STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215094	A. Building B. Wing	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Healthcare Center	1234 Washington Road Westminster, MD 21157

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on interviews and documentation review, it was determined that the facility failed to treat residents with dignity and respect by 1) failing to answer call bells in a timely manner to either prevent residents from having urinary accidents or change residents who have urinary and bowel incontinence, 2) telling a resident to urinate in their pants, and 3) failing to provide care and services to resident's dependent on staff for activities of daily living. This was evident for 13 (#39, #32, #1, #12, #29, #28, #27, #22, #21, #53, #20, #43, #47) of 53 residents reviewed during a complaint survey but had the potential to affect all residents. The findings include: 1) On 9/9/21 at 11:15 AM, Resident #39 stated, yes they are short staffed. I have to wait and hour to an hour and 1/2 for the call bell to be answered. Forget 11 to 7 because you will sit forever; 3 to 11 you wait a while and the staff complains. I need help wiping and by them not answering the call bell I sit in poop for 8 hrs. Until 11-7 came in I have to get washcloths and put on my gripper and hold onto the walker. 2) Resident #32 was interviewed on 9/10/21 at 9:50 AM and stated, Yes, they are short staffed. Sometimes the call bell will ring for 1 hour and 40 minutes to 2 hours. My roommate waits a long time to be fed. They get attitudes because we get attitudes. Some GNAs (geriatric nursing assistant) say, I don't have time. I have sat on a bedpan for 2 hours. I put myself on the bed pan because some GNAs said it is not their job, so I have to get a glove and garbage bag to keep my poop off my hand. I try to do myself, so I don't have to wait. 3) Resident #1 was interviewed on 9/10/21 at 10:00 AM and stated, I am not getting changed. I have gone 12 to 14 hours with no diaper change. I need to be fed. They sit the lunch tray under the tv, and they come back 30 to 60 minutes later. They say it's always only 2 of us on the floor. It takes 1 1/2 hours until the call bell is answered. 4) Resident #12 was interviewed on 9/10/21 at 10:10 AM and stated, I have to wait an hour or so for my call bell to be answered. I wet myself waiting. Sometimes it is embarrassing. They can't get me into the bathroom. At that time the resident started crying. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2021 Grievance log revealed a concern was expressed on 7/26/21 that Resident #12 had only 1 shower since being admitted on [DATE], had bed sheets that were not changed and waited a long time to be changed and nobody answers the call light. The resolution signed off on 7/28/21 was, this writer met with resident and staff. This issue was resolved by asking the staff to give shower as scheduled. 5) On 9/13/21 at 9:26 AM an interview of Resident #29 revealed, No they do not have enough staff. I don't get a full bath. In the morning I get a diaper change. I wait for 2 hours once the call bell is put on. It happens regularly. I break out with a rash in my private area because of sitting in a soiled diaper. I get very angry and upset. Our entire room didn't get changed for 12 hours. I got changed on the 11-7 shift at 4:30 AM and the next time changed it was 4:40 PM. I called the nurse's station up and down, then the front desk. When that didn't work, I called my husband and he tried to call in and did not get an answer, so I called 911. I reported it to them, and the state police interviewed me and asked for the name of the facility. We still had to wait. After that I could hear the front desk call the nurse overhead to pick up a phone line. It happens all the time. I am trying my damnest to get out of here. I am bedridden. Resident #29 continued, the 3-11 shift is absolutely horrible. They don't answer the call light. I turned the light on yesterday, 9/12/21 at 4 pm and it was not answered until after 7 pm. The weekend is the worst. They use agency that doesn't answer to anyone. 6) On 9/13/21 at 9:36 AM, an interview with Resident #28 revealed, you wait and wait. One day it took until 2:30 in the afternoon for someone to finally come in and give us care. I get aggravated because I don't like laying in my urine and feces that long. I am bedridden or in a wheelchair. 7) On 9/13/21 at 9:40 AM Resident #27 stated, they are short staffed and need more help. We have to wait over an hour or longer for the call bell to be answered. I wear a diaper and have to wait a long time. It is not a good feeling. I sometimes wait 3 hours, sometimes 6 hours. I would like to get the aides to lay in bed and lay in poop for 6 hours and tell me how they feel. Resident #29, #28 and #27, all roommates, stated on 9/13/21 at 9:43 AM that they had not seen a GNA since before 7:00 AM. They only saw a nurse who came in to pass meds. 8) Resident #22 stated on 9/13/21 at 1:14 PM, you wait, wait, wait. The resident had a hard time talking due to a stroke and was stuttering and anxious when telling the surveyor about staffing. The nurses and techs are downright obnoxious. You can ask for something and they seem to forget as soon as they walk out of the room. Then you have to call again and wait another hour or two. During shift change they don't introduce self to me. Sometimes I haven't seen a GNA all day. 9) Resident #21 stated on 9/13/21 at 1:16 PM, Nursing and the doctor leaves a lot to be desired. I put the call bell on, and it takes a couple of hours. People walk by and wave and keep going. I have accidents. I don't feel good about it. It is embarrassing when you go in your pants. They told my roommate, the resident who used to be next to me (Resident #22). They told him to just go in his pants. I'm a grown man and it is inhumane. I was left to lay soiled 30 hours and my wife had to call. They deliver food but no one changes me until my wife called the front desk. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the July 2021 Grievance log confirmed the resident's spouse made a complaint on 7/13/21 and the resolution was, this writer met with this resident and expressed his concern about the call light not being answered on time and inadequate staffing. The writer met with staff to in-service them on answering the call light promptly and adequate staffing was discussed with my superior. 10) On 9/17/21 at 11:04 AM an interview of Resident #53 confirmed the complaints of short staffing. There was a day we stayed in bed all day during day shift. The care is spotty. There are not enough aides available. One time I was left 24 hours before being changed. I was leaking and felt filthy - all wet. The 2 staff that changed me, I didn't know if they were angry with me because they were speaking in a different language that I could not understand. They were angry. Pulled at me. It was a horrible evening shift. It was in August. They were angry I had to be changed. I usually get changed at 9AM, before 3 PM and then before I got to sleep which is around 9 PM. The other night it was past 11 PM. I was so tired, but I couldn't fall asleep until I was changed. 11) On 9/13/21 at 1:41 PM Resident #20's family member stated, I came in on 9/7/21 at 3:30 PM. [His/her] bag (ileostomy) and diaper from all night had not been changed. No shower. Review of Resident #20's GNA documentation for September 2021 revealed gaps in documentation for dressing, float heels, bathing, bed mobility, behavior monitoring, bladder continence, bladder tracker, bowel continence, bowel movement, locomotion on and off the unit, personal hygiene, turn and repositioning, amount eaten, eating, and fluid intake. On 9/7/21 there was no GNA documentation on all 3 shifts, day, evening, and night shift that had indicated that any GNA care was given. Review of Grievance logs that were given to the surveyor by Staff #14 revealed care concerns were expressed by Resident #20's family member on 6/16/21 related to no shower. The actions taken were, Administrator has spoken to sister of resident and discussed concerns with plan in place and staff aware that resident is to be bathed and changed. Increased communication is also to be implemented to help reduce frustration. 12) Review of Grievance logs for July 2021 revealed Resident #43's family member called in on 7/2/21 and stated that Resident #43 was not receiving showers twice per week. The resolution on 7/4/21 was, this writer made it mandatory in-service that all staff must give residents showers twice a week. 13) Resident #47's family member was interviewed on 9/17/21 at 12:57 PM who stated, since the Pandemic, [he/she] goes days without a bath, as many as 4 -5 days, which is completely unacceptable. Review of Resident #47's GNA documentation for September 2021 revealed gaps in documentation for dressing, float heels, bathing, bed mobility, behavior monitoring, bladder continence, bladder tracker, bowel continence, bowel movement, locomotion on and off the unit, personal hygiene, turn and repositioning, amount eaten, eating, and fluid intake. On the following days there was no documentation to validate care was given on 9/1 day and evening shift, 9/2 day and evening shift, 9/5 all 3 shifts, 9/6 evening shift, 9/7 all 3 shifts, 9/8 day shift, 9/9 day shift, 9/10 day shift, 9/11 day and evening shift, 9/12 evening shift, 9/13 day and evening shift, 9/14 evening shift, 9/17 all 3 shifts, 9/18 day and evening shift, 9/20 day and night shift. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #47's shower/bathing logs in the GNA tasks were blank for 9/2, 9/9, 9/13 and 9/20. The bathing/shower logs in the GNA task for August 2021 were blank for 8/2, 8/9, 8/12, 8/16, 8/19, 8/23, and 8/30/21. Discussed with the Nursing Home Administrator on 9/22/21 at 1:00 PM.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 31145 Based on medical record review and staff interview, it was determined the facility 1) failed to notify the physician that an urgent surgeon's appointment and diagnostic test had not been acted on promptly, 2) failed to inform the physician that an urgent appointment was not scheduled to occur until 6 months later, and 3) failed to notify a resident's responsible party of changes in a resident's condition in acceptable time frame. This was evident for 3 (#1, #11, #14) of 53 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #1's medical record on 9/9/21 at 8:15 AM revealed the resident was seen by a neurologist on 8/20/21 and a neurology consult report dated 8/20/21 documented, MRI c-spine w/o contrast, URGENT at [name of hospital] and referral to spine surgeon, URGENT at [name of hospital]. A physician's order was written on 8/20/21 that stated, MRI C-Spine w/o contrast urgent at [name of facility] one time for cervical stenosis. An MRI (magnetic resonance imaging) is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body. On 9/15/21 at 11:47 AM during interview, Staff #33 stated that she called a day or 2 after 8/20/21 to [name of hospital] and was able to get an appointment for February 3, 2022. When asked why Resident #1 had to wait an additional 6 months, Staff #33 said, because the resident has a pacemaker, and they need a specialized machine and [name of hospital] is 6 months out. The surveyor asked, even for an emergent request. Staff #33 said, yes. The surveyor asked if she notified the doctor because there was no documentation in the medical record that the physician was notified that it would take another 6 months for an urgent request. She said she spoke to the physician about it and will document it today (9/15/21). The surveyor asked Staff #33 when the physician was notified and she stated, before I went out on leave on September 1. On 9/15/21 at 1:10 PM, an interview was conducted with Staff #36 (Nurse Practitioner). When the surveyor showed Staff #36 the urgent request, Staff #36 said it was not acceptable to wait to call and make the appointment 2 days after the order was written and she was not aware of that delay. On 9/15/21 at 2:48 PM, an interview was conducted with Staff #38 (physician). When asked about Resident #1's neurology appointment, Staff #38 stated he was told that they got a neurology appointment at [name of hospital]. The surveyor asked if he was aware of when the appointment was to take place. Staff #38 said, no. The surveyor informed him the appointment was not until February 2022. Staff #38 stated, That's new to me. The surveyor asked if he expected the resident to be seen sooner since it was urgent, and he said yes. Staff #38 stated, my expectation was urgently as possible. I was not notified that [he/she] was not being seen urgently. Staff #38 stated, I will be calling the facility immediately to handle this. 39709 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2). Resident #11 was admitted to facility with advance directive which stated medical power of attorney responsible party (POA/RP) to make medical and financial decisions for Resident #11. On 9/9/21 surveyor reviewed complaint MD00160116 that revealed a concern that Resident #11 was transferred out of the facility to an acute hospital for a change of physical condition after experiencing a fall in the facility. Review of facility admission record face sheet revealed that the facility was provided with the contact information of whom to contact in any change of physical or mental condition for the resident in event of medical emergency. Review of nursing progress note written on 10/28/20 revealed staff documented Resident #11 experienced a physical change in condition at 11:00 p.m. The facility documented notifying the primary care clinician on 10/27/20 at 11:30 p.m. The facility did not notify the family/responsible party member of change in resident's condition. The family/responsible party member was not notified until 10/29/20 over 24 hours later of Resident #11's fall and hospital transfer for further medical evaluation. 2). Resident #14 was admitted to facility with advance directive which stated medical power of attorney responsible party (POA/RP) to make medical and financial decisions for Resident #14. On 9/14/21 revealed Resident #14 surveyor reviewed complaint MD00158828 that revealed a concern that Resident #14 had experienced a change of physical condition after experiencing a fall in facility. Review of facility admission record face sheet revealed that the facility was provided with the contact information of whom to contact in any change of physical or mental condition for the resident in event of medical emergency. Review of notification note written on 9/16/21 revealed that staff documented a change in condition and that the physician was notified on 9/26/20 at 09:30 a.m. and the POA/responsible party member notified on 9/27/20 at 5:15 p.m. of Resident #14's change in condition over 25 hours later. On 9/14/21 at 12:00 p.m., surveyor conducted an interview with the facility Administer and she acknowledged there was a delay in notification to responsible party of change in condition for Resident's #11 and #14. All findings discussed with the facility Nursing Home Administrator and Director of Nursing on 9/22/21 during the survey and prior to facility exit conference at 1:15 p.m.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation and interview, it was determined that facility staff 1) failed to assure that resident medical records remained private and confidential as evidenced by resident information being left visible on the medication administration computer while the nurse entered the resident's room and 2) failed to ensure a resident's foley catheter drainage bag was in a privacy bag. This was evident for 1 of 5 random observations of medication carts and 1 (#51) of 2 residents observed with a foley catheter during a complaint survey. The findings include: 1) Observation was made, on 9/9/21 at 6:10 AM, of Resident #33's electronic medical record displayed on an opened computer screen that was sitting on top of a medication cart. The resident's medications were on display and the opportunity to look at additional information was available. The medication cart was sitting in the hallway outside of room [ROOM NUMBER]. Staff (LPN) #12 came out of a resident's room and walked up to the medication cart where the surveyor was standing and the surveyor informed Staff #12 of the finding. 2) Observation was made, on 9/17/21 at 1:40 PM, of Resident #52 lying in bed in his/her room. Resident #52's foley catheter bag was lying on the floor wedged under the frame of the over the bed tray table. There were 600 milliliters (ml) or yellow urine in the bag. A second observation was made on 9/17/21 at 2:16 PM. The foley catheter bag was still in the same position and had not been emptied. The foley catheter bag was visible from the hallway as the resident's bed was the closest bed to the door. A Foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. The resident's foley catheter bag was not placed in a privacy bag to enhance privacy to the resident. Observation was made on 9/17/21 at 2:16 PM of Resident #51. Resident #51 had a foley catheter that was placed in a privacy bag. Discussed with the Nursing Home Administrator on 9/21/21 at 9:37 AM.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40601 Based on surveyor observation throughout a complaint survey, it was determined that the facility failed to maintain a sanitary, orderly, and comfortable environment. The findings include: On 9/9/21 at 8:26 AM, a dead bug was observed on the bottom floor under the stairs opposite the nurse's station. At 8:28 AM, Shower room [ROOM NUMBER]C's commode and assist chair were observed splattered with dried fecal matter. On 9/15/21 at 1:16 PM, the hallway beside room [ROOM NUMBER] was observed with 3 dead beetles on the floor. The corner of the wall opposite this door was observed with 4 dead bugs covered with dust. At 1:17 PM, a squashed bug was observed on the floor outside the 1st floor medicine room, opposite the business office. On 9/22/21 at 12:50 PM, the walls of the memory care unit were observed with scuffed walls revealing drywall, approximately 1 ft from the ground. Peeling wallpaper was observed under the handrail opposite the sitting room leading to the patio. The Administrator and Interim Director of Nursing were made aware of these findings during the exit conference on 9/22/21.

