medication had physician ordered parameters. On 8/1/22 at 2:40 PM the Director of Nursing was informed of the concern and confirmed the findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 31145 Based on medical record review and staff interview it was determined the facility failed to keep a resident's drug regimen free from unnecessary drugs by failing to 1) monitor the blood pressure and heart rate prior to administering a blood pressure medication and 2) follow physician ordered blood pressure parameters for administering Metoprolol, a blood pressure medication. This was evident for 1 (#80) of 7 residents reviewed for unnecessary drugs during the annual survey. The findings include: On 7/29/22 at 7:43 AM a review was conducted of Resident #80's medical record. Review of July 2022 physician's orders revealed the order Metoprolol 25 mg. 1/2 tablet every 12 hours at 8 AM and 8 PM. The order stated to hold the medication if SBP (systolic blood pressure) was less than 110 or HR (heart rate). The top number of the blood pressure refers to the amount of pressure in the arteries during the contraction of the heart muscle. This is called systolic pressure. The bottom number refers to the blood pressure when the heart muscle is between beats. This is called diastolic pressure. Review of Resident #80's July 2022 Medication Administration Record (MAR) revealed that blood pressures or heart rate were not being documented at 8 AM and 8 PM when the medication was signed off as given. The MAR was only initialed that the blood pressure medication was given. Review of the vital sign section of the medical record for blood pressures and heart rate revealed no consistency in times when the blood pressure was taken and that would correlate when the medication was given. There were some days where the blood pressures were taken in the vicinity of 8 AM or 8 PM and there were days when there was no blood pressure documented near those time frames. On 7/12/22 at 16:21 (4:21 PM) the blood pressure was documented as 107/63 in the vital sign section and documented on the MAR that it was given. The SBP of 107 was outside of parameters. On 7/8/22 at 16:39 (4:39 PM) the blood pressure was documented as 107/67 in the vital sign section, which was below the SBP parameter, and signed off as given on the MAR. On 7/29/22 at 9:45 AM an interview was conducted with Certified Medicine Aide (CMA) #76. The surveyor asked how the CMA knew to give the Metoprolol. CMA #76 stated she takes her own vital signs before giving the medication. CMA #76 was asked if she recorded that anywhere and she said she gives the list of readings to the nurse to document. She said she used to be able to document the blood pressures but cannot anymore. On 8/1/22 at 2:40 PM the Director of Nursing (DON) was informed of the concern and confirmed the finding with the DON.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 31145 Based on medical record review and staff interviews, it was determined that facility staff failed to ensure residents were free from significant medication errors as evidenced by failing to follow a physician's order related to holding blood pressure medications if outside of physician ordered parameters. This was evident for 1 (#251) of 5 residents reviewed for medication pass observation and 1 (#151) of 2 residents reviewed for death during the annual survey. The findings include: Blood pressure is a measurement of the pressure that the blood places on the arteries as it is moving through the arteries. The top number is the systolic pressure, which is a measurement of the pressure when the heart pumps the blood out into the arteries. The bottom number is the diastolic pressure which is a measurement of the pressure when the heart is between beats (resting). 1) On 7/26/22 at 7:58 AM observation was made of medication administration for Resident #151. After the medication administration observation, the resident's medical record was reviewed. Review of Resident #151's July 2022 physician's orders revealed the order, Midodrine HCl Oral Tablet 5 MG (Midodrine HCl) Give 1 tablet by mouth three times a day for hypotension (low blood pressure) hold if SBP (systolic blood pressure) is greater than 100. This order was in effect from 7/15/22 to 7/22/22. Midodrine is used to treat low blood pressure. It works by causing blood vessels to tighten, which increases blood pressure. The physician also ordered the medication Carvedilol 6.25 mg to be given twice a day for hypertension and to hold if the blood pressure was less than 110/60. Review of Resident #151's July 2022 MAR documented on 7/16 at 12:00 PM the b/p was 120/62, on 7/16 at 4:00 PM the b/p was 118/75, on 7/18 at 12:00 PM the b/p was 139/86, on 7/19 at 1:00 PM the b/p was 104/57, on 7/22 at 8:00 AM the b/p was 119/72 and on 7/22 at 6:00 PM the b/p was 125/70. The Midodrine was given outside of physician parameters as the systolic blood pressure (top number) was above 100. The medication should have been held. On 7/20/22 at 8:00 PM the b/p was 108/64 and the Carvedilol 6.25 mg. was given. The medication should have been held as the blood pressure was below the physician ordered parameters. Continued review of the July 2022 physician's orders revealed the Midodrine order was changed effective 7/23/22 to Midodrine 2.5 mg. (3) times a day versus 5 mg. (3) times a day. Further review of Resident #151's July 2022 MAR documented on 7/24 at 8:00 AM and 1:00 PM the b/p was 112/66, on 7/25 at 9:00 AM the b/p was 117/64, on 7/27 at 9:00 AM and 1:00 PM the b/p was 112/53, on 7/28 at 8:00 AM the b/p was 117/68 and at 1:00 PM the b/p was 120/68. The Midodrine was given outside of physician parameters as the systolic blood pressure was above 100. The medication should have been held. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/28/22 at 2:21 PM an interview was conducted with Licensed Practical Nurse (LPN) #9. LPN #9 signed off on 7/27/22 at 9:00 AM and 1:00 PM that the Midodrine was given for a blood pressure of 112/53. LPN #9 stated he gave the medication. The surveyor asked if he gave the medication with a systolic b/p of 117. He said, yes. On 7/28/22 at 2:43 PM LPN #9 came into the conference room where the surveyor was located with a paper that had Resident #151's handwritten blood pressure on it. LPN #9 stated, when I first came in this morning the b/p was 90/66. I gave the medication and rechecked it and it was 117/68 and that is the number I wrote on the MAR. LPN stated he did the same thing for 7/27/22 at 8:00 AM and 1:00 PM. The 8:00 AM and 1:00 PM b/p was documented on the MAR as 112/53. LPN #9 was asked if he saved his handwritten paper from 7/27/22 and he said, no. Review of the Medication Administration Policy that was given to the surveyor by the Director Of Nursing (DON) documented the policy, medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Number 8 of the policy documented, obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. Number 17 of the policy documented, sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR. The concerns for medication administration outside of physician ordered paramaters was discussed with the DON on 8/1/22 at 2:40 PM 2) On 8/4/22 at 7:30 AM Resident #251's medical record was reviewed. Review of a CRNP (Certified Registered Nurse Practitioner) noted dated 12/16/21 documented Resident #251 was a new admission who had been hospitalized for 10 days due to shortness of breath, chest pain and high blood pressure. Resident #251 was treated for COPD (Chronic Obstructive Pulmonary Disease) exacerbation and pneumonia. The note documented the resident's hypertension resolved after treatment of COPD exacerbation and pneumonia and tapering of the prednisone. Continued review of Resident #251's medical record revealed a December 2021 physician's order for Hydralazine 25 mg. every 8 hours, hold for b/p less than 110/60, heartrate less than 60, that was written on 12/15/21. Review of Resident #251's December 2021 MAR documented on 12/19/21 at 1700 (5:00 PM) the blood pressure was 96/58. The medication was checked off and initialed as given. Review of Resident #251's January 2022 physician's orders revealed an order for Lisinopril 20 mg. (2) tablets every morning for hypertension, hold for b/p less than 110/60. On 1/3/22 at 9:00 AM the b/p was 102/76 and the medication was checked off as given. The b/p was outside of physician ordered parameters. There was no documentation that the physician was notified to ask if the medication should be held or given. Further review of Resident #251's January 2022 physician's orders revealed an order for Metoprolol Succinate 25 mg. once a day at 8:00 AM for hypertension. Hold if b/p less than 110/60, HR less than 60. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #251's January 2022 MAR documented the b/p was 108/61 on 1/3/22 at 8:00 AM and the medication was checked off as given outside of physician ordered parameters. The DON stated that an agency nurse was responsible for administering the medications.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44484 Based on observation and staff interview it was determined facility staff 1) failed to keep medication carts locked when unattended and 2) failed to date medication and biologicals when opened, and failed to discard insulin, food supplements, inhalers, and oral medications when expired. This was evident on 2 of 4 nursing units observed during the annual survey. The findings include: 1) On 7/21/22 at 09:01 AM observation was made of an unlocked and unattended medication cart in the hallway outside of room # 208. The surveyor was able to open the drawers to the medication cart to observe insulin, eye drops and resident medications. When LPN #1 came out of a resident's room, the surveyors asked about the unlocked and unattended medication cart. LPN #1 stated, I was right here. I only stepped into the room. The other nurse called me and closed the door. The Director of Nursing (DON) was informed of the observation. 2) On 7/22/22 at 8:07 AM observation was made of a medication room on the first-floor nursing unit. The opened medication Ozempic 2mg/1.5ml was observed in the medication refrigerator. There was no date opened on the box. The Ozempic had a dispensed date of 6/26/22. The instructions for Ozempic stated to dispose of the medication 56 days after opening. LPN #9 was notified of the findings. 3) On 7/22/22 at 8:20 AM observation was made of medication cart #2 located on the second-floor nursing unit. The following medications were opened that did not contain the date the package was opened. Resident #88's, Symbicort RX# 4945753, Resident #56's Lantus 100u/ml RX# 6096041 that was prescribed on 6/10/22, Resident #47's Lantus 100u/ml RX# 6014897 that was dispensed on 6/9/22, Resident #57's Symbicort RX6191937 that was dispensed on 6/13/22, and Resident #400's Flovent HFA 220 mcg. RX#5240367 package that was opened on 1/6/22. According to the manufacturer, Symbicort should be discarded 3 months after it is removed from the foil pouch. According to the manufacturer, the insulin Lantus should be discarded 28 days after first use. According to the manufacturer, Flovent should be discarded within 6 weeks of opening for 50-mcg strength Flovent or 2 months for 100 and 250 mcg strengths of Flovent once the foil pouch is opened. 4) On 7/22/22 at 8:25 AM observation was made of the first-floor medication storage room. Resident #72's Omeprazole RX # 6120554 had an expiration date of 7/3/22. On 8/11/2022 at 3:00 PM the surveyor met with the Director Of Nursing (DON) to inform her of the various observations and concerns with the unlocked and unattended medication carts, expired medications and supplies found in the medication room. 31145 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) On 7/29/22 at 11:26 AM observation was made of an unlocked and unattended medication cart sitting in the hallway on the second floor nursing unit outside of room [ROOM NUMBER]. Staff #76 was observed down the hallway at another medication cart. Staff #76 did not look down the hallway while preparing medications and walked in room [ROOM NUMBER] at 11:31 AM. Resident #84 was observed sitting in a wheelchair in the hallway across from the unlocked and unattended medication cart. The surveyor walked up to the medication cart and opened the top drawer. The surveyor found the following: Two opened and undated Advair Diskus 100/50. One was in a opened box labeled with Resident #87's name and was on count #52. There was no date opened on the box or Diskus and it was dispensed on 6/11/22. There was a yellow sticker on the front of the box that stated discard 1 month after opening. The other Diskus was not in a box. There was no date on the Diskus. In the second drawer was a plastic 30 ml. medication cup with 3 pills and 2 capsules. The medication cup was sitting on top of a 30 ml. plastic medication cup that had crushed white pills. There was 1 opened Advair Diskus 250/50 that was not dated when opened and was on count #5 for Resident #99. The medication was dispensed on 5/2/22. There was a yellow sticker on the box that stated, discard 1 month after opening. Staff #76 walked down the hall towards the surveyor. The surveyor as her if that was her medication cart and she said no and kept on walking. The surveyor stood at the unlocked medication cart until 11:39 AM when LPN #25 walked up, locked the cart and said, I must not have locked it when I went to a patient's room. LPN #25 was shown the Advair Diskus boxes that were not dated and opened and she said, Do you want me to write today's date on them. Review of the Medication Storage Policy that was given to the surveyor by the Director of Nursing documented number 1, all drugs and biologicals will be stored in locked compartments (i.e. medication carts, cabinets, drawers, refrigerators, medication rooms). Only authorized personnel will have access to the keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. The DON was informed on 7/29/22 at 11:50 AM of observations regarding medicaiton carts and administration.

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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 observation and staff interview it was determined that the facility failed to have quality laboratory supplies for resident diagnostic testing in 1 of 2 medication rooms observed during the annual survey. The findings include: Observation was made on [DATE] at 8:07 AM in the first-floor medication room by 2 surveyors of the following expired blood collection tubes that were observed in a light blue bin labeled lab specimen supplies: (14) purple blood collection tubes, Lot #9315422 exp (expiration) ,d+[DATE] (13) blue top collection tubes, Lot #0009468 exp [DATE] (3) orange top collection tubes, Lot #0240566 exp [DATE] (5) red top collection tubes, Lot #0218175 exp [DATE] (3) purple top collection tubes, Lot #226552 exp [DATE] (3) blue top collection tubes, Lot # 0184336 exp [DATE] Licensed Practical Nurse (LPN) #9 was in the medication room at the time of the observation and was asked if the nurses drew blood for residents. LPN #9 stated, when the lab can't get here. On [DATE] at 10:41 AM an interview with the Director of Nursing (DON) revealed the facility had a lab that came into the facility to do blood draws, however, if a STAT (immediate) is needed a manager would do the lab draw. The DON stated they can do blood draws on both floors, all units. At that time the DON was informed of the expired blood collection tubes. The DON stated that she was informed by the LPN. To assure accurate test reliability, specimen containers must be used by the expiration date.

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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. 31145 Based on medical record review and interview it was determined that facility staff failed to provide timely dental care. This was evident for 1 (#28) of 3 residents reviewed for dental during the annual survey. The findings include: On 7/28/22 at 7:54 AM a review of Resident #28's medical record revealed a progress note dated 4/7/22 at 11:22 AM that documented that a fax request was made for dental services for Resident #28. A 5/9/22 at 11:51 AM progress note stated that Resident #28 was complaining that when s/he eats the upper teeth that broke were sharp and hurting his/her gum. The Nurse Practitioner (NP) was notified and an order was given to have dental consult. A 6/30/22 at 1:49 PM progress note documented that Resident #28 told staff that his/her teeth hurt when he/she tried to eat. A 6/30/2022 at 15:37 (3:37 PM) dietician note documented, per nursing, resident reports difficulty chewing PBJ snack related to dental issues. On 7/14/22 at 6:02 PM a dietician note documented that Resident #28 occasionally had chewing issues reported from nursing due to dental issues. On 8/4/22 at 12:45 PM an interview was conducted with the Director of Nursing (DON) and the DON was asked if Resident #28 ever had the dental consult that was ordered on 4/4/22. The DON replied that Resident #28 was seen by the dentist on 7/14/22 at the facility. The DON was asked why it took 14 weeks for Resident #28 to be seen. The DON stated that they switched to a new vendor to supply dental care.

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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. 31145 Based on observation and interview, it was determined the facility failed to consistently maintain a sanitary environment in the kitchen. This was evident during the initial tour of the kitchen and during 2 subsequent visits. The findings include: 1) Dietary staff failed to utilize personal protective equipment (PPE) in a manner that met minimum standards and minimized risk for infectious spread during an active COVID-19 outbreak in the facility. Consistent with the 4/2/2020 CMS guidance, on 4/27/2021, the Centers for Disease Control and Prevention (CDC) published updated guidance which stated, In general, fully vaccinated HCP (health care provider) should continue to wear source control while at work. 1a) Observation was made on 7/21/22 at 8:01 AM, during the initial tour of the kitchen, of Staff #3 at the food service table plating breakfast with her mask below her chin. Staff #4 was also at the plating table with her mask below her nose. 1b) Observation was made on 7/26/22 at 11:07 AM of lunch being prepared in the kitchen. During an interview with Staff #50, Staff #50 wore her K95 mask below her nose while testing the temperatures of food being placed on lunch trays. 1c) Observation was made on 7/26/22 at 11:09 AM while in the kitchen of Staff #4 wearing her K95 mask at her chin and below her nose while putting cooked macaroni in the puree machine. Staff #51 and Staff #3 also had their K95 masks below their nose while in the kitchen. The facility was currently in a COVID-19 outbreak. 1d) On 8/5/22 at 10:42 AM observation was made of Staff #51 washing dishes in the kitchen with her mask below her nose. 2) Dietary staff failed to follow standard infection control guidelines by having personal belongings in the kitchen by the food plating area: Observation was made on 7/26/22 at 11:09 AM while in the kitchen of an employee's phone and keys sitting inside a green food caddy next to the food plating area. 3) Kitchen floor tile cracked and broken: Observation was made of the kitchen on 8/5/22 at 10:42 AM of the ceramic tile on the floor where the dishes were being washed. There were several broken and cracked tiles at the dishwashing area and over by the food plating area of the kitchen. Staff #2 stated that the maintenance director was aware of the broken tile, and it was on the to do list to repair. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Director of Nursing was informed of the observations on 8/9/22 at 11:20 AM.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 31145 Based on observation, record review, and interview it was determined the facility failed to provide rehabilitation services following the recommendation from an orthopedic physician consult. This was evident for 1 (#55) of 2 residents reviewed for rehabilitation. The findings include: On 7/21/22 at 9:54 AM observation was made of Resident #55 lying in bed. Resident #55's left arm appeared contracted. On 8/1/22 at 1:37 PM Resident #55's medical record was reviewed. Resident #55 was admitted to the facility in May 2017 with diagnoses that included but were not limited to a cerebral infarction affecting the left dominant side and nontraumatic intracerebral hemorrhage. On 8/8/22 at 10:23 AM an interview was conducted with Staff #53, physical therapist (PT). Staff #53 stated that Resident #55 was currently not on a program due to him/her being at baseline. Continued review of Resident #55's medical record revealed a progress note dated 3/22/22 at 15:00 (3:00) PM which documented that the resident returned from an ortho (orthopedic) appointment with the recommendation to continue PT/OT (physical therapy/occupational therapy). Review of the medical record failed to produce a copy of the consultation report dated 3/22/22. On 8/11/22 at 8:12 AM a request was made to the Director of Nursing (DON) for a copy of the 3/22/22 consult. Review of the Report of Consultation dated 3/22/22 documented that Resident #55 had, left side complete weakness with left elbow flexion contracture, no motor function. The recommendation stated, continue OT/PT - patient has severe flexion contracture without motor function of [his/her] left upper extremity and lower extremity. On 8/11/22 at 10:14 AM an interview was conducted with Staff #53 (PT) who stated, I just recently knew about the ortho consult. I just found out about the ortho consult from 3/22/22 today, from the DON. It feels like there has been a lapse in communication because we didn't know there were any orders coming from consult because [he/she] wasn't on consult, and we didn't know about any updates. Usually if on case load and they have a consult, we do go through the physician notes. Discussed with the DON and Nursing Home Administrator on 8/11/22 at 4:15 PM.