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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. 31982 Based on review of the medical record and interview with staff, it was determined the facility staff failed to provide and document sufficient preparation and orientation to a resident to ensure safe and orderly discharge from the facility in a form and manner that the resident can understand. This was evident for 1 (#8) of 53 residents reviewed. The findings include: Review of Resident #8's medical record on 9/16/21 at 7:00 AM revealed that Resident #8 was discharged from the facility on 3/22/21 to an assisted living facility. A progress note written by Staff #14 on 3/22/21 at 9:57 indicated: called the resident's POA (Power of Attorney); resident will be picked up on this date at 3pm by his/her family for transportation to assisted living facility (ALF). Another progress note was written by nursing on 3/22/21 at 16:21 (4:21 PM) and stated, discharged to the other facility with family. The interdisciplinary progress notes failed to reveal documented evidence that the resident was provided sufficient preparation and orientation in a form and manner that he/she could understand to ensure a safe and orderly discharge. The Administrator was made aware of this concern on 9/16/21 at 8:12 AM and indicated she would see if she could find the documentation, however, none was provided.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31145 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#1) of 53 residents reviewed during a complaint 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. 1a. Review of Resident #1's medical record on 9/9/21 at 8:15 AM revealed a 2/25/21 physician's note which documented the resident was admitted for generalized weakness status post fall and that the resident reported worsening generalized weakness over a period of a few months. A 3/25/21 at 7:17 AM nurse's note documented, unwitnessed fall. Resident stated, After coming out of the bathroom, I lost my balance and fell . Due to fall, resident sustained hematoma to left side of the forehead, and small cut to left nostril due to glasses. Review of Resident #1's quarterly MDS with an assessment reference date (ARD) of 5/29/21, Section J, falls coded that the resident did not have a fall since the previous assessment. The facility failed to capture the fall of 3/25/21. 1b. Continued review of Resident #1's medical record revealed an MDS with an ARD of 8/30/21; Section N, Opioids; failed to capture that Resident #1 took an opioid for pain control on 8/24/21, 8/25/21 and 8/26/21. Section I Diagnosis, did not capture Radicular pain M54.10/729.2 Radiculopathy, lower limb spasticity M62.838/728.85, and muscle spasms that was documented in a Nurse Practitioner's 7/27/21 visit as the primary diagnoses. On 9/22/21 at 1:00 PM, the surveyor asked the Nursing Home Administrator (NHA) if the MDS Coordinator could come speak to the surveyor. The NHA stated the MDS coordinator was not available. Surveyor informed NHA of the MDS errors.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview, it was determined that facility staff failed to develop and initiate comprehensive, resident centered care plans. This was evident for 6 (#51, #52, #20, #28, #29, #45) of 53 residents reviewed during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. 1) Observation was made on 9/17/21 at 2:16 PM of Resident #51 lying in bed with a foley catheter bag lying on the floor in a covered bag with the top of the covered bag open. Review of Resident #51's medical record on 9/20/21 at 11:55 AM revealed the resident was admitted to the facility on [DATE] from an acute care facility with diagnoses including, but not limited to, sepsis, type 2 diabetes mellitus, obstructive and reflux uropathy and tubulo-interstitial nephritis. Obstructive uropathy occurs when urine cannot drain through the urinary tract. Urine backs up into the kidney and causes it to become swollen. Reflux nephropathy is a condition in which the kidneys are damaged by the backward flow of urine into the kidney. Interstitial nephritis is a kidney disorder in which the spaces between the kidney tubules become swollen (inflamed). Review of the hospital discharge summary, dated 8/5/21, revealed that a foley catheter was placed in the resident in the emergency department, over 1 liter of urine was removed, and the resident was severely dehydrated and was diagnosed with sepsis. Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. The hospital discharge instructions stated, follow-up with [name of urology practice] in 1 week and to keep the foley catheter in until seen by urology. A Foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. Over 6 weeks had passed since the resident was admitted to the facility and there was no documentation in the medical record that the resident was sent to the urology appointment. Review of the care plan section of the medical record failed to produce a care plan for a urinary catheter which would have been a person centered guide that staff could have used to determine the resident's goals and interventions for the use of the foley catheter. Cross Reference F690 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 9/17/21 at 1:40 PM, surveyor observed Resident #52 lying in bed. Resident #52's foley catheter bag was lying on the floor wedged under the frame of the over the bed tray table. There were 600 cc. of urine in the bag. A second observation was made on 2:16 pm and the bag was still in the same position and had not been emptied. The resident was left vulnerable for infection as the urinary bag was left on the floor, susceptible to other organisms. Review of Resident #52's medical record on 9/20/21 at 10:40 AM revealed that Resident #52 was admitted to the facility on [DATE] from an acute care facility with diagnoses that included, but were not limited to, respiratory failure, sepsis, pneumonia due to COVID-19, and obstructive and reflux uropathy. Continued review of Resident #52's medical record revealed a care plan that was initiated on 9/12/21, Indwelling Supra pubic Catheter, Obstructive Uropathy. The care plan should have been for a regular urinary catheter that was inserted into the bladder through the urethra (the tube that carries urine out of the body). A suprapubic catheter is a type of catheter that is left in place. Rather than being inserted through the urethra, the catheter is inserted through a hole in the abdomen and that goes directly into the bladder. Discussed with the NHA on 9/21/21 at 9:37 AM. 3) Review of Resident #20's medical record on 9/14/21 at 8:45 AM revealed the resident had an ileostomy. An ileostomy is the result of an operation that connects the last part of the small intestine (ileum) to the abdominal wall. Intestinal waste passes out of the ileostomy and is collected in an external ostomy system which is placed next to the opening. Review of Resident #20's care plan, has an ileostomy that was initiated on 11/20/19 had an intervention, empty ileostomy every shift and as needed. Document amount of contents. Review of Resident #20's September 2021 Treatment Administration Record (TAR) revealed the area where the nurses were to document the amount of contents and instead of the amount of the amount that was empty from the ileostomy, Staff had checked off either yes, a check mark, med (medium) or the amount in milliliters (only 4 times for 60 opportunities). The documentation for recording information for the care plan was not correct. 4) Review of Resident #28's medical record on 9/13/21 at 11:15 AM revealed a care plan, ADL Self Care Performance deficit that had interventions that were incomplete. The incomplete interventions were, Resident requires ____assistance with ambulation Resident requires _____ assistance with bathing Resident requires _____ assistance with dressing Resident requires _____ assistance with eating Resident requires _____assistance with hygiene Resident requires ___assistance with locomotion Resident requires ____assistance with toileting and Resident requires _____assistance with transfers. The care plan was not resident centered and was incomplete. 5) On 9/13/21 at 9:26 AM an interview of Resident #29 revealed, No they do not have enough staff. I don't get a full bath. In the morning I get a diaper change. I wait for 2 hours once the call bell is put on. It happens regularly. I break out with a rash in my private area because of sitting in a soiled diaper. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #29's annual MDS (Minimum Data Set), with an assessment reference date of 7/8/21, documented that the resident was always incontinent of bowel and bladder. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. Review of Resident #29's medical record on 9/22/21 at 11:00 AM revealed no care plan for urinary and bowel incontinence. 6) Observation was made on 9/14/21 at 1:55 PM of Staff #46 (geriatric nursing assistant, GNA) wheeling Resident #45 at a fast speed in a wheelchair around the station 1 and 2 nurse's station, through the lobby and over to the receptionist desk. Resident #45 was yelling/screaming loudly while being pushed in the wheelchair. Observation was made of Staff #46 pulling the resident backwards across the lobby while the resident was still screaming. At that time, Staff #14 intervened and asked Staff #46 to turn the resident's wheelchair around towards Staff #14. Staff #14 calmly spoke to the resident. At that time the surveyor approached the Nursing Home Administrator (NHA) and informed her of the observation of the speed that Staff #46 was pushing the elderly resident in the wheelchair. The NHA came back to the conference room on 9/14/21 at 2:48 PM, and informed the surveyor that she had interviewed a couple of people and stated she didn't feel that staff's actions were abusive. The NHA stated they had a visitation today for Resident #45 that wasn't scheduled, and the aide was trying to get the resident ready and was rushing. She said the wheelchair legs didn't fit right on the wheelchair and the resident started swinging his/her arms at Staff #46. To make the visiting schedule, Staff #46 was pushing the wheelchair in a rush. The NHA stated that Staff #46 got the resident on the elevator and through the hall and she thought Staff #46 was wheeling Resident #45 fast so the resident wouldn't hit anyone with his/her arms. The NHA stated Staff #46 took the resident to the receptionist area and because the resident was swinging his/her arms Staff #46 didn't want the resident to hit the receptionist, so Staff #46 moved the resident backwards. The NHA stated that it was an educational moment for Staff #46 and felt Staff #46 could have handled the situation better, but Staff #46 was a good GNA and really cared for the residents. The NHA stated she was going to suspend Staff #46 while investigating the incident and educate her on the handling of dementia residents. Review of Resident #45's medical record on 9/14/21 at 2:10 PM revealed Resident #45 was admitted to the facility in June 2021 with diagnoses that included, but were not limited to, dementia, major depressive disorder, anxiety, and unspecified psychosis. Continued review of the medical record revealed physician's orders for an antipsychotic medication, Seroquel 25 mg. twice per day and Xarelto Tablet 20 MG (Rivaroxaban), 1 tablet by mouth in the evening for DVT (deep vein thrombosis) which was ordered on 6/5/2021. Further review of Resident #45's medical record revealed there was no care plan for the Seroquel, no care plan for the Xarelto and no care plan for dementia. Discussed with the NHA on 9/22/21 at 1:00 PM.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39709 Based on medical record review and staff interviews, it was determined that the facility failed to revise/update care plans that addressed interventions for residents after they experienced a fall. This was evident for 2 (#14, #5) out of 5 resident's reviewed for falls during a complaint survey. The finding includes: 1) The care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. On 09/14/21 surveyor review of complaint MD00158828 revealed a concern that Resident #14 had experienced a change of physical condition after experiencing a fall on 9/16/20 in facility. Medial record review revealed a fall care plan. with admission initiation date of 03/06/2018, which included goals and approach interventions for fall prevention. Continued record review revealed that the facility failed to update or revise the care plan that addressed the resident's fall which occurred on 09/16/20. On 9/14/21 at 12:00 p.m., surveyor conducted an interview with the facility administer and she acknowledged that Resident #14's plan of care for falls was not revised or updated to reflect the resident's fall on 9/16/20. All findings discussed with the facility Administrator and Director of Nursing during the survey and prior to facility exit conference on 9/22/21 at 1:15 p.m. 43096 2) A Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinarian tool that allows many facets of the resident's care. One of the sections of the MDS: the Activities of Daily Living (ADLs) are tasks related to everyday life, (eating, bathing, dressing, toileting and transferring). The ADLs are reviewed and scored to identify the resident's self-performance level and determine the amount of staff support needed to perform each task. A review of Resident #5's medical record on 9/14/21 at 12:15 PM revealed the resident was admitted to the facility on [DATE] with diagnoses which included a history of a traumatic brain injury from a motor vehicle collision that left them paralyzed on the right side of their body. Review of the resident's November 2019 quarterly Minimum Data Set (MDS) revealed in section G that the resident had upper and lower extremity impairments on one side that required total care (assistance of 2 or more staff) for their bed mobility and transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review revealed care plan interventions, dated 12/29/19, for Activities of Daily Living (ADL) care stated, that the Resident is dependent and required 1 person staff assistance for daily care. A review of the medical record on 9/22/21 at 9:30 AM revealed Resident #5 had a fall on 1/21/20. A progress note dated 1/21/20 at 5:15 AM revealed that Resident #5 rolled off the bed when the GNA turned the resident while providing care. However, review of the care plan revealed there was no changes regarding the provision of ADL care. (Cross Reference F 689)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 31982 Based on medical record review and interview with staff, it was determined that the facility staff failed to develop a complete discharge summary to communicate required information to the resident, resident's representative, and continuing care provider at the time of discharge including a recapitulation of the residents stay, a reconciliation of pre and post discharge medications and final summary of the resident's status. This was evident for 1 (#8) of 53 residents reviewed during the complaint survey. The findings include: Review of Resident #8's medical record on 9/16/21 at 7:00 AM revealed that