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of pertinent documentation, observation and interview it was determined that the facility administration failed to 1) ensure that all staff, including agency staff, were educated on elopement prevention, 2) update the facility assessment to address elopement and COVID-19, 3) correct deficiencies from a previous complaint survey and 4) obtain and utilize resources necessary to provide for the needs of the residents. This was evident from 7/21/22 to 8/11/22 (16 days) of the annual survey which resulted in 52 Federal citations and identification of an Immediate Jeopardy. The findings include: 1) After an elopement in May 2021 facility administration failed to ensure that all staff were educated regarding elopement and failed to have a process in place to educate agency staff which resulted in an Immediate Jeopardy being identified on 8/2/22 at 9:40 AM. On 8/1/22 a review of facility-reported incident MD00167212 revealed on 5/10/21 at 6:58 AM, Resident #208 eloped from the facility and was brought back to the facility by police at about 8:30 AM on 5/10/21. During the investigation of the elopement several interviews were conducted with staff, including agency staff. On 8/1/22 at 3:46 PM LPN #29 was asked if anyone on his unit (1 West) had a wander guard. LPN #29 stated, just about everyone wears a wander guard. (it was noted that only 2 residents in the facility wore a wander guard at that time). RN#30 (agency nurse) was standing next to LPN #29 and stated, I know nothing. I would direct you to the unit manager or Director of Nursing. On 8/1/22 at 3:50 PM LPN #31 was asked if she knew who on her unit was an elopement risk. LPN #31 stated, this is my first day. LPN #31 was asked if she was oriented to the unit and she stated, it depends on if it is a [corporate name] facility. LPN #31 stated she was not oriented here, just told her schedule. LPN #31 was asked if there was an elopement binder on the unit and her reply was, I have not seen one. On 8/2/22 at 7:28 AM the surveyor asked LPN #26, who was on the second floor, 2 East unit, if there was anyone on the unit that was an elopement risk she stated, I don't think so. On 8/2/22 at 7:31 AM GNA #32 (agency) was on the second-floor west wing unit and was asked if any of her residents were an elopement risk. GNA #32 stated, I don't think so. GNA #32 was asked if she was educated prior to her shift about elopement and she stated, no. On 8/11/22 at 11:14 AM the nursing staffing scheduler was interviewed and stated, the staff on most days and shift are agency. She stated, on weekends the numbers can go up to 75 percent agency. On a given day more than half of our staff is agency. On the weekends it is a lot of agency staff, but we make sure there is a supervisor for every shift. The nursing staffing scheduler confirmed that there had been no formal process to educate agency staff related to elopement. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Education sign-in sheets that were provided to surveyors on 8/3/22 at 3:40 PM for the elopement on 5/10/21 was compared to the current staffing roster that was provided to surveyors on entrance to the facility on [DATE]. It was noted that (2) requests had been made for a complete staffing list for May 2021 on 8/4/22 and 8/5/22 at 9:30 AM and as of 3:30 PM on 8/5/22 the list was not provided. There were 31 staff names with a date of hire prior to 5/10/21 that were not educated that were on the current staffing roster. Cross Reference F689 2) Facility administration failed to update the facility assessment to address elopement, COVID-19 and how the facility was managing without a staff developer and missing unit managers and how they were managing with over 50 percent of the staff being agency staff. Review of the Facility Assessment (FA) revealed there was nothing documented in the assessment about elopement or COVID-19 which should have documented the elopement in May 2021 and quarantine of new admissions and anyone with symptoms along with the need for constant testing. The FA documented (0) about infectious diseases. Review of the top ten high risk threats did not list COVID-19 or elopement. Included in the high risk was a bomb threat, which the facility has never had per the NHA on 8/10/22 at 3:11 PM. Additionally, the Facility Assessment that was given to the surveyors after they entered the building on 7/21/22, documented the FA was reviewed with the QA committee on 7/19/22. On 8/10/22 at 2:22 PM, both the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed and stated they did not have a QA meeting in July 2022. They stated the meeting was supposed to take place on 7/21/22, however the state surveyors entered the building so the meeting was postponed. The ADON stated they have QA meetings every third Monday of the month. On 8/11/22 at 1:07 PM an interview was conducted with the QA Director. The QA Director was also the ADON, the infection control nurse, the staff educator and currently was helping with managing the 2 [NAME] nursing unit. She was asked about the facility assessment and stated, I have never reviewed the facility assessment. I don't even know what it is. On 8/10/22 at 3:11 PM an interview was conducted with the NHA regarding the QA meeting. The NHA stated he changed the meeting. The NHA did not say why the QA meeting did not take place on Monday, July 18, 2022. The NHA stated the meeting was supposed to be on Tuesday, July 19, however the state surveyors walked in on Thursday, July 21. The NHA could not explain the discrepancy. The NHA did state that the Facility Assessment was not reviewed with QA and that he had put the date on the assessment in his computer and printed it out because it was supposed to be discussed. The NHA gave the surveyors an inaccurate document. Cross Reference F838 and F865 3) Failed to correct deficiencies from a previous complaint survey. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/22/22 a review of the survey binder revealed a plan of correction for a complaint survey that ended on 7/29/21. Citation F623 was cited as the facility failed to give a written copy of a resident's transfer notice to the resident/resident representative (RP). The corrective action that the facility stated they were taking was to put measures in place to prevent re-occurrence and that residents would receive a copy of the transfer notice at the time of transfer. The facility documented the RP would be sent a copy of the transfer paper in writing by the admission office following the transfer. On 7/26/22 at 2:23 PM a review of Resident #83's electronic and paper medical record revealed Resident #83 was transferred to the hospital on 5/29/22 and 6/3/22 for a change in medical condition. Further review of Resident #83'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. On 8/11/22 at 8:51 AM an interview was conducted with Staff #52, the Admissions Director. Staff #52 was asked if she sent out written notification to the responsible party related to transfers. Staff #52 stated, I did that in November but then was told nursing was handling that as they go out. This was a repeat deficiency. Citation F656, person centered comprehensive care plans was cited on the 7/29/21 complaint survey and the correct action was, staff development re-educated IDT members for writing care plans on the facility policy and procedure for developing comprehensive care plans. This was a repeat deficiency and comprehensive care plans will be cited again at a widespread level as the corrective action was ineffective. Citation F688, increase/decrease in ROM/Mobility was cited on the 7/29/21 complaint survey. Preventive measures put into place was a log tool that was created for monitoring residents ordered splinting devices to ensure monitor placement. Unit managers will visualize splints monthly. This was a repeat deficiency as F688 will be cited again for 3 (#17, #53, #55) of 6 residents reviewed for positioning and mobility related to a palm protector being worn and active range of motion not being done. Citation F921, Safe, sanitary, and comfortable environment was cited on the 7/29/21 complaint survey and the measures that were put into place were, staff will be educated on the importance of recording work orders. The plan stated the facility will be removing and replacing the carpet starting October 2021. This was a repeat citation as the carpet on the second floor has not been replaced and during the entire annual survey the second floor carpet remained dirty, stained, and had debris from ongoing renovations. On 8/2/22 at 11:00 Staff #36 was interviewed and stated, we are not cleaning the carpet since we are doing renovations. Staff #35 stated, I have been here a few months and have not seen any carpet cleaning. The NHA stated at the beginning of the survey that the renovations have been going on since 2019. From 7/21/22 to 8/11/22, while surveyors were in the building, there were no active renovations. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/11/22 at 1:07 PM the QA Manager (who was also the ADON), with the DON in the room was asked to see documentation that the items in the plan of correction from 7/29/21 were reviewed in QA meetings. She stated, in September 2021 was the breakdown and audit list with a date of compliance of 9/10/21. The QA Manager and the DON could not find any documentation for October 2021, November 2021, or December 2021. The DON and ADON stated those items were not discussed in QAPI. 4) Facility Administration failed to obtain and utilize resources necessary to provide for the needs of the residents. Advanced directives were not being addressed for residents residing in the facility. A sample for 14 of 16 residents confirmed the finding. On 7/28/22 at 9:43 AM The Director of Social Work was interviewed and stated, Everybody is responsible for asking about advanced directives. She continued, I am thin here. I have been asking for help. I am responsible for the whole building. Sometimes I am here 12 hours a day, 5 days a week and I can't get my documentation done all the time. Between admissions, discharges, the waiver program, communicating with the Ombudsman and family conflicts. I have never had any help. Cross Reference F578 On 8/11/22 at 1:07 PM an interview was conducted with the QA Director. The QA Director was also the ADON, the infection control nurse, the staff educator and currently was helping with managing the 2 [NAME] nursing unit. There was no unit manager on 2 east as the manager resigned in January 2022 according to the ADON. Review of GNA personnel files revealed yearly evaluations were not being done and given to the GNA. The evaluations, to assess the GNAs areas of weakness, are used to determine their educational needs. The required minimum of 12 hours per year education for GNAs was not being done as the ADON could not produce documentation that anyone was keeping track of the education and the number of hours. Review of resident medical records revealed concerns with nephrostomy tubes being dislodged during care. On 8/4/22 at 2:45 PM the Director of Nursing (DON) was asked about staff education on Nephrostomy tube care. The DON stated that she could not find any in-service sheets and/or staff sign-in sheets to show that staff had the training. Cross Reference F947, F730 and F726

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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. 15701 Based on review of facility records and interview with staff, it was determined the facility failed to conduct and document an accurate facility-wide assessment that was up to date. This was evident during review of the sufficient and competent nurse staffing task of the annual 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 6/30/22. Date assessment reviewed with QAA/QAPI (Quality Assessment and Assurance/ Quality Assurance and Performance Improvement committee) was 7/19/22. On 8/11/22 at 1:07 PM an interview was conducted with the QA Director. The QA Director was also the ADON, the infection control nurse, the staff educator and currently was helping with managing the 2 [NAME] nursing unit. She was asked about the facility assessment and stated, I have never reviewed the facility assessment. I don't even know what it is. On 8/10/22 at 3:11 PM an interview was conducted with the NHA regarding the Facility Assessment. The NHA acknowledged that the Facility Assessment was not reviewed with the QAA/QAPI committee and that he had put the date on the assessment in his computer and printed it out because it was supposed to be discussed. The NHA gave the surveyors an inaccurate document. Review of the Facility Assessment (FA) revealed there was nothing documented in the assessment about elopement or COVID-19 which should have documented an elopement in May 2021 and quarantine of new admissions and anyone with symptoms along with the need for constant testing. The FA documented 0 related to infectious diseases. Review of the top ten high risk threats did not list COVID-19 or elopement. Included in the high risk was a bomb threat, which the facility has never had per the NHA on 8/10/22 at 3:11 PM. On 8/11/22 at 11:14 AM the nursing staffing scheduler was interviewed and stated, the staff on most days and shift are agency. She stated, on weekends the numbers can go up to 75% agency. On a given day more than half of our staff is agency. On the weekends it is a lot of agency staff, but we make sure there is a supervisor for every shift. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility assessment did not address the high quantity of agency staff that are utilized daily and the components to provide education/training and/or competencies for all the contractual staffing. The facility does not have a staff developer, but the FA states the facility provides staff training/ education and competencies that is necessary to provide care and support needed for our resident population Cross Reference F726, F730, 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** 31145 Based on medical record review and interview, it was determined the facility staff failed to maintain a medical record in the most accurate form. This was evident for 10 (#251, #84, #76, #53, #18, #28, #61, #401, #73, #24) of 38 residents reviewed in the investigative stage of the annual survey. The findings include: A medical record is the official documentation for a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1a) On 8/4/22 at 7:30 AM a review of Resident #251's medical record revealed a 1/4/22 physician's note, Lab work today is being ordered stat. A review of the written physician's orders sheet dated 1/4/22 had the order, give Lokelma 10 gm x 1 for hyperkalemia. The order sheet did not have a time that the order was written. Review of the electronic order in the facility's electronic medical record system documented the order was put into the system at 1534 (3:34 PM), however it was unknown if that was the time the physician ordered the medication. 1b) Further review of Resident #251's paper medical revealed COVID-19 Test results dated 12/15/21 was blank for results for the Rapid Point of Care Testing. COVID-19 test results dated 1/2/22 for Rapid Point of care Testing for a symptomatic resident with shortness of breath were blank for results. 1c) Review of the documentation in the facility reported incident (FRI) MD00175285 documented Resident #251 was seen by the medical provider on 1/4/22 and found to not be at baseline. The resident, called 911 self and upon arrival they informed the resident that he/she would be waiting in the ER (emergency room) for an extended period and the resident declined to be transferred to hospital. On 8/4/22 at 9:40 AM physician #73 was interviewed and stated that EMS was here but informed the resident that he/she would have to wait at the hospital. He/She said, No, I prefer to stay. The surveyor informed physician #73 that there was nowhere in the medical record that indicated the resident or staff called 911. Physician #73 stated, I can assure you 911 was called and when they got here, [he/she] stated [he/she] did not want to wait at the hospital. On 8/4/22 at 10:36 AM the Director of Nursing (DON) was asked for documentation of the 911 call. The DON stated she would look for documentation. As of 8/11/22 at 4:15 PM no further documentation was presented to the surveyor. 2) On 8/2/22 at 7:33 AM LPN #33 was asked if he checked the wander guard for Resident #84. LPN #33 stated, I occasionally check it. He/she has physical limitations. I don't need to check it because [his/her] room is right next to the nurse's station. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/2/22 at 7:36 AM Resident #84's medical record was reviewed and revealed a physician's order, use wander guard universal tester to check that wander guard bracelet is functioning. Review of Resident #84's Treatment Administration Record (TAR) for August 2022 revealed LPN #33's initials and checkmark that he checked the bracelet on night shift of 8/1/22. On 8/2/22 at 7:41 AM, with a second surveyor, another interview with LPN #33 was conducted. LPN #33 was asked if he checked Resident #84's wander guard for function and he said, no. The surveyor asked LPN #33 to open Resident #84's TAR and the surveyor pointed out that he signed off that the wander guard check was done. LPN #33 stated, there is the alarm over there by the door. The surveyor read the order to LPN #33 and pointed out that he signed off that he checked the resident's wander guard functionality. LPN #33 confirmed that he did not check the wander guard even though he signed off on the TAR that he did check it. It was noted on Resident #84's August and July 2022 TAR that LPN #33 checked off that the Resident #84's wander guard was functioning every time he worked on the night shift, even though he told the surveyor that he did not need to check it because the resident's room was by the nurse's station. 3) On 7/28/22 at 1:00 PM a review of Resident #76's medical record revealed Resident #76 was admitted to the facility in February 2022 with diagnoses that included asthma, COPD, and hypertension. A July 2022 physician's order stated, oxygen therapy, continuous 2 liters of oxygen by nasal canula as needed for asthma. The oxygen order was originally written on 3/16/22. Review of Resident #76's July 2022 Medication Administration Record (MAR) revealed the order for continuous 2 liters of 0xygen by nasal canula as needed for asthma. The MAR did not have documentation from the nurses that oxygen was being administered at any time and there was no documentation of Resident #76's response to oxygen therapy. 4) On 7/25/22 at 10:59 AM Resident #53's medical record was reviewed. Review of Resident #53's July 2022 physician's orders revealed an order for Resident #53 to wear a left palm guard from 8:00 AM to 8:00 PM daily. On 7/25/22 at 12:10 PM observation was made of Resident #53 sitting in the first-floor activity room with no palm guard present in the left hand. Review of Resident #53's July 2022 Treatment Administration Record (TAR) documented the palm guard was signed off as being worn. On 7/28/22 at 2:09 PM observation was made of Resident #53 in the main hallway across from the information desk on the first floor. Resident #53 was not wearing the left palm protector. Review of Resident #53's July 2022 TAR documented the palm guard was signed off as being worn. 5a) On 8/8/22 at 2:37 PM a review of Resident #18's July 2022 Medication Administration Record (MAR) revealed Staff #10 failed to document that Resident #18 received tube feeding on 7/12/22, 7/13/22, and 7/14/22. On 8/9/22 at 2:19 PM review of Resident #18's August 2022 MAR revealed the physician's order, enteral feed order every 4 hours flush tube with 200 ml q (every) 4 hours. The order failed to stated what to use to flush Resident #18's tube feeding. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5b) On 8/9/22 at 9:53 AM a review of Resident #18's July and August 2022 TAR documented that once per week the oxygen tubing was changed on night shift. Observation was made on 7/21/22 at 11:23 AM of Resident #18 and his/her room. There was no evidence of an oxygen tank or an oxygen concentrator in the resident's room. Resident #18 was not wearing any type of oxygen delivery tubing. Several observations were made of the resident and his/her room from 7/21/22 to 8/11/22 and there was never any observations of oxygen in the resident's room. On 8/8/22 at 2:30 PM an interview was conducted with the DON and she confirmed that the resident had not used oxygen since the spring of 2022. The DON was informed that the nurses were signing off that the resident's oxygen tubing was being changed weekly when there was no evidence of oxygen usage. 6) On 7/28/22 at 7:54 AM a review of Resident #28's medical record revealed progress notes dated 4/7/22 at 11:22 AM that documented the dental provider was faxed a request for dental services. On 8/4/22 at 12:45 PM an interview was conducted with the Director of Nursing (DON) regarding Resident #28's chewing problems. The DON replied that the resident was seen by dentistry on 7/14/22 at the facility. The DON was informed that the dental consult was not found in Resident #28's medical record. On 8/5/22 at 10:13 AM the DON informed the surveyor that she had reached out to the previous dental provider about the dental consult and she was currently looking internally for the consult. On 8/5/22 at 10:31 AM the DON was able to produce a document that indicated Resident #28 was seen by the dentist. The DON confirmed the consult was not in the medical record. The DON was informed of all findings on 8/9/22 at 11:20 AM. 7) On 8/4/22 at 9:14 AM, an agency Licensed Practical Nurse (LPN) staff #86, was observed to provide wound care and replace the wound dressing to the multiple areas on resident #61's feet and legs. Upon completion of the observed wound treatments, resident #61's medical record was reviewed to reconcile the physician orders to the observed wound care. Based on the medical record review it was discovered that the nurse staff #86 failed to provide the prescribed treatment ordered as Wound location: right medial plantar great toe cleanse with Dakin, apply Medi-honey and dressing everyday shift for wound care. Review of the Treatment Administration Record (TAR) on 8/4/22 at 2:50 PM revealed that the nurse had signed off on the record as completed. Staff #86 was interviewed at 2:55 PM on 8/4/22. She confirmed that she had not provided the treatment as ordered and acknowledged that she had sign off on the order. The Director of Nursing was informed of the nurse's omission at 3:24 PM on 8/4/22. 