Resident #8 was discharged from the facility on 3/22/21 to an assisted living facility. A form labeled Discharge Summary: Recapitulation of Stay MD-V4 was in the medical record. Section A. Nursing, indicated that copies of treatment, discharge medication, all orders, lab results, consults and most recent diagnostic test results were attached. There were no attachments to the form. Line 5 Nurse completing this section of the form indicated: Social Services for Nursing-Nurse has reviewed. It was signed as completed by Staff #14 and dated 3/22/21. No nursing signature was present to indicate that a nurse had reviewed the information including any attachments. Section C. Dietary Manager was signed by Staff #14 for dietary with no indication that the Dietician or Dietary Manager provided input or reviewed and approved the information provided. Section D. Activity Director, Activity pursuit indicated Resident spends his/her time in bed and is offered in room supplies. It did not identify which activities the resident enjoys, what supplies are provided nor his/her level of participation and any assistance required. This section was also signed by Staff #14 and indicated Social Services for Activities. There was no indication that Activities provided input or reviewed and approved the information that was documented. There was no indication that a nurse, physician, dietary staff, or activity director reviewed or provided input to Resident #8's discharge summary/recapitulation of stay. The form did not include a reconciliation of the residents pre discharge medications with his/her post discharge medications, a recapitulation of the resident's stay (a concise summary of the resident's stay and course of treatment in the facility), nor a final summary of the resident's status at the time of discharge. Section E. Signatures was not signed and dated by the resident/representative and the physician in the spaces provided to indicate it was reviewed and accepted. During an interview on 9/16/21 at 8:12 AM the Administrator was made aware of these concerns and indicated that she would see if there was any additional documentation to indicate that the required discharge summary was completed however, none was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 31145 Based on interview and documentation review, it was determined that facility staff failed to provide showers to residents who were dependent on staff for hygiene assistance or documented evidence that a shower was given or refused to residents. This was evident for 5 (#20, #47, #27, #36, #34) of 53 residents reviewed during a complaint survey. 1) On 9/13/21 at 1:41 PM, an interview was conducted with Resident #20's family member who stated, I came in on 9/7/21 at 3:30 PM. [His/her] bag (ileostomy) and diaper from all night had not been changed. [He/She] had not had a shower. On 9/14/21 at 8:45 AM, a review of Resident #20's medical record revealed the resident was scheduled to receive a shower two times a week, every day shift on Tuesday and Friday. Review of the Geriatric Nursing Assistant (GNA) documentation for September 2021 revealed blank spaces on 9/7/21, 9/10/21, and 9/17/21. Review of Resident Shower Sheets revealed only 1 shower sheet which was dated 9/10/21 for the 3-11 shift. There were no other shower sheets for Resident #20. Review of Resident #20's GNA (geriatric nursing assistant) documentation for September 2021 revealed gaps in documentation for dressing, float heels, bathing, bed mobility, behavior monitoring, bladder continence, bladder tracker, bowel continence, bowel movement, locomotion on and off the unit, personal hygiene, turn and repositioning, amount eaten, eating, and fluid intake. On 9/7/21, there was no GNA documentation on all 3 shifts, day, evening and night shift. Review of nursing schedules for 9/7/21 revealed that the census on the unit was 57 residents and the resident to staff ratio was 1 staff to 19 residents. 2) Resident #47's medical record was reviewed on 9/20/21 at 11:00 AM. Resident #47 was scheduled for a shower 2 times a week on Monday and Thursday. Review of the GNA shower book on the unit revealed no shower documentation for Resident #47. Review of the GNA tasks for bathing for August 2021 revealed no documentation that a shower was given as evidenced by blank spaces on 8/2, 8/9, 8/12, 8/16, 8/19, 8/23, and 8/30/21. For September 2021 there were blank spaces on 9/2, 9/9, 9/13 and 9/20. Further review of Resident #47's GNA documentation for September 2021 revealed gaps in documentation for dressing, floating heels, bathing, bed mobility, behavior monitoring, bladder continence, bladder tracker, bowel continence, bowel movement, locomotion on and off the unit, personal hygiene, turn and repositioning, amount eaten, eating, fluid intake on the following days: 9/1 day and evening shift, 9/2 day and evening shift, 9/5 all 3 shifts, 9/6 evening shift, 9/7 all 3 shifts, 9/8 day shift, 9/9 day shift, 9/10 day shift, 9/11 day and evening shift, 9/12 evening shift, 9/13 day and evening shift, 9/14 evening shift, 9/17 all 3 shifts, 9/18 day and evening shift, 9/20 day and night shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Review of Resident #27's medical record on 9/21/21 at 9:30 AM revealed a quarterly MDS with an assessment reference date of 7/9/21 that documented Resident #27 was totally dependent on staff for bathing. Review of physician's orders for Resident #27 revealed that the resident was to receive a shower 2 times a week on day shift on Wednesday and Saturday. Review of the Shower Schedule revealed that Resident #27 received showers on Tuesday and Friday, however, nurses signed off that he/she was receiving showers on Wednesdays and Saturdays. Review of Shower Sheets for Resident #27 that were given to the surveyor on 9/22/21 revealed there were only 2 dates on showers sheets that were filled out for Resident #27. The dates were 7/16/21 and 7/13/21. Review of the GNA tasks for bathing for the previous 30 days revealed documentation that a bed bath was given on 8/20, 8/27, 9/3, 9/10, 9/14, 9/17 and 9/18. Resident #27 was only receiving a bed bath once a week until 9/14/21. 4) Review of the Station 3 shower schedule revealed that Resident #36 was scheduled to receive showers on Tuesday and Fridays during the evening shift. Review of the GNA shower book on the unit revealed no shower documentation for Resident #36. Review of the GNA tasks for bathing for September 2021 revealed no documentation that a shower was given as evidenced by blank spaces on 9/3, 9/7 and 9/17/21. 5) Review of the Station 3 shower schedule revealed that Resident #34 was scheduled to receive showers on Tuesday and Fridays during the evening shift. Review of the GNA shower book on the unit revealed the only shower documentation for Resident #36 was dated 9/10/21. Review of the GNA tasks for bathing for August and September 2021 revealed no documentation that a shower was given as evidenced by blank spaces on 8/20, 8/31, 9/7. Additionally, it was documented a bed bath was given, not a shower. There was no documentation that the resident refused to have a shower. Interview of Staff #4 on 9/15/21 at 10:25 AM revealed the shower sheet was to be completed by the GNA and kept in the paper file at the nurse's station. Staff #4 stated, the GNA should document both in the GNA tasks and shower log after they help residents with their shower. Interview of Staff #31 on 9/22/21 at 12:20 PM revealed, the GNA needs to complete the 'shower sheet' and save it in the shower book which is placed at the nurse's station. Staff #32 (GNA) stated, after we assist with a resident's shower, we fill out the shower sheet and document in the GNA task. The surveyor stated, so you mean the GNAs need to document on both the shower sheet and GNA task and the response was, yes, we document in both places. Discussed with the Nursing Home Administrator on 9/22/21 at 1:00 PM.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview, it was determined the facility failed to ensure that residents were seen timely by outside consultants, that diagnostics were performed and appointments were made urgently per physician's orders. This was evident for 4 (#1, #24, #8, #9) of 53 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #1's medical record on 9/9/21 at 8:15 AM revealed that Resident #1 was admitted to the facility on [DATE] for rehabilitation for bilateral lower extremity weakness, ambulatory dysfunction and pain, and a recent fall per a physician's history and physical dated 2/25/21. On 9/10/21 at 10:00 AM, an interview was conducted with Resident #1 who stated, I needed to see a neurologist and I didn't see one until August 2021. I need an MRI of my neck and spine, and they say I have to wait until next February 2022 to get into [name of hospital], so now it is going to be another 6 months until they figure out what my problem is, and it is delaying me from going home. An MRI (magnetic resonance imaging) is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body. Review of physician's orders for Resident #1 revealed that an order that was written on 3/22/21, schedule neurology appointment. A 7/1/21 Nurse Practitioner (NP) note documented, s/p (status post) ortho (orthopedic) pain consult. He is recommending MRI of C-spine. Resident is pending Neuro evaluation. Would be ideal to obtain MRI of C spine (and brain) prior yet resident with pacer. Will have to attempt to find Radiology place that can accommodate. Disc with resident and staff. A 8/12/21 NP note documented, Resident missed Neuro appt 2/2 (secondary to) transportation issue. [He/she] is asking the next step. Voicing concern over finding out what is wrong with [him/her]. Discussed need for imaging again with Ortho provider: imaging essential. Disc (discussed) with UM (unit manager) and order placed to obtain MRI Brain & C-spine with/without contrast @ either [name of hospital] or [name of hospital]. It was noted that this NP note was not written and placed in the medical record until 8/22/21 at 9:51 AM. Continued review of the medical record revealed the resident was seen by a neurologist on 8/20/21 and a neurology consult report dated 8/20/21 documented, MRI c-spine w/o contrast, URGENT at [name of hospital] and referral to spine surgeon, URGENT at [name of hospital]. A physician's order was written on 8/20/21 that stated, MRI C-Spine w/o contrast urgent at [name of facility] one time for cervical stenosis. On 9/15/21 at 9:52 AM, Staff #33, RN unit manager was asked about Resident #1. Staff #33 stated the resident was slow with therapy. The surveyor asked about the neurology appointment and Staff #3 stated she had to investigate it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/21 at 11:47 AM, the surveyor asked Staff #33 if there was any update related to the neurology appointment. Staff #33 said, with the original appointment there was a misunderstanding with the appointment and that was with the old scheduler who is no longer here. She left in June. Staff #33 stated she called a day or 2 after 8/20/21 to [name of hospital] and was able to get an appointment for February 3, 2022. When asked why Resident #1 had to wait an additional 6 months, Staff #33 said, because the resident has a pacemaker, and they need a specialized machine and [name of hospital] is 6 months out. The surveyor asked, even for an emergent request. Staff #33 said, yes. The surveyor asked if she notified the doctor because there was no documentation in the medical record that the physician was notified that it would take another 6 months for an urgent request. She said she spoke to the physician about it and will document it today (9/15/21). The surveyor asked Staff #33 when the physician was notified and she stated, before I went out on leave on September 1. An interview was conducted with Staff #35 on 9/15/21 at 12:50 PM who stated Resident #1, had issues with his/her neck and was waiting for spinal surgery. We are doing range of motion passive and active, working on trunk strength, bed mobility. Staff #35 stated that therapy recommended that Resident #1 see a neurologist. The surveyor asked if Staff #35 was concerned because there had been no follow-up on making the neurologist appointment. Staff #35 stated, yes, the patient was asking about it, the nurse and the Nurse Practitioner. We initiated the request from evaluations and as time went on, we asked again and again, and we were always waiting for information. Staff #35 stated, that is why I have not discontinued his/her therapy because I didn't want him/her to lose his/her strength. On 9/15/21 at 1:10 PM, an interview was conducted with Staff #36 (Nurse Practitioner). Staff #36 stated she just started in July 2021 and only saw the resident one time on 8/10/21 for chronic disease management. Staff #36 stated she was not aware of the neurology appointment, that she saw the resident for another issue. When the surveyor showed Staff #36 the urgent request, Staff #36 said it was not acceptable to wait to call and make the appointment 2 days after the order was written. On 9/15/21 at 2:48 PM an interview was conducted with Staff #38 (physician). When asked about Resident #1's neurology appointment, Staff #38 stated he was told that a neurology appointment at [name of hospital] was scheduled. The surveyor asked if he was aware of the date of the appointment. Staff #38 said, no. The surveyor informed him the appointment was not until February 2022. Staff #38 stated, That's new to me. The surveyor asked if he expected the resident to be seen sooner since it was urgent, and he said yes. Staff #38 stated, my expectation was urgently as possible. I was not notified that [he/she] was not being seen urgently. Staff #38 stated, I will be calling the facility immediately to handle this. 43096 2) Resident #24's medical record was reviewed on 9/21/21 at 8:50 AM. A review of a neurology consultation, dated 5/26/2021, revealed that additional testing needed that included an MRI of the brain. In addition, after the resident's MRI was completed, the resident was to have a follow-up visit scheduled for the week of 6/25/2021. A further review noted that the MRI was conducted on 7/21/21, however, as of 9/22/21, the follow-up visit with the neurologist had not been arranged by the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/21/21 at 11:00 AM, an interview was conducted with a Staff #4 (LPN). During the interview, Staff #4 stated that she was not sure if the MRI testing was done for the resident, however, if Resident #24 had the MRI, the result would be filed in a paper copy of the medical record. On 9/21/21 at 2:10 PM, an interview was conducted with the interim Director of Nursing (Staff #8). During the interview, Staff #8 stated that The staff member responsible for scheduling appointments has not been here for a few months, so the facility staff is catching up on scheduling resident appointments. I'm not sure how it (Resident #24's follow-up appointment) was missed. 