43096 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8) On 7/28/22 at 10:21 AM, the surveyor conducted Resident #401's medical record review. The medical record review revealed that Resident #401 was involved in resident-to-resident abuse with Resident #13 on 5/1/21. Further review of the facility self-report revealed Resident #13 pushed Resident #401 out of the chair in front of Resident #13's room. There was no reported injury for both residents. Resident #13's progress note dated 5/1/21 at 4:49 PM stated, Pt (patient: meant Resident) is legally blind and normally feels his/her way by tapping when he/she comes out from the room. He/she felt hands and touched the other pt sitting who was seated on the chair by his/her room door and became agitated, pulled, and shoves the other pt. The nurse jumped in to separate them and the chair tilted in the process and the other pt ended up on the floor. No injuries were observed. Vital signs stable. Both were separated from each other. Police were made aware. NP(nurse practitioner) and RP (responsible party) made aware. However, the same note was documented in Resident #401's progress note dated 5/1/21 at 5:25 PM. During an interview with the Director of Nursing (DON) on 7/28/22 at 11:35 AM, she confirmed that Resident #401 was a victim and Resident #13 was the aggressor. The DON was made aware of inaccurate documentation. 9) On 7/29/22 at 10:37 AM review of Resident #73's electronic medical record (EMR) revealed a different resident's medical record saved under Resident #73's (EMR) in the MISC (miscellaneous) section. There was a PDF file with an effective date of 6/6/22 named, please delete please delete.pdf containing a provider's visit summary with other residents' names and diagnoses. Another PDF file named, please delete. pdf with the effective date of 6/3/21 was found in Resident #73's EMR. This 'please delete.pdf file was about one other facility resident's podiatry records. During an interview with the DON on 7/29/22 at 1:50 PM, she was made aware that the wrong medical record was found in Resident #73's medical record. On 8/5/22 at 2:00 PM, the surveyor verified that, please delete please delete.pdf and please delete.pdf were removed from Resident #73's medical records. 42507 10) On 7/21/22 at 11:12 AM, in an interview with Resident #24, s/he stated that the Social Worker has not been in for a while. On 7/27/22 at 2:12 PM, review of Resident #24's clinical records revealed the resident was admitted to the facility on [DATE]. On 7/28/22 at 8:35 AM, review of progress notes revealed last documented social services notes was on 12/3/21 at 1:21 PM: Note Text: Care Plan: Quarterly Nursing, Rehab, Dietician, Activities, SS, resident, and R/p via telephone held care review meeting. R/p was updated regarding each discipline and clothing process update discussed. Resident is remaining LTC, and no changes noted at this time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/28/22 at 9:50 AM, in an interview with the licensed social worker (SW #74), s/he stated that s/he has been seeing the Resident #24, and the last encounter was yesterday 7/27/22 when the resident came to her/his office. However, there was no notes in the resident's records about the visit. When asked about the last documented social work notes being the one dated 12/3/21, SW #74 stated that s/he was working alone and responsible for the whole building, working long hours and not being able to write notes/document on every resident encounter. On 8/1/22 at 2:15 PM, the DON was made aware that the Social Worker was not documenting resident visits, and the last documented social work notes on Resident #24 was on 12/3/21.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15701 Based on interviews, reviews of facility and resident records, and current survey findings it was determined that the facility failed to have an effective Quality Assessment Performance Improvement (QAPI) plan to ensure care and services are maintained at acceptable levels of performance and continually improved. This had the potential to affect all residents within the facility. The findings include. A copy of the facility's Quality Assessment Performance Improvement (QAPI) plan was received at the initiation of the survey. The undated QAPI plan was reviewed, and per the plan, there was no indication that the plan was refined and revisited. Much of the plan was written in generalizations such as Under the section titled Feedback, Data systems and Monitoring the plan stated the facility will put in place systems to monitor care and service, drawing data from multiple sources. Feedback systems will actively incorporate input from staff, residents, families, and others as appropriate. Under the section titled Systematic Analysis and Systemic Action the plan stated the facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of change. The facility applies a thorough and highly organized/structured approach to determine whether and how identified problems may be caused or exacerbated by the care and services are organized or delivered. [NAME] Lake at Pikesville approach comprehensively assesses all involved systems to prevent future events and promote sustained improvement. [NAME] Lake at Pikesville also has developed policies and procedures regarding expectations for use of root cause analysis when problems are identified. As the survey progressed and non-compliance was determined it was shared with the administrative staff that there was not any indications/feedback that the QAPI committee identified the issues and developed action plans related to the areas of concern. An interview was conducted with members of the Quality Assessment Performance Improvement committee on 8/11/22 at 1:53 PM that included the DON, ADON, NHA, and 2 AITs (Administrator in Training). The QAPI plan was read to the group questioning how facility-wide training was conducted informing everyone about the QAPI plan and what was the documentation process of the education about the QAPI plan. Responses to reading excerpts of QAPI plan and the questions asked were not returned. The annual survey process resulted in 52 Federal citations with areas of potential systematic concerns identified by the survey process included, Right to formulate advance directives, Safe Clean Homelike environment, Investigation of alleged abuse violations, Notice of requirements before transfer, Notice of bed hold, Accuracy of assessments, Baseline care plans, Development of comprehensive care plans, Revision of care plans, physician services, Infection control and prevention, COVID-19 testing of residents and staff, and Required in-service training of nurse assistants with yearly performance evaluations. The QAPI committee had not developed any action plans related to the areas of identified non-compliance.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 15701 Based on interviews, reviews of facility and resident records, current survey findings and the facility's prior complaint surveys it was determined that the facility failed to have an effective Quality Assessment Performance Improvement (QAPI) program to develop and implement effective plans of action to correct identified quality deficiencies. This failure resulted in 4 repeat deficiencies found during the current annual survey. This was evident during the survey process and review of the Quality Assurance Program. The findings include: On 7/22/22 a review of the survey binder revealed a plan of correction for a complaint survey that ended on 7/29/21. Citation F623 was cited as the facility failed to give a written copy of a resident's transfer notice to the resident/resident representative (RP). The corrective action that the facility stated they were taking was to put measures in place to prevent re-occurrence and that residents would receive a copy of the transfer notice at the time of transfer. The facility documented the RP would be sent a copy of the transfer paper in writing by the admission office following the transfer. On 7/26/22 at 2:23 PM a review of Resident #83's electronic and paper medical record revealed Resident #83 was transferred to the hospital on 5/29/22 and 6/3/22 for a change in medical condition. Further review of Resident #83'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. On 8/11/22 at 8:51 AM an interview was conducted with Staff #52, the Admissions Director. Staff #52 was asked if she sent out written notification to the responsible party related to transfers. Staff #52 stated, I did that in November but then was told nursing was handling that as they go out. This was a repeat deficiency. Citation F656, person centered comprehensive care plans was cited on the 7/29/21 complaint survey and the correct action was, staff development re-educated IDT members for writing care plans on the facility policy and procedure for developing comprehensive care plans. This was a repeat deficiency and comprehensive care plans will be cited again at a widespread level as the corrective action was ineffective. Citation F688, increase/decrease in ROM/Mobility was cited on the 7/29/21 complaint survey. Preventive measures put into place was a log tool that was created for monitoring residents ordered splinting devices to ensure monitor placement. Unit managers will visualize splints monthly. This was a repeat deficiency as F688 will be cited again for 3 (#17, #53, #55) of 6 residents reviewed for positioning and mobility related to a palm protector being worn and active range of motion not being done. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Citation F921, Safe, sanitary, and comfortable environment was cited on the 7/29/21 complaint survey and the measures that were put into place were, staff will be educated on the importance of recording work orders. The plan stated the facility will be removing and replacing the carpet starting October 2021. This is a repeat citation as the carpet on the second floor has not been replaced and during the entire annual survey the second floor remained dirty, stained, and had debris from ongoing renovations. On 8/2/22 at 11:00 Staff #36 was interviewed and stated, we are not cleaning the carpet since we are doing renovations. Staff #35 stated, I have been here a few months and have not seen any carpet cleaning. The NHA stated at the beginning of the survey that the renovations have been going on since 2019. From 7/21/22 to 8/11/22, while surveyors were in the building, there were no active renovations. On 8/11/22 at 1:07 PM the QA Manager (who was also the ADON), with the DON in the room was asked to see documentation that the items in the plan of correction from 7/29/21 were reviewed in QA meetings. She stated, in September 2021 was the breakdown and audit list with a date of compliance of 9/10/21. The QA Manager and the DON could not find any documentation for October 2021, November 2021, or December 2021. The DON and ADON stated those items were not discussed in QAPI.

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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 and staff interviews it was determined that the facility failed to implement an effective infection control program and facility staff failed to follow infection control practices and guidelines to prevent the development and transmission of disease by 1) failing to keep contact/isolation room door closed on the 1st East unit. This was evident for 1 (Resident #401) of 15 residents' rooms observed, 2) failing to provide education and convey updates to staff on COVID-19. This was evidenced by 49 out of 115 staff who did not receive COVID-19 education in November 2021, 3) failing to change oxygen tubing and label when changed. This was evidenced by 1 (#76) of 3 residents reviewed for respiratory care and 4) failed to follow infection control practices in the laundry room and kitchen. This was evident for 5 staff (#3, #4, #51, #15 and #16) observed in the kitchen and laundry room during survey. These practices had the potential to affect all residents. The findings include: 1) During observation of the first floor East wing on 7/25/22 at 12:38 PM, Resident #401's private room was halfway opened. The surveyor noted that the PPE (Personal Protective Equipment) drawer was placed in front of Resident #401's room. The PPE drawer had disposable gowns, gloves, and a bottle of alcohol-based hand rub. A contact precaution sign was also posted on Resident #401's room door. The surveyor observed Resident #401 for 10 minutes, and the resident was alone in the room without ongoing treatment or care from the staff. On 7/25/22 at 2:10 PM, a medical record review for Resident #401 revealed the resident had an order of contact/droplet precaution- started 7/14/22 due to COVID-19 exposure. The second observation was on 7/26/22 at 7:31 AM. Resident #401's room door was one third of the way opened. The surveyor observed that the resident sat on a chair without attending staff. No active treatment or care was provided by facility staff while the surveyor observed the opened door for 5 minutes. Resident #401's room was half way opened on 7/28/22 at 1:46 PM. No active care, treatment, or interventions were ongoing. On 8/1/22 at 8:40 AM, during an interview with a Unit Manager (#48), she confirmed that the isolation room door should always be closed. The Director of Nursing was aware of the above concerns during an interview on 8/8/22 at 4:02 PM. 2) During an interview with the Infection Control Preventionist (ICP) on 8/1/22 at 11:22 AM, she stated COVID-19 related education (called understanding COVID-19) was provided to all staff. She explained that the education included hand washing, PPE (Personal Protective Equipment) use, vaccine information, and updated policies. The ICP stated this education had the benefits, risks, and potential side effects of receiving the COVID-19 vaccine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/1/22 at 3:10 PM, the ICP submitted a copy of the in-service sign-in sheet for the COVID-19 vaccine policy dated 11/9/21. The sign-in sheet listed a total of 115 staff. However, 49 out of 115 staff did not sign the sheet. The Director of Nursing was made aware of the concern that all staff had not received education and conveyed an update on COVID-19 on 8/8/22 at 4:02 PM. As of the time of exit on 8/11/22, no additional information had been provided regarding these concerns. 31145 3) The facility failed to follow minimal standards of infection control guidelines by failing to date, label and change oxygen tubing. 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 7/21/22 at 1:00 PM observation was made of Resident #76 in bed wearing a nasal cannula and receiving oxygen via an oxygen concentrator. Subsequent observations were made of Resident #76 on 7/25/22 at 12:05 PM, 7/26/22 at 10:04 AM, 7/28/22 at 3:06 PM, and 7/29/22 at 9:26 AM either receiving oxygen via nasal cannula or the oxygen tubing off the resident's face and lying on top of the bed linen. For all of the observations there was nothing on the tubing that indicated the date the tubing was changed. On 7/28/22 at 1:00 PM Resident #76's medical record was reviewed. There were physician's orders for oxygen continuously as needed that were written on 3/16/22. There were no orders for when to change the oxygen tubing. On 7/29/22 at 9:26 AM an interview was conducted with RN #24. RN#24 was asked what the procedure was for changing the oxygen tubing. RN #24 stated, that is in the orders section. When RN #24 reviewed the physician's orders he stated, there are no orders for changing the O2 tubing. On 8/1/22 at 11:09 AM a review of the facility policy on Oxygen Administration included the following guideline: 6) Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include: a) Follow manufacturer recommendations for the frequency of cleaning equipment filters b) Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated etc. 4) Dietary staff failed to utilize personal protective equipment (PPE) in a manner that met minimum standards and minimized risk for infectious spread during an active COVID-19 outbreak in the facility. Consistent with the 4/2/2020 CMS guidance, on 4/27/2021, the Centers for Disease Control and Prevention (CDC) published updated guidance which stated, In general, fully vaccinated HCP (health care provider) should continue to wear source control while at work. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5 a) Observation was made on 7/21/22 at 8:01 AM, during the initial tour of the kitchen, of Staff #3 at the food service table plating breakfast with her mask below her chin. Staff #4 was also at the plating table with her mask below her nose. 5 b) Observation was made on 7/26/22 at 11:07 AM of lunch being prepared in the kitchen. During an interview with Staff #50, Staff #50 wore her K95 mask below her nose while testing the temperatures of food being placed on lunch trays. 5 c) Observation was made on 7/26/22 at 11:09 AM while in the kitchen of Staff #4 wearing her K95 mask at her chin and below her nose while putting cooked macaroni in the puree machine. Staff #51 and Staff #3 also had their K95 masks below their nose while in the kitchen. The facility was currently in a COVID-19 outbreak. 5 d) On 8/5/22 at 10:42 AM observation was made of Staff #51 washing dishes in the kitchen with her mask below her nose. 6) Dietary staff failed to follow standard infection control guidelines by having personal belongings in the kitchen by the food plating area: Observation was made on 7/26/22 at 11:09 AM while in the kitchen of an employee's phone and keys sitting inside a green food caddy next to the food plating area. The Director of Nursing was informed of the findings on 8/9/22 at 11:20 AM. 42507 7) Observation was made of the laundry room on 7/26/22 at 11:00 AM. Upon entry into the clean folding area, surveyors observed on top of a table against the wall the following food items next to clean laundry: a bottle of three quarters full of lemonade, soda in a large McDonald's cup, two empty plastic bottles, a small pack of yellow mustard, a closed food [NAME], and a small pack of skin protection ointment. On another corner of the room was a bottle of soda on the floor that was one third full. In addition, surveyors observed two laundry room staff, Laundress #15, and Laundress #16, in the soiled area with no gowns/aprons and/or gloves on. Both staff were not wearing face covering /masks even though the facility was in a COVID-19 outbreak status. Laundress #16 was observed washing linen in the sink with unloved hands. In the laundry drying room was noted some pieces of what looked like remnants of an incontinence brief in a large yellow bin on the floor next to one of the drying machines that was running. One of the laundry staff, Laundress #15, stated they were pieces of tape from a diaper and immediately removed them from the bin. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/26/22 at 11:10 AM, in an interview with the Environmental Services Manager (EVES Manager #14), s/he stated that there should be no food or drinks in the folding area and in the laundry rooms but sometimes it gets so hot that it's difficult to ask staff not to drink down here. EVES Manager #14 stated that the break room was upstairs, and staff was expected to eat and drink in the break room. EVES manager #14 was made aware of surveyors' observations. S/he stated s/he was going to re-educate the staff. On 7/26/22 at 11:20 AM, in an interview with laundry staff, Laundress #16, s/he stated that the expectation was for staff not to eat in the laundry rooms, but they could drink. S/he further stated that they could have their drinks in the clean/folding area as long as it was covered. Laundress #16 stated that no one has ever told me not to drink down here. On 7/27/22 at 11:55 AM, surveyor requested and reviewed the facility policy on soiled Laundry and Bedding: Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely. Further review of the policy did not indicate anything about food and/or drinks in the laundry room. On 8/1/22 at 2:15 PM, the Director of Nursing (DON) was made aware of the laundry room observations on 7/26/22. The DON stated that the EVES Manager #14 had already notified her of some of the surveyors' observations. The Nursing Home Administrator was informed of all concerns on 8/11/22 at 4:15 PM during the exit conference.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on record review and staff interview, it was determined that the facility staff failed to document that resident and/or their Responsible Parties (RPs) were provided education on Pneumococcal vaccines before requesting consent. This was evident for 1 (Resident #401) of 5 residents reviewed for Immunizations during the survey. The findings include: Pneumococcal vaccine helps to prevent pneumococcal disease, which is any type of illness caused by streptococcus pneumonia bacteria. The Centers for Disease Control and Prevention (CDC) recommends a pneumococcal vaccine for age [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions or risk factors. (Centers for Disease Control and Prevention- vaccines and preventable disease) Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people [AGE] years and older, pregnant people, and people with certain health conditions or a weakened immune system are at the greatest risk of flu complications. Influenza (Flu) vaccines can prevent influenza. (Centers for Disease Control and Prevention- vaccines and preventable disease) On 8/1/22 at 9:00 AM, Resident #401's medical record review was conducted. A facility's consent form (named Vaccination Status Questionnaire & Consent) dated 10/7/20 was filed in the resident's paper chart. The resident consented to the Flu vaccine and didn't mark the Pneumococcal vaccine session. During an interview with the Director of Nursing (DON) and Infection Control Preventionist (ICP) on 8/1/22 at 3:10 PM, the ICP stated the facility uses the immunization tab under electronic medical records for residents' consent and education for the vaccine. The ICP also said the form (vaccination status questionnaire & consent) was not in use since the facility changed the form, the form covered just FLU. The DON submitted copies of the immunization tab for Resident #401 on 8/1/22 at 4:00 PM. The review of the vaccine immunization record revealed that Resident #401's RP refused the pneumonia vaccine on 3/12/20. However, no other documentation was found in the record that the resident received education regarding the benefits or risks of receiving the Pneumococcal vaccine. During an interview with the DON on 8/8/22 at 4:00 PM, the DON was aware of the above concern.