31982 3) Review of Facility Reported Incident #MD00163807 on 9/14/21 at 1:00 PM revealed that, on 2/12/21 at 4:00 AM, Resident #9 was observed lying in the bed with Resident #8. The residents were both assessed to have no injury, their responsible parties were notified as well as the physician, interventions were put into place and the facility investigated the incident. Review of the facility investigative documentation revealed that physician orders for psychiatric consults were written on 2/12/21 at 12:19 PM for Resident #8, and on 2/12/21 at 12:35 PM for Resident #9. The documentation reviewed included a report of a psychiatric consult that was conducted on 2/16/21 for Resident #9., however,a review of Resident #8's medical record documentation failed to reveal that a psychiatric consult was obtained for Resident #8. The Administrator was made aware of these concerns on 9/16/21 at 8:12 AM. She indicated that she would see if she could find that the consult was done. No evidence was provided to the surveyor to indicate that a psychiatric consult was obtained for Resident #8 as ordered.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 43096 Based on record review, observation, and staff interview, it was determined that the facility staff failed to put measures in place to safely provide care for a resident by failing to ensure that specialty bed mattresses were properly secured on bed frames and failing to follow the specified number of staff support needed when providing care for residents. This resulted in the resident falling out of the bed and sustaining a fractured shoulder. This was found to be true for 1 of 5 (Resident #5) residents reviewed for accident hazards during the survey. The findings include: A care plan is a guide that addresses the needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. A Minimum Data Set (MDS) is a comprehensive assessment of the resident completed by the facility staff. The MDS is a multi-disciplinarian tool that allows many facets of the resident's care. One of the sections of the MDS is Activities of Daily Living (ADLs) which are tasks related to everyday life, (eating, bathing, dressing, toileting and transferring). The ADL score reviews each ADLs, to assess the resident's self-performance and determine the amount of staff support needed to perform each task. On 9/14/21 at 12:15 PM, during a tour on the Station 3-Unit, a resident reported to surveyors that a staff member dropped Resident #5 off the bed and broke his/her arm. A review of Resident #5's medical record was conducted on 9/14/21 at 12:15 PM. The resident was admitted to the facility with diagnoses that included a history of a traumatic brain injury from a motor vehicle collision that left them paralyzed on the right side of their body. Review of section G of the quarterly MDS assessment, dated 5/11/21, revealed documentation that Resident #5 had upper and lower extremity impairments on one side that required total care (assistance of 2 or more staff) for their bed mobility and transfers. Further medical record review revealed that Resident #5 had a fall on 1/21/2020. A progress note, dated 1/21/20 at 5:15 AM, indicated that Resident #5 had rolled off the bed when a GNA turned the resident to provide care. The fall resulted in a medium size hematoma to the resident's right upper forehead. A progress note, dated 1/22/20 at 10:16 AM, stated the mattress was not supported by the bedframe. Related to this fall, the care plan interventions included: Maintenance to check Resident's bed daily, initiated on 1/22/2020 and Maintenance to evaluate Resident's bed, initiated on 1/21/2020. On 9/15/21 at 2:45 PM, review of the facility's Occurrence and Occurrence Follow-up Report, dated 6/24/21, revealed that Geriatric Nursing Assistant (GNA) #23 provided morning hygiene care for Resident #5 by him/herself on 6/24/21. During the care, the GNA asked the resident to assist by turning to their side. When the resident turned, the mattress slid from off the bed and the resident fell to the floor and hit their shoulder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of the medical record revealed a Nurse Practitioner's (NP# 33) note, dated 6/24/21 at 10:09 AM that indicated the resident had a left fractured shoulder requiring the provision of pain management with medication. A review of Resident #5's care plan, on 9/16/21 at 1:52 PM, revealed that care plan interventions dated 4/28/21, for Activities of Daily Living (ADL) care stated that Resident was dependent on staff for getting out of bed early in the morning and for it to be performed by night shift (total dependence on 2 staff using a mechanical lift device for transfers). On 9/16/21 at 11:08 AM, an interview was conducted with Maintenance Supervisor (staff #27). He explained that Resident #5 was in a used Bariatric (extra wide) bed when the fall occurred. The bed had support extensions that held the bed in place. However, for an unknown reason, the support springs were not there, which caused the mattress to slip off the bed on 6/24/21. During an interview conducted with Staff #27 on 9/17/21 at 11:00 AM, he stated that although the maintenance team does routine bed inspections, he had not done daily bed checks for Resident #5. However, he was unable to provide evidence that any inspections of Resident #5's mattress was done by the maintenance team since the care plan intervention was initiated on 1/21/20. An interview was conducted with the Resident #5's nightshift GNA (#23) on 9/16/21 at 6:58 AM regarding the 6/24/21 fall. GNA #23 stated that Resident #5 required total care for bed mobility, ADL care, and hygiene. They added that there was a book at the nurse's station that described the care needed for each resident on the unit. Although GNA #23 was aware that the resident required 2 staff members for the resident's bed mobility, they turned the resident without assistance from another GNA because they were able to do it on their own. However, during interviews with Resident #5's Licensed Practical Nurses (LPN #22) and LPN #2 on 9/16/21 at 7:05 AM, they indicated that there was no book as described by GNA #23 on the unit, however, it was expected that the nursing staff refer to the residents' individual care plans and the residents' Treatment Administration Records (TARs) to inform them of the type and the number of staff assistance that was needed to provide daily ADL care for residents. On 9/22/21 at 09:15 AM, the Nursing Home Administrator (NHA) and Corporate Strike Team Member (Staff #30) requested an interview with the surveyor team. During the interview, Staff #30 stated that there was an additional ADL care plan, dated 12/29/19, for Resident #5. This care plan indicated the resident required one person assistance with ADL care, however, the quarterly MDS assessment for Resident #5 that was completed 5/11/21 had documentation that the resident required total care (assistance of two or more staff) for their bed mobility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review, staff interview, and observation, it was determined that the facility failed to 1) follow hospital discharge instructions for a follow-up appointment with a urologist 1 week after discharge from the hospital, 2) ensure that a resident admitted to the facility with a urinary catheter was comprehensively assessed to continue with a foley catheter, 3) develop a care plan which included the use of the catheter and associated interventions and 4) follow infection control guidelines related to the care of the urinary catheter. The failure of the facility to assess the foley catheter usage placed the resident at risk for infection. This was evident for 2 (#51, #52) of 5 residents reviewed for foley catheters during a complaint survey. The findings include: 1) Review of Resident #51's medical record on 9/20/21 at 11:55 AM revealed the resident was admitted to the facility on [DATE] from an acute care facility with diagnoses including, but not limited to, sepsis, type 2 diabetes mellitus, obstructive and reflux uropathy and tubulo-interstitial nephritis. Obstructive uropathy occurs when urine cannot drain through the urinary tract. Urine backs up into the kidney and causes it to become swollen. Reflux nephropathy is a condition in which the kidneys are damaged by the backward flow of urine into the kidney. Interstitial nephritis is a kidney disorder in which the spaces between the kidney tubules become swollen (inflamed). Review of the hospital discharge summary, dated 8/5/21, revealed that a foley catheter was applied to the resident in the emergency department, over 1 liter of urine was removed, and the resident was severely dehydrated and was diagnosed with sepsis. Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. The hospital discharge instructions stated, follow-up with [name of urology practice] in 1 week and to keep the foley catheter in until seen by urology. A Foley catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. Over 6 weeks had passed since the resident was admitted to the facility and there was no documentation in the medical record that the resident was sent to the urology appointment. An interview was conducted with Staff #33 (unit manager) on 9/20/21 at 3:05 PM who stated, the appointment scheduler quit, and we couldn't find who had already gone out on appointments and who had not. Then after 14 days the resident was sent downstairs to the other unit. There was no follow-up done by nursing. Continued review of the medical record revealed that the resident was seen by the attending physician (Staff #34) on 8/8/21. There was no documentation in the physician's history and physical about a foley catheter. The physician documented, urinary: (-) dysuria. Dysuria is painful or difficult urination. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was seen again by Staff #34 on 8/15/21 for a weekly visit and documented, Patient presents for follow-up evaluation and ongoing management. No change in management at this time. Again, there was no documentation about a foley catheter. An interview was conducted on 9/21/21 at 12:12 PM with Staff #34 (physician). Staff #34 stated, it would be the floor manager's responsibility to set up a 3 day trial regarding if the foley catheter needs to remain in place. Staff #34 stated it was customary to see a foley catheter in patients. The surveyor asked Staff #34 if he knew that Resident #51 was supposed to have a urology consult 1 week after discharge. Staff #34's response was, no. Cross Reference F710 Continued review of the medical record failed to produce any bladder assessments done by nursing or any documentation that the nursing staff questioned the continued use of a urinary catheter. Review of the care plan section of the medical record failed to produce a care plan for a urinary catheter which would have been a person centered guide staff could have used to determine the resident's goals and interventions for the use of the catheter. Furthermore, it was observed on 9/17/21 at 2:16 PM of Resident #51 lying in bed with a foley catheter bag lying on the floor in a covered bag with the top of the covered bag open. Allowing the urinary catheter bag to lie directly on the floor placed Resident #51, who had been admitted to the facility after having sepsis, at risk for infection as germs could travel from the floor along the catheter to the point of entry into the bladder and cause infection. 2) Observation was made on 9/17/21 at 1:40 PM of Resident #52 lying in bed. Resident #52's foley catheter bag was lying on the floor wedged under the frame of the over the bed tray table. There were 600 cc. or urine in the bag. A second observation was made on 2:16 PM and the bag was still in the same position and had not been emptied. The resident was left vulnerable for infection as the urinary bag was left on the floor, susceptible to other organisms. Review of Resident #52's medical record on 9/20/21 at 10:40 AM revealed that Resident #52 was admitted to the facility on [DATE] from an acute care facility with diagnoses that included but were not limited to respiratory failure, sepsis, pneumonia due to COVID-19, and obstructive and reflux uropathy. Continued review of Resident #52's medical record revealed a care plan that was initiated on 9/12/21, Indwelling Supra pubic Catheter, Obstructive Uropathy. The care plan should have been for a regular urinary catheter that was inserted into the bladder through the urethra (the tube that carries urine out of the body). A suprapubic catheter is a type of catheter that is left in place. Rather than being inserted through the urethra, the catheter is inserted through a hole in the abdomen and that goes directly into the bladder. Observation was made by 2 surveyors on 9/21/21 at 9:40 AM of Resident #52 lying in bed eating breakfast. The foley catheter had been removed. Interview of Resident #52 revealed the foley catheter was removed yesterday before dinner. There was no documentation in the medical record that the catheter was removed, there was no order for the catheter to be removed and the nurses signed off that foley catheter care was given every shift on 9/20/21 and overnight. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discussed with the NHA on 9/21/21 at 9:37 AM. During an interview on 9/21/21 at 10:22 AM with Staff #33, RN unit manager, he/she revealed he/she was with the nurse when he/she got the order to discontinue the foley catheter. The surveyor informed Staff #33 that there was no order in the medical record, no documentation, and no assessment. Staff #33 looked through the medical record and confirmed that nothing was documented. The surveyor asked Staff #33 how the nursing staff monitored Resident #52's urinary output once the catheter was removed. Staff #33 stated, they monitor the resident for voiding by counting the diapers. There was no documentation that the resident was monitored for voiding.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation, medical record review and staff interview, it was determined that the facility failed to ensure that a physician supervised the care of a resident as evidenced by the physician's failure to evaluate a resident to determine if the foley catheter that the resident was admitted with, needed to remain as part of their treatment. This was evident for 1 (#51) of 2 residents reviewed for foley catheters during a complaint survey. The findings include: Observation was made on 9/17/21 at 2:16 PM of Resident #51 lying in bed with a foley catheter bag lying on the floor in a covered bag with the top of the covered bag open. A Foley catheter is a flexible tube applied to the body which is used to empty the bladder and collect urine in a drainage bag. Review of Resident #51's medical record, on 9/20/21 at 11:55 AM, revealed that the resident was admitted to the facility on [DATE] from an acute care facility with diagnoses including, but not limited to, sepsis, type 2 diabetes mellitus, obstructive and reflux uropathy and tubulo-interstitial nephritis. Obstructive uropathy occurs when urine cannot drain through the urinary tract. Urine backs up into the kidney and causes it to become swollen. Reflux nephropathy is a condition in which the kidneys are damaged by the backward flow of urine into the kidney. Interstitial nephritis is a kidney disorder in which the spaces between the kidney tubules become swollen (inflamed). Review of the hospital discharge summary, dated 8/5/21, documented that a foley catheter was applied to Resident #51 in the emergency department, that over 1 liter of urine was removed, and that the resident was determined to be severely dehydrated and was diagnosed with sepsis. Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. The hospital discharge instructions stated, follow-up with [name of urology practice] in 1 week and to keep the foley catheter in until seen by urology. Over 6 weeks had passed since the resident was admitted to the facility, and there was no documentation in the medical record that the resident was sent to the urology appointment. An interview was conducted with Staff #33 (unit manager) on 9/20/21 at 3:05 PM who stated, the appointment scheduler quit, and we couldn't find who had already gone out on appointments and who had not. Then after 14 days, the resident was sent downstairs to the other unit.There was no follow-up done by nursing regarding the resident's urology appointment. Continued review of the medical record revealed that the resident was seen by the attending physician (Staff #34) on 8/8/21. There was no documentation in the physician's history and physical about a foley catheter. The physician documented, urinary: (-) dysuria. Dysuria is painful or difficult urination. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/21, The resident was seen again by Staff #34 for a weekly visit and they documented, Patient presents for follow-up evaluation and ongoing management. No change in management at this time. An interview was conducted on 9/21/21 at 12:12 PM with Staff #34 (physician). Staff #34 was asked what his procedure was when a new admission came into the facility. Staff #34 stated that he gets sent the discharge paperwork and he will start his review at home so when he comes in to see the resident, he knows what he is looking at. Staff #34 stated that he goes through the whole discharge. Staff #34 stated, it would be the floor manager's responsibility to set up a 3 day trial regarding if the foley catheter needs to remain in place. Staff #34 stated it was customary to see a foley catheter in patients. The surveyor informed Staff #34 that both of his progress notes did not mention the foley catheter and questioned if he should have documented that, since he did a full body assessment. Staff #34 stated he does a head to toe assessment on his patients. Staff #34 stated, yes, I should have documented that. The surveyor asked Staff #34 if he knew that Resident #51 was supposed to have a urology consult 1 week after discharge. Staff #34's response was, no. The surveyor asked Staff #34 if he reviewed the discharge summary from the hospital and he said that he did. The Nursing Home Administrator was advised of the concern on 9/21/21 at 9:37 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 and/or certified registered nurse practitioner (CRNP) failed to write, sign and date medical visit progress notes in resident medical records the day the resident was seen. This was evident for 6 (#1, #30, #21, #40, #45, #35) of 53 residents reviewed during a complaint survey. The findings include: 1) Review of Resident #1's medical record on 9/9/21 at 8:15 AM revealed Nurse Practitioner (NP) visits dated 3/31/21, 4/7/21, 4/9/21, 4/12/21, 4/13/21, 4/19/21, 4/21/21, and 4/22/21 that were not printed off and placed in Resident #1's medical record until 5/18/21. The 4/27/21, 4/28/21, 5/12/21, and 5/14/21 visits were not printed off and placed in Resident #1's medical record until 5/19/21. A 6/7/21 visit was in the medical record on 6/14/21, a 6/15/21 visit was in the medical record on 6/27/21, a 7/12/21 visit was in the medical record on 7/25/21, a 7/21/21 note was in the medical record on 7/27/21 and an 8/12/21 note was in the medical record on 8/22/21. Review of physician visits for Resident #1 revealed the last physician's visit in the medical record was dated 4/29/21. 2) Review of Resident #30's medical record on 9/14/21 at 8:30 AM revealed the last physician's visit that was in the medical record was dated 5/27/21. 3) Review of Resident #21's medical record on 9/14/21 at 8:45 AM revealed the last physician's visit in the medical record was dated 4/19/21. 4) Review of Resident #40's medical record on 9/14/21 at 9:00 AM revealed the last physician's visit that was in the medical record was dated 2/25/21. Interview with Staff #4 on 9/14/21 at 12:54 PM confirmed that the above residents did not have physician visits in the medical record. 5) Review of Resident #45's medical record on 9/14/21 at 1:58 PM revealed an NP note dated 7/2/21 was not put into the medical record until 7/19/21. 6) Review of Resident #35's medical record on 9/22/21 at 8:36 AM revealed the last physician's note in the medical record was a History and Physical dated 3/2/21. There were no other physician's visits in the medical record. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/14/21 at 2:00 PM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA was informed of the concern that the physician had not seen the above residents. The NHA stated that the physicians document in another system (Kareo). The physicians are then supposed to cut and paste their notes into the facility's electronic medical record system. The NHA stated that the notes were probably there but not in the chart. The NHA stated that the physicians were in the building at least once or twice per week and a NP was in the building every day. The NHA stated there was a process in the electronic system to track the visits and that the Director of Nursing (DON), the Assistant Director of Nursing (ADON) or MDS Coordinator could pull the visits up. The NHA stated it would be the responsibility of a medical records (MR) staff member, but they currently did not have MR staff because the employee quit in June, therefore, medical records was behind. The NHA confirmed that all residents had recently been seen by the physician. Cross Reference F725

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation, family and resident interviews, medical record review and review of facility documents, it was determined that the facility failed to have sufficient nursing staff to meet the needs of the residents. This was evident for 16 (#39, #32, #1, #12, #31, #30, #29, #28, #27, #25, #24, #23, #22, #21, #35, #53,) of 17 resident interviews. This is a repeat deficiency from the last annual survey completed on 5/17/19 and complaint survey completed on 10/23/19. The findings include: Nine out of 22 complaints that the Office of Health Care Quality (OHCQ) received and reviewed on this complaint survey had to do with the facility not having sufficient nursing staff to provide essential care to the residents that resided at the facility. Complaints consisted of geriatric nursing assistants (GNAs) having 20 to 30 residents to take care of during any given shift. There were concerns that the residents were not receiving timely care, showers and were left in wet and soiled diapers and were in bed all day due to lack of staffing. Review of the Resident Census and Conditions CMS 672 form that was completed by the Interim Director of Nursing during the complaint survey indicated that 107 residents were either totally dependent on nursing staff for toileting or required the assistance of one or two nursing staff for assistance with toilet use. It was also documented that 110 of the 123 residents in the building were dependent on staff for bathing, 117 residents were totally dependent or required assistance of 1 to 2 staff for dressing, 103 residents required assistance for transferring and 99 of the 123 residents were either totally dependent or required assistance of 1 or 2 staff members for eating. There were 95 residents documented with occasional or frequent incontinence of the bladder and 95 residents documented on a urinary toileting program. Per the instructions on the CMS 672, a urinary toileting program is a systematically, implemented, individualized urinary toileting program (i.e. bladder rehabilitation/retraining, prompted voiding, habit training/scheduled voiding) to decrease or prevent urinary incontinence or minimizing or avoiding the negative consequences of incontinence. 1) Staffing Boards 1a) Surveyors entered the facility on 9/9/21 at 6:10 AM. Observation was made of the nursing staffing board on the first floor nursing unit for the 7:00 AM to 3:00 PM shift. There were 3 GNAs and 1 hospitality aide for 57 residents. The role of the hospitality aide was to answer call lights, pass water, pass food trays, and make beds. The ratio was 1 GNA for 19 residents for actual care. 2) Staff interviews (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2a) An interview was conducted on 9/9/21 at 6:16 AM with Staff #1. Staff #1 stated, Yes, we work short staffed. Sometimes I have 30 or more residents by myself. We are always short; the floor is consistently short. I get my work done and I turn and reposition my people. When you come on, you know you are going to be short and have to work at that pace. When I come on duty, there are residents that were not changed. There was a resident with feces all over and was eating it. I went and got the supervisor, and she made the nurses go in and clean the resident up and give the resident a bed bath. I don't remember the date. They allow the 3-11 GNAs to leave and not check to see if people have been changed. 2b) An interview was conducted on 9/9/21 at 6:25 AM with Staff #2 who stated, sometimes if we are short the only thing that may not get done is charting by the GNAs. When I come on duty, I hear complaints from residents who say they haven't been changed, their call light has been on a long time, dinner trays are still in the rooms and haven't been taken out. 2c) An interview was conducted on 9/9/21 at 11:04 AM with Staff #13 who stated, we are short staffed. We can't give showers, especially last week. I can have 24-25 residents. Somedays are very rough. I can only do the basic care. 2d) An interview was conducted on 9/9/21 at 11:09 AM with Staff #14 who stated, most days are a staffing challenge, more so on day shift. I see care not given. Call lights are on, and residents need care. The weekends are the worse. Some Sundays residents are in bed all day because there is not enough staff to get them up. Their nails are dirty, disheveled, and men are not getting shaved. 2e) An interview was conducted with Staff #11 on 9/9/21 at 11:24 AM. The staff member requested to remain anonymous for fear of retaliation. Staff #11 stated that nursing is routinely short staffed. Residents complain they cannot get up or get changed. GNAs tell the residents that they are short and can't get the residents up. Some residents told Staff #11 that Resident #34 was so soiled it was down his/her legs, up his/her arms and back on Sunday. Residents were upset about it according to Staff #11. 2f) Staff #10 was interviewed on 9/10/21 at 10:07 AM and stated that she was from the staffing agency and usually worked at the facility 5 days a week. Staff #10 stated she usually had 14 to 16 patients on the skilled unit during day shift. 2g) Staff #6 was interviewed on 9/13/21 at 9:22 AM and stated, go talk to the ladies in that room over there, they will tell you. When you have 20 to 30 people you can't give care. You can't change them every 2 to 3 hours. The posted staffing is always incorrect. They put people's names on the board when they aren't here. 2h) Staff #39 was interviewed on 9/13/21 at 11:11 AM and stated, they have been working with 3 GNAs. Once in a while it is 2 GNAs. A couple of times in the past 3 weeks we have only had 2 GNAs on day shift. We get new admissions. We are short on the weekends and the supervisor has to work the floor. 2i) On 9/14/21 at 8:35 AM, an interview was conducted with Staff #14 who stated, yes, we are short staffed. There are 2 GNAs with 60 residents. The schedules that they put up are inaccurate. The residents complain of laying in urine and feces. There is a lack of care. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2j) On 9/15/21 at 7:37 AM, Staff #16 was interviewed and stated, we are short staffed. When 11-7 works short they let us know who didn't get changed on second rounds. We then also have to go get new pullups and soap to stock up on. 2k) On 9/17/21 at 7:15 AM, Staff #26 was interviewed and stated she works as needed. Most of the time they do not have enough staffing. On night shift there are 2 GNAs and 2 nurses. The care is not good. The GNAs do not do many rounds. Sometimes 2 rounds per shift on nights but mostly 1. It depends on who the aide is. We tell the agency GNAs to do 3 rounds and they don't do them. When the aides first get here, they may do rounds when they do vitals. Then they will do rounds around 4:30 AM to 5:00 AM, which is still not sufficient. The aides usually have 20-25 patients, and they can't get everything done and people do not come in on time. It is unsafe because we will do narcotic count with the nurse that is going off and then the nurse coming on will pick up the keys from the other nurse. An observation on the second floor nursing unit on 9/17/21 at 7:23 AM revealed there was 1 nurse for day shift on the unit. The 2 night shift nurses had to wait for the rest of day shift to get in. At 7:30 AM, they were still waiting for 2 day shift nurses. 2l) An interview was conducted on 9/17/21 at 7:30 AM with Staff #25 who was an agency nurse. Staff #25 stated that she sometimes will work at the facility 3 days a week. Staff #25 said they work short staffed. Staff #25 said, patient care suffers. They don't get up in the morning, there is no bathing. I also work as a GNA on the floor. Regarding rounds it depends on the GNA. Usually only 1 round is done on the residents. Aides let the call bell ring so the nurses will have to answer them. An observation on 9/17/21 at 7:35 AM on the second floor nursing unit revealed that a nurse was pulled from the first floor unit to the second floor unit. There were only 2 GNAs on the floor at that time with a hospitality aide. They were still waiting for the third GNA and the third nurse who showed up at 7:50 AM. 2m) On 9/17/21 at 10:20 AM, Staff #14 stated, Resident #47's daughter had a lot of concerns about the resident not being bathed and that it was written and expressed to the nurse supervisor. [He/she] is a compassionate care and the daughters see what is going on and not going on. Every day [he/she] gets Door Dash from [name of fast food restaurant] and a soda and it will sit on the weekends at the front desk, and she (the daughter) will call in on the weekends and the phone rings and rings. [He/she] needs someone to cut the cheeseburger and put it in [his/her] hand. 3) Resident interviews 3a) On 9/9/21 at 11:15 AM, Resident #39 stated, yes they are short staffed. I have to wait and hour to an hour and 1/2 for the call bell to be answered. Forget 11 to 7 because you will sit forever; 3 to 11 you wait a while and the staff complains. need help wiping and by them not answering the call bell I sit in poop for 8 hrs. Until 11-7 came in I have to get washcloths and put on my gripper and hold onto the walker. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3i) On 9/13/21 at 9:40 AM, Resident #27 stated, they are short staffed and need more help. We have to wait over an hour or longer for the call bell to be answered. I wear a diaper and have to wait a long time. It is not a good feeling. I sometimes wait 3 hours, sometimes 6 hours. I would like to get the aides to lay in bed and lay in poop for 6 hours and tell me how they feel. Resident #29, #28 and #27, all roommates stated on 9/13/21 at 9:43 AM that they had not seen a GNA since before 7:00 AM They only saw a nurse who came in to pass meds. 3j) Resident #25 was interviewed on 9/13/21 at 9:53 AM and stated, they are short staffed. Sometimes I wait 40 minutes for someone to come in. 3k) Resident #24 was interviewed on 9/13/21 at 1:03 PM and stated, the care is poor. When you need something, you have to wait. I needed pain medicine for my foot and the patches changed. She (nurse) said she would be back, and I haven't seen her since. The call light is on over an hour before anyone comes in. 3l) Resident #23 stated on 9/13/21 at 1:10 PM, Yes, they are short staffed. I can't get my nails trimmed. Look at this. The resident showed the surveyor a long nail on the pinky finger. They don't answer the call bell. 3m) Resident #22 stated on 9/13/21 at 1:14 PM, you wait, wait, wait. The resident had a hard time talking due to a stroke and was stuttering and anxious when telling the surveyor about staffing. The nurses and techs are downright obnoxious. You can ask for something and they seem to forget as soon as they walk out of the room. Then you have to call again and wait another hour or two. During shift change they don't introduce self to me. Sometimes I haven't seen a GNA all day. 3n) Resident #21 stated on 9/13/21 at 1:16 PM, Nursing and the doctor leaves a lot to be desired. I put the call bell on, and it takes a couple of hours. People walk by and wave and keep going. I have accidents. I don't feel good about it. It is embarrassing when you go in your pants. They told my roommate, the resident who used to be next to me (Resident #22); they told [him/her] to just go in [his/her] pants. I'm a grown man and it is inhumane. I was left to lay soiled 30 hours and my wife had to call. They deliver food but no one changes me until my wife called the front desk. 3o) Resident #35 was interviewed on 9/17/21 at 10:52 AM and stated, I have to wait and wait to get water to wash up. I am pretty independent. I am speaking for everyone. We wait too long to be changed. There is a staffing problem. I am still waiting to be washed up and it is 10:52 AM. The GNA will walk in and say I will tell your aide. They are supposed to help when they come in. We don't know who the nurse or aide is on any given day. I toilet myself because they don't come quick enough. When Resident #35 was asked if he/she missed the ice cream social because they were short staffed the response was, I took a French Whore bath. I did go to the ice cream social; I did not miss going but I could not go smelling. There are people sitting in bed over the holiday weekend and not being changed. They are short staffed at least 3-4 days a week. The weekends vary. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3p) On 9/17/21 at 11:04 AM an interview was conducted with Resident #53 who confirmed the short staffing. Resident #53 stated, there was a day we stayed in bed all day during day shift. The care is spotty. There are not enough aides available. One time I was left for 24 hours before being changed. I was leaking and felt filthy. I was all wet. The 2 staff that changed me, I didn't know if they were angry with me because they were speaking in a different language that I could not understand. Resident #53 continued, I was changed at 9AM this morning. I then am supposed to get changed around 3 pm and before I go to sleep. The other night it was past 11 pm. I was so tired but couldn't fall asleep until I was changed. 4) Family members 4a) On 9/13/21 at 1:41 PM Resident #21's family member stated, I came in on 9/7/21 at 3:30 PM. [His/her bag (colostomy) and diaper from all night had not been changed. No shower. I called the NHA, and she came. On 9/11/21 at 2:49 PM, my [Resident #21] called me and said [he/she] turned the call bell on at 1:40 PM, that the bag needed to be emptied. At 2:51 PM, I called station 3 about it. At 4:35 PM [Resident #21] called me again and said it still had not been emptied. I called the desk again and no one answered. I left a voice mail message for someone else. I called again at 4:42, 4:45 and 4:48 and the phone rang 30 times, and no one answered. My [Resident #21] called and said at 5:10 PM (name of GNA) came in and said, don't worry, I'll take care of you, and he cleaned [him/her] up and changed the bag. I don't know what else to do. [Resident #21] is susceptible to falls. We came to an agreement to check the bag every 2 hours. [His/her] skin is sensitive. 4b) Resident #47's family member was interviewed on 9/17/21 at 12:57 PM who stated, since the Pandemic, [he/she] goes days without a bath, as many as 4 -5 days, which is completely unacceptable. There was an episode a couple of weeks ago when I had lunch sent to [him/her] from [name of restaurant]. The coke was accidentally dumped over into [his/her] lap. The aide refused to clean [him/her] up and change [his/her] clothes saying [he/she] spilled the soda on [him/herself]. It really didn't matter who spilled it what mattered was that [resident #47] was soaking wet and needed to be cleaned up. I had to call the center several times before someone answered and then no one at the nurse's station would answer either. I had to call several times before I was finally connected to the nurse's administrator, by this time I was furious that [resident #47] was left to fend for [him/herself] and was crying [his/her] eyes out that [he/she] was freezing and soaked. The administrator on duty ended up having to go down and clean up [resident #47]. I then called social work's extension and left a message as to what happened. She called me the next day and said she would write up another complaint. She has had to write up several complaints over the past year in reference to [resident #47's] treatment or lack thereof. She continued, this is completely unacceptable. 5) Observations 5a) Observation was made on 9/13/21 of the call light ringing for room [ROOM NUMBER] from 9:45 AM to 10:03 AM which was 18 minutes. 5b) Observation was made on 9/13/21 of the call light ringing for room [ROOM NUMBER] from 10:01 AM to 10:17 AM which was 16 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5c) Observation was made on 9/13/21 of the call light ringing for room [ROOM NUMBER] from 10:37 AM to 10:51 AM which was 14 minutes and the call light for room [ROOM NUMBER] from ringing from 10:54 AM to 11:06 AM which was 12 minutes. During the observation the interim Director of Nursing and a nurse were standing by the nurse's station while the call lights were ringing. 6) Appointments and medical records 6a) On 9/13/21 at 8:47 AM, an interview was conducted with the Nursing Home Administrator (NHA), Staff #37 regarding who was responsible for making appointments for the residents. The NHA stated, the unit managers or hospitality aides on light duty. It was the medical records staff member, but that position is now vacant. When asked how long the position has been vacant the NHA stated, 60 days but might be longer than that. Cross reference F684 6b) An interview was conducted with Staff #20, the Social Services Director on 9/15/21 at 10:15 AM. She confirmed that Resident #12's certifications of incapacity were not filed in the residents medical record and were in the to be filed. She indicated that Resident #12 and several other residents were evaluated by Psychogeriatric services and the medical director on 8/13/21 and their certificates of incapacity were completed that day. When asked to explain what the to be filed is, she explained that there were bins used by Social Service for documents that need to be filed. She explained that the facility did not have a medical records person, and a medical records consultant comes in from time to time. She stated, we file as much as we can, the receptionist does some to help out. When asked how soon she expected certifications of incapacity to be filed in the resident's medical records she stated immediately then went on to say there are many healthcare challenges right now, all departments are assisting with answering call bells and assisting to meet the resident's needs, and these things were more important than filing right now. Upon inquiry, the surveyor was provided with 2 certificates of incapacity for all 8 residents signed and dated by the physicians on 8/13/21. Cross Reference F842 7) Scheduling of Staff and schedules 6a) On 9/15/21 at 7:53 AM an interview was conducted with Staff #19 with the interim DON present. Staff #19 stated she is responsible for scheduling the nursing staff in addition to working the floor as a GNA. Staff #19 stated, in the morning I am in and out, between the office and working the floor. Usually Mondays and Fridays. The surveyor expressed concern because the actual worked nursing schedules that the surveyor had requested along with staffing assignment sheets did not match. Staff #19 stated that the schedules that the surveyor was given were not completed and were not the actual worked schedules that the surveyor asked for. She stated the actual worked schedules are in a computerized system on-shift that had been down for 2 days. She said the NHA said to just give the surveyor what you have. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When Staff #19 was asked about staffing the units she said, we can use 4 GNAs for station 3 (the first floor unit) if the facility census is between 117-127 residents and up to 5 in the morning, 4 in the evening and 3 overnight if higher. This started a year ago. If it falls below 117 it depends. For full downstairs on station 3 that would equal 63 beds. When asked if a census of 60 residents on a unit would be considered full, she said, yes and we could have 5 GNAs during the day. Staff #19 stated there were usually 3 GNAs working and 1 GNA that would go out with a resident to dialysis. Staff #19 stated, 3 GNAs for 60 residents is considered short and it is all hands on deck. Station 1 and 2 (the second floor unit) is 3 GNAs during the day depending on the census. ACU (dementia unit) 24 beds is 2 GNAs for days, 2 for evenings and 1 for night. 7b) Review of the staffing assignment sheets along with the actual worked scheduled revealed the following staffing concerns. Day Shift: 7:00 AM to 3:00 PM Evening Shift: 3:00 PM to 11:00 PM Night Shift: 11:00 PM to 7:00 AM Hospitality Aide job duties: pass water, beverages, answer call lights, make beds per interview of the hospitality aide. A sample for the scheduling in July 2021 revealed staffing for the day shift on the first floor was consistent for 3 GNAs to 58 residents for a 1:19 staff to resident ratio. 7/17/21: Day shift Station 3: 3 GNAs for 58 residents which equaled a 1 to 19 staff to resident ratio. 7/18/21: Day shift Station 1 and 2: 2 GNAs and 1 hospitality aide for 41 residents which equaled 1 to 20 staff to resident ratio for actual care. For the night shift, there was 1 LPN (agency) and the RN supervisor who was also the nurse on the ACU (dementia) unit for 24 residents, was responsible for the other half of residents for Station 1 and 2, and was supervisor for the entire facility. 7/18/21: Day and evening shift Station 3: 3 GNAs for 58 residents, 1:19 staff to resident ratio, night shift 1:29 ratio. 7/19/21: Day shift Station 3: 3 GNAs for 58 residents, 1:19 ratio, night shift 2 GNAs for 58 residents, 1:29 ratio. A sample of the scheduling in August 2021 revealed the following: 8/1/21: Station 1 and 2: Day shift census: 47 3 GNAs equals 1:15 ratio 8/1/21: Station 3: Day shift census: 60 2 GNAs and 1 hospitality aide equals 1:30 ratio for actual care. Night shift: census: 60 1 GNA for the entire unit with 2 nurses equals 1:60 GNA to resident ratio. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8/2/21: Station 1 and 2: Day and evening shift census 47: 2 GNAs equals 1:23.5 ratio, Night shift 1 GNA for 47 residents along with 2 nurses. 8/2/21: Station 3: Day and evening shift census 60: 3 GNAs and 1 hospitality aide equals 1:20 GNA ratio for actual care. There was no hospitality aide on evening shift and night shift had 1 GNA for 60 residents along with 2 nurses. 8/5/21: Station 3: Day shift 3 GNAs and 1 hospitality aide for 61 residents equaled 1:20 ratio. 8/5/21: Station 1 and 2: Day shift 2 GNAs and 1 hospitality aide for 45 residents equaled a 1:22.5 ratio for actual care given. 8) Facility Assessment The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. This must be done annually or sooner if needed. On 9/15/21 at 9:25 AM, the NHA gave the surveyor a copy of the facility assessment. The facility assessment tool was just completed for the period 9/2021 through 8/2022. The date of the assessment or update was dated September 5, 2021, and the date assessment reviewed with QAA/QAPI committee was signed September 21, 2021. The facility's average daily census was 125. The assessment documented the facility resources that were needed to provide competent support and care for the resident population every day and during emergencies: The staffing plan model was based off historical needs. This model was used by the scheduler to create the initial work schedules. The assessment documented that factors such as census, patient acuity, and other patient needs may affect the schedules. Licensed nurses, 10 to 12 was the average number needed , nurse aides 26 to 28. The staffing plan for licensed nurses providing direct care was RN or LPN charge (1) for each shift: 1:27 LPN ratio days and evenings 1:32 LPN ratio nights 1:10 days for direct care staff (GNA) 1:12-18 ratio evenings 1:22-27 ratio nights During the 10 days that the surveyors were on site there was never a 1:10 GNA to resident ratio during day shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor discussed all the concerns with the Nursing Home Administrator several times during the survey and during the exit conference on 9/22/21 at 1:15 PM.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 31145 Based on documentation review and staff interview, it was determined the facility failed to retain complete and accurate posted daily nurse staffing data. This was evident for nursing schedules and assignment sheets reviewed from July 17, 2021, to September 8, 2021. The findings include: On 9/9/21 at 9:15 AM, the surveyor requested from the Nursing Home Administrator (NHA) the actual worked nursing schedules for the time 7/17/21 to 9/8/21 along with the daily assignment sheets for each nursing unit. The schedules and staff assignment sheets were reviewed on 9/14/21. The findings were as followed: 1) There was no resident census documented on the nursing schedules. The NHA had to hand write the census upon surveyor request. 2) The staffing schedule and the assignment sheets failed to have the nursing hours or resident to staff ratios. 