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 43096 Based on medical record review and staff interview, it was determined the facility failed to document providing education regarding the benefits, risks, and potential side effects of receiving the COVID-19 vaccine to residents and staff. This was evident for 1 (Resident #401) of 5 residents and 2 (staff #10 and #20) of 4 facility staff members reviewed for COVID-19 vaccinations during the survey. The findings include: 1) On 8/1/22 at 09:00 AM, Resident #401's immunization medical record was reviewed. There was documentation found as [name-Responsible Party(RP)] refused vaccine in the electronic medical record (EMR) immunization under the COVID-19 vaccine tab. However, no documentation was found for evidence of education provided under the resident's paper chart or electronic medical record. During an interview with the Infection Control Preventionist (ICP) and the Director of Nursing (DON) on 8/1/22 at 3:10 PM, they stated the facility staff provided vaccination education to the resident or RP and documented it under EMR. The DON also said, sometimes education should be charted under progress note, too. The surveyor requested supporting documentation for Resident #401's COVID-19 vaccine education. However, no supportive documentation for Resident #401's COVID-19 vaccine education was submitted to the surveyor until the exit meeting on 8/8/22 at 4:00 PM. 2) A review of COVID-19 vaccination records for randomly selected 4 facility staff members was conducted on 8/1/22 at 11:00 AM. Staff #20 was an unvaccinated direct resident care person. On 8/1/22 at 11:40 AM, the ICP submitted a Request for Medical Exemption from COVID-19 Vaccination Form for Staff #20 that was signed on 3/9/22. However, no supportive documentation was found to support Staff #20 receiving education about the COVID-19 vaccine. 3) Staff #10 was an unvaccinated direct resident care person. The ICP also submitted staff #10's Request for Medical Exemption from COVID-19 Vaccination Form signed on 5/12/22. However, there was no documentation that Staff #10 received education regarding the COVID-19 vaccine. An interview was conducted with the ICP on 8/1/22 at 11:22 AM. The ICP stated the facility provided COVID-19-related education to staff: hand washing, PPE (Personal Protect Equipment), and the COVID-19 vaccine. The ICP asked to submit a COVID-19 staff education log for the benefits, risks, and potential side effects of receiving the COVID-19 vaccine. The ICP submitted in-service sign-in sheets for staff on 8/1/22 at 3:00 PM. However, the submitted documentation did not include staff #10 and #20, who received education on COVID-19 vaccine benefits, risks, and potential side effects. The Director of Nursing was made aware COVID-19 vaccine education issue on 8/8/22 at 4:00 PM.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 31145 Based on observation and staff interview it was determined the facility failed to keep the second walk-in freezer and dishwasher in the kitchen in safe operating condition. This was evident during the initial tour of the kitchen and during 2 subsequent visits. The findings include: 1) On 7/21/22 at 8:07 AM observation was made of the second walk-in freezer during the initial tour of the kitchen. There were small mounds of ice covering the inside ceiling of the freezer. Staff #2, the dietary manager stated, when it gets hot and humid in here and when the door is open there is ice build-up. On 7/26/22 at 11:29 AM a second observation was made of the second walk-in freezer. The ceiling had small mounds of ice scattered throughout the ceiling. The District Manager was with the surveyor during the observation and stated, we have had problems for a while with the freezer and that is why the fans are here. There were industrial size fans in the kitchen by the outside of the freezer. 2) Observation was made on 8/5/22 at 10:35 AM in the kitchen of the commercial dish washer running during the wash cycle. The gauge on the dishwasher was reading 140 degrees Fahrenheit (F). According to manufacturer's instructions the wash cycle should reach 160 degrees F. On 8/5/22 at 10:37 AM an interview was conducted with dietary aide, Staff #51. Staff #51 was handwashing and rinsing dishes next to the dishwasher. Staff #51 was asked what the temperature requirements for the dishwasher cycle were and she replied, I don't know. At that time Staff #2, the Dietary Manager was informed that the dishwasher was not washing the dishes at the required temperature and that her staff were not monitoring the gauge on the dishwasher machine and were not aware of what the temperature should be. Staff #2 put a test strip in the dishwasher, and it registered over 160 degrees F. On 8/5/22 at 11:22 AM, Staff #2 informed the surveyors she had re-run the dishwasher machine 3 additional times and each time it registered at 160 degrees F, but that she had also put a service call out to have the dishwasher serviced. The Director of Nursing was informed on 8/9/22 at 11:20 AM and the Nursing Home Administrator was informed on 8/11/22 at 4:15 PM.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 15701 Based on observations and interviews, it was determined the facility failed to ensure that residents had access to alert staff for assistance through the facility's call bell system. This was evident in 1 (resident #61) of 32 resident call bells activated during this survey. The findings include: On 7/21/22 at 10:13 AM resident #61 was observed sitting on the edge of his/her bed asking for assistance. She was informed to utilize her call bell. She was observed to press her call button and there was not a light or sound. Resident #61's call light was not operational. The resident's roommate was not in the room at the time. The surveyor pressed the call button that was for the resident's roommate and a sound was heard and the light above the door lit up. From the hallway, the unit manager (staff #48) was observed going into resident #64's room and was heard informing the resident that she will get someone and turned off the call light. The Unit manager was interview at 10:17 AM on 7/21/22. She was asked about when resident #61 would be attended to. She indicated that they would get her up and into his/her wheelchair soon. I asked her if she knew how often call bell function is checked she did not know and responded with an assumption that maintenance checks daily. Resident #61's call light was checked at 3:10 PM on 7/22/22 and was found in operable. I asked the Unit Manager to check the resident call light and she collaborated that the resident's call light was not working. The unit manager was reminded of the interview with the surveyor on 7/21/22 and that the call light was not functioning at that time. She indicated that she would notify maintenance. The maintenance man (staff #11) was interviewed, upon replacement of resident #61's call light cord, on 7/22/22 at 3:40 PM. The maintenance man indicated that random weekly checks of resident call lights are performed. He revealed that he is the only maintenance man and that he does not have a helper. When asked he indicated that the building was approximately [AGE] years old.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on observation and staff interviews, it was determined that the facility staff failed to provide a safe, functional, sanitary, and comfortable environment for residents, evidenced by 1) ongoing renovation construction in the facility building since October 2019, 2) uncapped sides of handrails at the 2-East wing, 3) broken wall behind the water purifier on the second floor near between 2-West nursing station and medication storage room, and 4) approximately 1.5 cm x 0.5 cm size, rusty, flat metal piece with one side that was sharpened and the other side was flat found on the hallway on the 2nd floor of the facility. This deficient practice has the potential to affect all residents, staff, and visitors in the facility. The findings include: 1) Surveyors conducted a facility tour on 7/21/22 at 8:10 AM. During a tour of the facility's second-floor units, surveyors observed carpet on the hallways that was covered with debris from paint, wall scrapings, and wallpaper that was on the entire second floor. At 8:40 AM on 7/21/22, the surveyor observed the bottom of the walls that were scrapped and unfinished wallpaper on the first floor of the facility. During an interview with the Nursing Home Administrator (NHA) on 7/21/22 at 3:25 PM, he stated the facility's renovation started in October 2019 and stopped because of COVID-. The NHA also explained the renovation was more cosmetic, the construction workers worked on the second floor for wallpaper and some ceilings, and later they would change the carpets. The NHA added, sometimes construction workers come during surveys, and sometimes they don't. On 7/26/22 at 8:17 AM, the surveyor observed the second-floor hallway carpet was still dirty and covered with paint debris, as same as the surveyors' initial facility tour performed on 7/21/22. During an interview with a housekeeper (Staff #36) on 8/4/22 at 9:06 AM, she stated that she has not vacuumed the carpet since the building was under ongoing renovation. She said she swept the floors and picked up big pieces of dirt (pointing to the fragments of paint debris that were on the carpeted hallway floor). On 8/4/22 at 10: 40 AM, the surveyor had a facility tour with the NHA and maintenance director (Staff #11). During the tour, the surveyor informed concerns related to the ongoing renovation. The NHA stated due to the COVID-19, and the construction was delayed. The NHA also said he understood to complete this renovation to keep residents' safety. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) During the facility tour on 7/21/22 at 9:20 AM, uncovered sides of handrails were found on 2- East wing around room [ROOM NUMBER]. The surveyor observed a brown wooden handrail in the corner of the 2nd floor east wing. The handrail was approximately 15 cm long with a brown wooden piece, and there was a 1-inch-thick plastic bump on the middle of each side 7 cm less long. The caps for the end of bump handrails were missing between rooms [ROOM NUMBERS] left sides (toward room [ROOM NUMBER]), between rooms [ROOM NUMBERS] on both sides, and the right-side cap was missing between rooms 245 and the staff lounge (on room [ROOM NUMBER] side), and the right-side cap was missing between rooms [ROOM NUMBERS] (toward 237). On 8/4/22 at 2:19 PM, the surveyor verified these rough, uncovered handrails with the Director of Nursing. 3) During the facility tour on 7/25/22 at 10:20 AM, the surveyor observed a damaged wall on the second floor between the 2-West nursing station and shower room near rooms [ROOM NUMBERS]. The damaged wall was about 15 inches x 20 inches, and the water valve in the wall was visibly exposed. There was an unplugged water purifier in front of the damaged wall. On 8/4/22 at 12:21 PM, a Licensed Practical Nurse (LPN #37) confirmed the water purifier was not in use. However, a hose of the water purifier was connected to the water valve in the exposed wall. On 8/4/22 at 2:19 PM, the surveyor had rounding with the Director of Nursing (DON) and verified concerns related to the broken wall. The DON stated that the machine (water purifier) was not working, and nothing was coming out of it. 4) On 7/29/22 at 2:10 PM, the surveyor observed approximately a 1.5 cm x 0.5 cm size, rusty, flat metal piece with one side that was sharp and another side that was flat was found on the hallway on the second floor of the facility between rooms [ROOM NUMBERS]. The surveyor brought a Licensed Practical Nurse (LPN #26) to the site where the metal piece was located and asked LPN #26 what it was. LPN #26 put a glove on, picked it up, and responded, I don't know what it is. During an interview with the Director of Nursing (DON) on 7/29/22 at 2:40 PM, the surveyor shared the concern related to an unsafe object on the floor. The DON stated, I have that metal piece on my desk. Understood your concerns.