3) Upon review of the actual worked staffing schedules, the surveyor had to compare the staffing schedules to the assignment sheets. There were vacancies on the actual worked staffing schedules that were given to the surveyor for every day from 7/17/21 to 9/8/21. There were also discrepancies comparing the staffing sheets to the schedules. Upon interview of the NHA and staffing scheduler, it was determined the staffing scheduler had not had time to go back and fill in the vacancies on the schedule. 4) On 9/15/21 at 7:53 AM, an interview was conducted with Staff #19 (staffing scheduler and GNA) along with the Interim Director of Nursing (DON) present. Staff #19 stated she did the schedules and worked the floor as a GNA (geriatric nursing assistant). Staff #19 stated, in the morning I am in and out between the office and working the floor. Usually Mondays and Fridays. Staff #19 stated that the schedules that the surveyor was given were not completed or the actual worked schedules that the surveyor asked for. Staff #19 stated the actual worked schedules were in a computerized system on-shift that had been down for 2 days. Staff #19 said, the NHA said to just give the surveyor what you have. When asked about staffing the units, Staff #19 said we can use 4 GNAs for station 3 if the facility census is between 117-127 and up to 5 in the morning, 4 in the evening and 3 overnight. This started a year ago. If it falls below 117 it depends. For full downstairs on station 3, that would equal 63 beds. When asked if a census of 60 residents would be considered full, she said yes, and they could have 5 GNAs during the day. Staff #19 said there were usually 3 GNAs and 1 GNA that goes out with dialysis residents. Staff #19 stated, 3 GNAs for 20 residents is considered short and it is all hands on deck. Station 1&2 is 3 GNAs during the day depending on the census. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/15/21 at 8:27 AM, the NHA came in and asked what was needed related to the schedules. The surveyor explained that the request was for the actual worked nursing schedules with the assignment sheets from July 15, 2021, to September 9, 2021. What was given to the surveyor were schedules that were not complete and did not match the assignment sheets. The NHA agreed that the schedules should have matched the assignment sheets. On 9/15/21 at 9:10 AM, a discussion was held with the NHA regarding what the requirements were for 18 months of actual worked nursing schedules that were to be retained. The NHA stated she now understood what needs to be retained.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 31145 Based on observation, staff interview and medical record review, it was determined the facility failed to provide person-centered care to a resident with dementia and failed to have a specific care plan for dementia. This was evident for 1 (#45) of 2 residents observed with a behavioral issue during a complaint survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Observation was made on 9/14/21 at 1:55 PM of Staff #46 (geriatric nursing assistant, GNA) wheeling Resident #45 at a fast speed in a wheelchair around the station 1 and 2 nurse's station, through the lobby and over to the receptionist desk. Resident #45 was yelling/screaming loudly while being pushed in the wheelchair. Observation was made of Staff #46 pulling the resident backwards at a fast rate of speed across the lobby while the resident was still screaming . At that time, Staff #14 intervened and asked Staff #46 to turn the resident's wheelchair around towards Staff #14. Staff #14 calmly spoke to the resident. At that time, the surveyor approached the Nursing Home Administrator (NHA) and informed her of the observation of the speed that Staff #46 was pushing the elderly resident in the wheelchair. The NHA came back to the conference room on 9/14/21 at 2:48 PM and informed the surveyor that she had interviewed a couple of people and stated she didn't feel it was abusive. The NHA stated they had a visitation today for Resident #45 that wasn't scheduled, and the aide was trying to get the resident ready and was rushing. She said the wheelchair legs didn't fit right on the wheelchair and the resident started swinging his/her arms at Staff #46. The NHA stated the resident was already exhausted from being upset downstairs. To make the visiting schedule, Staff #46 was pushing the wheelchair in a rush. The NHA stated Staff #46 got the resident on the elevator and through the hall and she thought Staff #46 was wheeling Resident #45 fast, so the resident wouldn't hit anyone with his/her arms. The NHA stated that Staff #46 took the resident to the receptionist area and because the resident was swinging his/her arms, Staff #46 didn't want the resident to hit the receptionist, so Staff #46 moved the resident backwards. The NHA stated that it was an educational moment for Staff #46 and felt Staff #46 could have handled the situation better, but Staff #46 was a good GNA and really cared for the residents. The NHA stated she was going to suspend Staff #46 while investigating the incident and educate her on the handling of dementia residents. Review of Resident #45's medical record on 9/14/21 at 2:10 PM revealed that Resident #45 was admitted to the facility in June 2021 with diagnoses that included, but were not limited to, dementia, major depressive disorder, anxiety, and unspecified psychosis. A 6/14/21 social services note documented that the resident was newly admitted from an assisted living facility and was apparently having some behaviors while there and was aggressive at times with staff and delusional. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 6/18/21 nursing note documented, resident agitated and combative with staff with providing hygiene. Writer assisted GNA with morning hygiene. Resident struck GNA and writer numerous times while providing care. A 7/2/21 Nurse Practitioner progress note documented, anxiety management and reports [he/she] does get nervous and needs medication. Resident #45 was seen by a psychiatrist on 9/8/21 and the plan was, staff encouraged to re-orient the patient to their surroundings, re-direct the patient and maintain safety and continue to provide support to the patient. Further review of Resident #45's medical record revealed an activities care plan and a mood problem and is at risk for depression and anxiety care plan. There was not a care plan for dementia care or a care plan that directed staff on what to do when the resident had behaviors and what non-pharmacological interventions were to be implemented. Discussed with the NHA on 9/22/21 at 1:00 PM.

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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** 31145 Based on observation, staff interview, and documentation review, it was determined that facility staff 1) failed to keep medication and treatment carts locked when unattended, 2) failed to date medication and biologicals when opened, and 3) failed to discard insulin when expired. This was evident on 2 of 3 nursing units observed during random observations made during a complaint survey. The findings include: 1) Observation was made on [DATE] at 6:10 AM, upon an unannounced entry into the facility, of an unlocked and unattended medication cart that was sitting in the hallway outside of room [ROOM NUMBER]. There were keys sitting on top of the medication cart along with the narcotic book. The surveyor was able to open the drawers to the medication cart to observe insulin, eye drops and resident medications. In the third drawer of the cart was a plastic 30 ml. medication cup with crushed pills mixed in apple sauce with a spoon in the cup. When Staff #12, LPN came out of a resident's room, the surveyor asked about the medication cup and the contents. Staff #12 stated, it was in there from the previous shift. At the time Staff #17, the night shift supervisor walked up and was informed. 2) Observation was made on [DATE] at 11:19 AM of a treatment cart that was left unlocked and unattended sitting in the hallway outside of room [ROOM NUMBER]. There were scissors in the top drawer, ointments, and dressings. There was an opened 1,000 ml. bottle, 0.25% Acetic Acid irrigation solution that was one quarter full that was labeled for a suprapubic flush, G147064. The bottle was not dated when opened. According to PDR.net (Physician's Desk Reference), 0.25% Acetic Acid Irrigation, USP, is indicated as a constant or intermittent bladder rinse to help prevent the growth and proliferation of susceptible urinary pathogens (especially ammonia forming bacteria) in the management of patients who require prolonged placement of an indwelling urethral catheter. Opened bottles should be used within 24 hours of opening to prevent bacterial growth. Staff #9 was informed at the time of observation. 3) Observation was made on [DATE] at 9:55 AM of Medication Cart C sitting in the hallway outside of room [ROOM NUMBER] unlocked and unattended. The surveyor was able to open the drawers and observed insulins and other resident medications. The surveyor also observed a Breo Ellipta 100 mcg/25 mcg. inhaler #0147295, that had no name on the inhaler but was marked with a date opened of [DATE]. According to the directions on the inhaler, the inhaler was good for 6 weeks after being opened. The interim Director of Nursing (DON) walked past the surveyor and asked if anything was needed. At that time, the surveyor informed the Interim DON that the cart was left unlocked and unattended. The Interim DON #8 looked for the nurse on the unit until 10:01 AM and could not find her so she came back and locked the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Observation was made on the first floor nursing unit on [DATE] at 7:42 AM of a medication cart sitting in the hallway with the keys on top of the cart. The cart was out of sight of the nurse's station and was unattended. Staff #18 walked up to the medication cart and stated, Oh, I was just going to get a piece of paper. The surveyor informed her that she left the medication cart unlocked. 5) Observation was made on [DATE] from 12:32 PM to 12:49 PM of medication cart A sitting unlocked and unattended outside of room [ROOM NUMBER]. The silver lock was in the out position. In the top drawer were insulin pens, lancets, and other medications. In the bottom drawer, was a 250 ml. Sterile Sodium Chloride 0.9% bottle, Lot 012320 that was opened with no date opened and was two thirds full. Sterile Sodium Chloride should be discarded within 24 hours of opening due to the risk of contamination. On [DATE] at 12:38 PM, surveyor observed a set of keys on a red plastic wrist coil key chain on the top right drawer of the medication cart. The surveyor was able to open another medication cart that was sitting outside of room [ROOM NUMBER] with those keys. Observation was made in the second medication cart of Resident #50's Admelog 100u/ml insulin that was opened on [DATE]. There was documentation on the insulin box that the insulin was only good for 28 days after opening. Resident #49's insulin aspartame was opened with no date opened. Resident #49's Admelog insulin was opened on [DATE]. The insulin was only good for 28 days. The insulins were not discarded after 28 days. At 12:49 PM on [DATE], the surveyor asked the hospitality aide, Staff #7 where the nurses were for the unit as 17 minutes had passed since the surveyor initially observed the medication cart unlocked and unattended. Staff #7 stated that 1 nurse was at lunch and the Interim DON was working the floor. At that time the Interim DON came around the corner and the surveyor showed her the medication carts. The Interim DON stated the medication carts were locked and the surveyor showed her the lock which was clearly jutted out and not flush with the cart. The surveyor also showed her the keys that were in the top drawer. On [DATE] at 1:00 PM, the surveyor met with the Nursing Home Administrator (NHA) to inform the NHA of the various observations and concerns with the unlocked and unattended medication carts.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview, it was determined the facility failed to perform laboratory blood testing as ordered by the physician. This was evident for 1 (#51) of 5 residents reviewed for foley catheter use during a complaint survey. The findings include. A doctor analyzes the laboratory blood test to see if results fall within the normal range. The doctor may also compare the results to results from previous tests. Laboratory tests are often part of a routine checkup to look for changes in patient health. They also help doctors diagnose medical conditions, plan, or evaluate treatments, and monitor diseases. Review of Resident #51's medical record on 9/20/21 at 11:55 AM revealed that the resident was admitted to the facility on [DATE] from an acute care facility with diagnoses including but not limited to sepsis, type 2 diabetes mellitus, obstructive and reflux uropathy and tubulo-interstitial nephritis. Review of the hospital discharge summary, dated 8/5/21, revealed documentation that Resident #51 had hypomagnesemia in the hospital and would require a repeat magnesium level 2 days after admission to the facility. Hypomagnesemia is an electrolyte disturbance caused when there is a low level of serum magnesium (less than 1.46 mg/dL) in the blood. Hypomagnesemia can be attributed to chronic disease, alcohol use disorder, gastrointestinal losses, renal losses, and other conditions. An interview was conducted with Staff #33, RN unit manager on 9/20/21 at 3:05 PM. Staff #33 stated, that level is normally in the blood work they get. Review of the blood work obtained after admission revealed that the magnesium level was not done. Staff #33 confirmed the finding. The Nursing Home Administrator was informed of the findings on 9/21/21 at 8:37 AM.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 43096 Based on a review of medical records and interviews with facility staff, it was determined that the facility failed to document radiology results in a resident's medical record. This was evident for 1 (#24) of 53 residents reviewed during a complaint survey. The findings include: Based on verbal complaint from an outside resource, Resident #24's family was concerned about a missed appointment with a physician and diagnostics imaging. Resident #24's medical record was reviewed on 9/21/21 at 8:50 AM. A review of a Neurology consultation note, dated 5/26/2021, revealed that an MRI (Magnetic resonance imaging) of the brain was to be conducted. Review of a progress note, dated 7/19/21, revealed that Resident #24 had an MRI scheduled on 7/21/21, however, further review of failed to find the results of the MRI testing. On 9/21/21 at 11:00 AM, during an interview conducted with Licensed Practical Nurse LPN #4), they stated any testing result reports should be filed in the electronic medical record or in the paper copy of the resident's chart. On 9/21/21 at 1:22 PM, an interview was conducted with the interim Director of Nursing (Staff #8). Staff #8 was asked for a copy of the MRI result. Staff #8 brought in the copy of the MRI result on 9/21/21 at 2:10 PM and indicated the result report was received from the imaging service agency by way of fax on 9/21/21 at 1:42 PM.