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on staff interview, observation, and documentation review it was determined the facility failed to ensure an adequate amount of potable emergency water was always available. This was evident during a tour of the kitchen during the annual survey. This had the potential to affect all residents. The findings include: On [DATE] at 8:01 AM an interview was conducted with Staff #50 while in the kitchen. Staff #50 was asked where the emergency water was located. Staff #50 stated the water was in the basement and proceeded to walk with the surveyors to the basement storage room. Observation was made in the basement storage room of 16 cases of water with 4 gallons in each case. There were an additional 26 cases of water on the other side of the room containing 4 gallons each. The total number of gallons of water on hand was 168 gallons. Potable water on hand is calculated at 1 gallon per resident (total bed capacity) x 3 days. The bed capacity for the facility on [DATE] was 140 residents. The facility should have had 420 gallons of water on hand to cover 140 residents for 3 days. The facility only had 168 gallons which was 252 gallons of water short for the required amount needed on hand. Additionally, the water on hand had expired [DATE] and was covered with cobwebs. On [DATE] at 10:50 AM Staff #77 was asked for information on emergency water and the Emergency and Disaster Plan. Staff #77 brought in the plan at 11:11 AM and the surveyor asked if there was anything else besides the statement on page 2 which stated, Other key points to know: 1. Emergency water is located in the basement. Staff #77 said that other references to water were in other emergency procedures throughout the plan. Review of the Emergency and Disaster plan under the Evacuation plan, pg. 15 food and water documented, the facility has an emergency supply of water located in the storage on the lower level of the facility. The Shelter-in-Place emergency procedure documented on pg. 18, emergency water is located in the lower-level facility. On pg. 20 under food service staff it documented, notify vendors to deliver supplies, including ice and water. The emergency policy for hurricane/tropical storms, pg. 36 #7 documented, alert food and emergency water vendors, medical supply vendors, and #10, begin stockpiling of water in tubs. For Winter Storm, pg. 47 #9 documented, dietary shall make sure an emergency supply of water is on hand. At least one gallon of water will be kept on hand for each resident. On [DATE] at 12:22 PM the NHA was asked if he had a water supply policy. The policy that was given to the surveyor was titled, Essential Services: Availability of Utilities - No Water and documented the Dining Service Director or designee will evaluate the conditions associated with the loss of water services and develop and direct the dining services emergency plan accordingly. Procedure 1 documented, Planning: In accordance with the facility master plan projections for the total number of people that may be required to shelter in place, the Dining Services Director will be responsible for maintaining a three-day inventory of bottled water for all residents, staff, and projected numbers of volunteers and visitors, or as required by state or local regulations. (continued on next page)

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F 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Director of Nursing was informed of the concern on [DATE] at 11:20 AM and the NHA was informed on [DATE] at 4:15 PM.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on observation, staff interviews, complaints from anonymous staff, and facility documentation review, it was determined that facility staff failed to maintain an effective pest control program, so the facility was free of pests. This practice had the potential to affect all residents, staff, and visitors. The findings include: During multiple observations in the facility building from 7/25/22 to 7/29/22, the surveyor observed dead bugs, crawling bugs, and flying bugs. -On 7/25/22 at 10:44 AM, a black, pinky nail-sized, smashed dead bug was found in front of room [ROOM NUMBER]. -On 7/25/22 at 7:49 AM, a dark brown, about 1.5 inches long, a smashed bug was found between room [ROOM NUMBER] and the medication room. -On 7/26/22 at 7:28 AM, a brown, pinky nail size dead bug was found on the 1st floor in front of the women's locker room. -On 7/26/22 at 8:39 AM, a dark brown, ring fingernail size, dead bug was found on the right side of the nursing office's director. -On 7/27/22 at 6:47 AM, a pinky finger size, brown dead bug was found in front of room [ROOM NUMBER] left side door. -On 7/27/22 at 8:36 AM, the surveyor observed a live bug, brown, about 2 inches long, moving toward room [ROOM NUMBER]. -On 7/28/22 at 1:46 AM, the surveyor observed a pinky nail size, brown live bug crawling between rooms [ROOM NUMBERS]. -On 7/29/22 at 7:23 AM, the surveyor observed a smashed dead bug, brown and about 3 inches long, in front of DON's office. -From 7/25/22 to 7/29/22, three dead flies were found behind the window blinds in the conference room. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/22 at 9:46 AM, an interview was conducted with the maintenance director (staff #11). Staff #11 stated that the facility had contracted a pest control company that visited the building twice a month. Staff #11 also explained that the pest control company did their regular interventions to prevent pest issues and follow up on the facility's concerns based on the pest control logbook. Any staff could write their concerns regarding pests, or Staff #11 could call the company for an extra visit. Staff #11 was asked whether the pest control company's visit or activities were tracked or not. The staff confirmed that there were no official documentation related to pest control company's interventions, recommendations, or report to the facility. On 7/29/22 at 9:10 AM, the surveyor investigated two complaints (MD00179186 and MD00166690). The complainants reported over ten cockroaches in and on patients on the first floor and brought this to the administrator's attention. The alleged event date was 2/21/22, and more than eight cockroaches scatter across the floor with the alleged date of May 2021. However, a review of the pest control log on 7/29/22 at 11:54 AM revealed that the contracted pest control company did not visit this facility around 2/21/22. The closest visit near the complaint submitted was on 3/2/22. During an interview with the Director of Nursing (DON) on 07/29/22 at 1: 50 PM, the surveyor informed the pest control program was ineffective. 31145 Several observations were made during the survey of insects in the facility. On 7/21/22 at 8:07 AM observed a live drain fly in the medication room on the first floor nursing unit. On 7/21/22 and 7/22/22 at 8:23 AM observed a gnat flying around the conference room. On 7/22/22 at 8:14 AM a fruit fly was observed flying outside of room [ROOM NUMBER]. On 7/27/22 at 10:15 AM observed a fly in the conference room. On 8/10/22 at 11:50 AM there were flies and gnats in the conference room, crawling on surveyor's drinks, papers, and computers.

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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. 15701 Based on review of employee file documentation and interview it was determined that the facility failed to have a process to ensure all Geriatric Nursing Assistants (GNAs) have no less than 12 hours of education per year and the education included annual dementia management training and resident abuse prevention training. This is evident for 5 of 5 GNA employment files reviewed and 1 (staff #69) of 5 GNAs that did not have abuse prevention training. This is evident for 5 (#68, #69, #70, #71, #72) of 5 GNA employment files reviewed and 1 (staff #69) of 5 GNAs that did not have abuse prevention training. The findings include: On 8/10/22, the Human Resources (HR) Director (staff #78) provided a requested list of the facility's Geriatric Nursing Assistants (GNAs) with hire dates. Out of a list of 23 GNAs, 5 employee files were selected at random. A meeting was held with the HR at 10 AM on 8/10/22 to review the GNA employment files for education and yearly performance Appraisals. The HR director did not have access to employee education files but was requested to obtain staffing education and competencies documentation of the 5 randomly selected GNAs. Upon several requests the documentation to show that the mandatory required annual education and validation of the 12 hours per year minimum education was not provided. On 8/10/22 at 2:28 PM an interview was conducted with the Assistant Director of Nursing (ADON). It had been previously revealed that the facility did not have a staff educator. The ADON acknowledged that staff development is shared between her and the DON. She is the facility's Infection control preventionist (ICP) and the Quality Assurance Performance Improvement (QAPI) coordinator. She was asked if she had a current process in place to track the education of the GNA's. She indicated that she only has sign-in education sheets. She does not have a process to keep tabs of the education each GNA has received, which was at least 12 hours of education per year. On 8/11/22 at 12:40 PM the ADON was interviewed. She acknowledged that there was a systematic issue that she was unable to track the requirement for a minimal of 12 hours of training per year. She had brought stacks of training documents wrapped in rubber bands, indicating that she had training documents labeled as In the know education for falls training and dementia training. She had In-service sign in sheets for Abuse Training. One set of documents was dated 11/23/21 as Abuse Training and the other set of documents was labeled as Reporting Abuse and neglect dated 12/13/21. The two sets of abuse training were reviewed for the 5 randomly selected GNA's. There was not any indication that GNA staff #69 had received abuse training from the 2 abuse training documents provided. When asked if all the staff have been trained on Abuse and Dementia she indicated no but a majority of the staff had received the 2 educations in question.