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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** 39709 Based on medical record review and staff interview, it was determined that the facility staff failed to keep a complete and accurate medical record. This was evident in 14 (#13, #12, #40, #41, #42,#44, #45, #35, #46, 1, #51, #20, #47, #52) out of 53 residents reviewed during a complaint survey. The finding 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. 1) Medical record review revealed that resident #13 was admitted to the facility with multiple medical diagnoses which included, but were not limited to, Cerebral Infarction with other chronic health condition which required medical ongoing treatment and monitoring. On 9/10/21 at 8:45am, the surveyor conducted medical record review for complaint intake #MD00158974 which revealed documentation that resident #13 experienced a fall on 10/27/20. Continued medical review revealed that the staff failed to document in the medical record a physical assessment, and a notification to physician or responsible party member in the medical record. On 9/14/21 at 1:25pm, surveyor conducted an interview with staff member #15 who had documented resident #13's fall. Staff member #15 informed the surveyor that the entry was an error in the medical record and that the resident had not experienced a fall on 10/27/20. The staff member #15 failed to correct this medical record entry error. During the same date and time, the Administrator verified that the staff member's documentation was not accurate. All findings discussed with the facility Administrator and Director of Nursing during the survey and prior to facility exit conference on 9/22/21 at 1:15 p.m. 31982 2) During a review of Resident #12's medical record on 9/13/21 at 8:13 AM, the surveyor was unable to find documentation in the electronic medical record (EMR) for the time period between 7/8/21 - 7/30/21. Review of Resident #12's Census List confirmed that the resident, who previously resided at the facility, was discharged on [DATE], and readmitted on [DATE] where he/she had remained since that date. Staff #37 the Administrator was made aware of the above findings. During an interview on 9/13/21 at 8:47 AM, the Administrator confirmed that Resident #12 was readmitted to the facility on [DATE] and indicated that, when Resident #12 came back to the facility on [DATE], he/she then had 2 medical records. She indicated that she had a call in to the administrator of the EMR to see if they would be able to assist the facility to retrieve the missing information from 7/8/21-7/30/21. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/13/21 at 9:06 AM, Staff #5 the regional corporate nurse explained that Resident #12 was discharged in March and when they returned to the facility on [DATE], they were issued a new medical record number. The Corporate office advised the facility that they needed to use Resident #12's original medical record number because that was his/her identifier. The facility went back to using the original medical record number on 7/30/21, however, the medical record documentation entered between 7/8/21 and 7/30/21 had been entered using the second medical record number. She indicated that, after the surveyor was unable to find medical record documentation, she remembered that Resident #12's records were under a different medical record number for a period of time. She was made aware that, when a search was done using Resident #12's name, the second medical record was not evident. She indicated that the only way to access the second record in the EMR was by entering the actual medical record number. She confirmed that anyone searching for Resident #12's medical record would not be aware of the existence of a second medical record nor it's number and would not be able to access the documentation contained in that record. She also confirmed at that time that neither she nor the facility realized that the information was not accessible until the surveyor inquired about the missing documentation and she recalled that a second medical record number was issued. Medical decision-making capacity is the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention (including no treatment). Capacity is the basis of informed consent. An evaluation and certification by 2 physicians is required to determine that a person lacks adequate decision making capacity (including decisions about life-sustaining treatments). Continued review of Resident #12's medical record on 9/10/21 at 1:34 PM revealed an Admission Record face sheet which indicated that Resident #12 was his/her own representative, that his/her mother was listed as emergency contact #1, Aunt was listed as emergency contact #2 and his/her significant other was listed as emergency contact #3. 3) Review of Resident #12's paper record on 9/13/21 at 2:00 PM revealed a Physicians' certification indicating that Resident #12 had adequate decision making capacity, signed by the Physician on 7/11/21. Further review of the resident's record on 9/14/21 at 11:36 AM revealed a Social Service Note, dated 9/13/21 15:01 (3:01 PM) by Staff #14, which indicated that the resident was determined to not be capable however, the record failed to reveal evaluations and certifications by 2 physicians that determined Resident #12 lacked adequate decision making capacity. An interview was conducted with Staff #14 on 9/14/21 at 3:20 PM. She was made aware of the above findings. When asked why her progress note indicated that Resident #12 lacked adequate decision making capacity, she indicated that she knew that certifications were done by 2 physicians that Resident #12 lacked decision making capacity, that they were here somewhere and that Staff #20, the Social Work Director had them. She indicated that she did not know why they were not in the resident's record. When asked how she knew that the certifications had been done, Staff #14 revealed an email, dated 8/14/21, which contained a list of residents to be evaluated for decision making capacity. The list included Resident #12 and 10 more residents. When asked if the other residents on the list were also certified as incapable by 2 physicians, she indicated that she was not sure, that she was not involved in the process, other than being notified. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the records of the 10 additional residents who were to be evaluated for decision making capacity were reviewed on 9/14/21 at approximately 4:00 PM and revealed that 2 no longer resided in the facility and 1 record contained 2 certifications of incapacity. The remaining 7 records revealed the following findings: A) Resident #40's medical record contained a psychiatric evaluation, dated 8/13/21, which indicated that the resident lacked the capacity to make informed decisions. A physicians certification, dated 2/26/20, was located in the medical record and indicated that he/she had adequate decision making capacity. B) Resident #41's medical record included a psychiatric evaluation, dated 8/13/21, indicating the resident lacked capacity to make informed decisions. Physician certifications, dated 8/1/19 and 8/24/20, indicated that he/she had adequate decision making capacity. C) Resident #42 had a psychiatric evaluation on 8/13/21 which indicated that he/she lacked capacity to make informed decisions. Physician certifications, dated 10/19/16 and 9/18/18, indicated that he/she had adequate decision making capacity. D) Resident #44 had a psychiatric evaluation, dated 8/13/21, that indicated he/she lacked capacity to make informed decisions. His/her medical record revealed One certificate signed by the Physician on 8/8/21 which indicated the resident lacked adequate decision making capacity however, a second certificate was not found in the record. E) Resident #45 had a psychiatric evaluation on 8/13/21, which indicated that the resident lacked capacity to make informed decisions. One certificate, signed and dated 6/6/21, by the physician indicated that he/she lacked adequate decision making capacity. Certification by a second physician was not found in the resident's record. F) Resident #35 had a psychiatric evaluation dated ,8/13/21, which indicated that the resident did not have the capacity to make medical decisions by himself/herself. No certification of capacity was found in his/her medical record. G) Resident #46 had a psych evaluation, dated 8/13/21, which indicated that he/she did not have the capacity to make medical decisions by himself/herself. A certification dated 7/14/21 was found in the medical record indicating the resident had adequate decision making capacity. None of the 7 residents had evaluations and certification by 2 physicians indicating that they lacked decision making capacity. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff #20, the Social Services Director on 9/15/21 at 10:15 AM. She confirmed that Resident #12's certifications of incapacity were not filed in the residents medical record and were in the to be filed. She indicated that Resident #12 and several other residents were evaluated by Psychogeriatric services and the medical director on 8/13/21 and their certificates of incapacity were completed that day. When asked to explain what the to be filed was, she explained that there were bins used by Social Service for documents that needed to be filed. She explained that the facility did not have a medical records person, and a medical records consultant came in from time to time. She stated, we file as much as we can, the receptionist does some to help out. When asked how soon she expected certifications of incapacity to be filed in the resident's medical records, she stated immediately then went on to say there are many healthcare challenges right now, all departments are assisting with answering call bells and assisting to meet the resident's needs, and these things were more important than filing right now. Upon inquiry, the surveyor was provided with 2 certificates of incapacity for all 8 residents signed and dated by the physicians on 8/13/21. During an interview on 9/15/21 at 12:10 PM, the Administrator was made aware of the above concerns and was asked how soon she expected the resident's certification for lack of decision making capacity to be filed in the resident's record. She stated, very soon after they were signed. 31145 4) On 9/10/21 at 10:00 AM, an interview was conducted with Resident #1 who stated, I needed to see a neurologist and I didn't see one until August 2021. I need an MRI of my neck and spine, and they say I have to wait until next February 2022 to get into [name of hospital], so now it is going to be another 6 months until they figure out what my problem is, and it is delaying me from going home. Review of physician's orders for Resident #1 revealed an order that was written on 3/22/21, schedule neurology appointment. A 7/1/21 Nurse Practitioner (NP) note documented, s/p (status post) ortho (orthopedic) pain consult. He is recommending MRI of C-spine. Resident is pending Neuro evaluation. Would be ideal to obtain MRI of C spine (and brain) prior yet resident with pacer. Will have to attempt to find Radiology place that can accommodate. Disc with resident and staff. Continued review of the medical record revealed the resident was seen by a neurologist on 8/20/21 and a neurology consult report dated 8/20/21 documented, MRI c-spine w/o contrast, URGENT at [name of hospital] and referral to spine surgeon, URGENT at [name of hospital]. A physician's order was written on 8/20/21 that stated, MRI C-Spine w/o contrast urgent at [name of facility] one time for cervical stenosis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/21 at 11:47 AM, the surveyor asked Staff #33 if there was any update related to the neurology appointment. Staff #33 stated that she called a day or 2 after 8/20/21 to [name of hospital] and was able to get an appointment for February 3, 2022. When asked why Resident #1 had to wait an additional 6 months, Staff #33 said, because the resident has a pacemaker, and they need a specialized machine and [name of hospital] is 6 months out. The surveyor asked, even for an emergent request. Staff #33 said, yes. The surveyor asked if she notified the doctor because there was no documentation in the medical record that the physician was notified that it would take another 6 months for an urgent request. She said she spoke to the physician about it and will document it today (9/15/21). The surveyor asked Staff #33 when the physician was notified and she stated, before I went out on leave on September 1. There was no documentation in the medical record about the appointment and the attempts made until the surveyor inquired about it on 9/15/21. Cross Reference F684 5) Observation was made, on 9/17/21 at 2:16 PM, of Resident #51 lying in bed. Resident #51 was on the first floor nursing unit in a room with 2 other residents. Resident #51's bed was closest to the door. The door was open and there were no signs on the door. Review of Resident #51's medical record, on 9/20/21 at 11:55 AM, revealed the resident was admitted to the facility on [DATE]. Review of Resident #51's treatment administration record (TAR) revealed documentation that the nurses' were initialing every shift that Resident #51 was on droplet precautions. On 9/21/21 at 7:59 AM, an interview was held with the Nursing Home Administrator and the interim Director of Nursing and they were informed of the nurses signing off that the resident was on droplet precautions when the resident was in a room with 3 other residents and the door was open with no isolation or precaution signs. The interim DON stated at that time that the resident was not on droplet precautions. The surveyor informed both that the interim DON was one of the nurses that signed off, that the resident was on droplet precautions. 6) Review of Resident #20's medical record on 9/14/21 at 8:45 AM, revealed the resident had an ileostomy. An ileostomy is the result of an operation that connects the last part of the small intestine (ileum) to the abdominal wall. Intestinal waste passes out of the ileostomy and is collected in an external ostomy system which is placed next to the opening. Review of Resident #20's September 2021 TAR revealed the area where the nurses were to document the amount of contents was checked off as either yes, a check mark, med (medium) or the amount in milliliters (only 4 times for 60 opportunities). The total amount of contents was not documented. Further review of Resident #20's GNA documentation for September 2021 revealed gaps in documentation for dressing, float heels, bathing, bed mobility, behavior monitoring, bladder continence, bladder tracker, bowel continence, bowel movement, locomotion on and off the unit, personal hygiene, turn and repositioning, amount eaten, eating, fluid intake on the following days: 9/1 day and evening shift, 9/2 day shift, 9/5 day and night shift, 9/6 evening shift, 9/7 all 3 shifts, 9/9 day shift, 9/10 day shift, 9/11 day shift, 9/12 evening shift, 9/13 day and evening shift, 9/14 evening shift, 9/17 day and night shift, 9/18 day and evening shift, 9/20 day and night shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) Review of Resident #47's GNA's documentation for September 2021 revealed gaps in documentation for dressing, float heels, bathing, bed mobility, behavior monitoring, bladder continence, bladder tracker, bowel continence, bowel movement, locomotion on and off the unit, personal hygiene, turn and repositioning, amount eaten, eating, fluid intake on the following days: 9/1 day and evening shift, 9/2 day and evening shift, 9/5 all 3 shifts, 9/6 evening shift, 9/7 all 3 shifts, 9/8 day shift, 9/9 day shift, 9/10 day shift, 9/11 day and evening shift, 9/12 evening shift, 9/13 day and evening shift, 9/14 evening shift, 9/17 all 3 shifts, 9/18 day and evening shift, 9/20 day and night shift. 8) Observation was made on 9/17/21 at 1:40 PM of Resident #52 lying in bed. Resident #52's foley catheter bag was lying on the floor wedged under the frame of the over the bed tray table.There were 600 cc. of urine in the bag. Observation was made by 2 surveyors, on 9/21/21 at 9:40 AM, of Resident #52 lying in bed eating breakfast. The foley catheter had been removed. Interview of Resident #52 revealed the foley catheter was removed yesterday before dinner. There was no documentation in the medical record that the catheter was removed, there was no order for the catheter to be removed, and the nurses signed off that foley catheter care was given every shift on 9/20/21 and overnight. The documentation issue was discussed with the NHA on 9/21/21 at 9:37 AM. On 9/21/21 at 10:22 AM, during an an interview with Staff #33, RN unit manager, it was revealed that she was with the nurse when she got the order to discontinue the foley catheter. The surveyor informed Staff #33 there was no order in the medical record, no documentation, and no assessment. Staff #33 looked through the medical record and confirmed that nothing was documented. The surveyor asked Staff #33 how the nursing staff monitored Resident #52's urinary output once the catheter was removed. Staff #33 stated, they monitor the resident for voiding by counting the diapers. There was no documentation that the resident was monitored for voiding.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on observation, record review, and staff interview, it was determined that the facility failed to maintain strict infection control processes as evidenced by staff failing to keep a resident's urinary catheter bag off the floor and failing to maintain a resident in isolation precautions. This was evident for 2 (#52, #51) of 5 residents reviewed for a foley catheter and 1 (#48) of 4 residents on isolation precautions. The findings include: A urinary catheter is a flexible tube placed in the body which is used to empty the bladder and collect urine in a drainage bag. According to the CDC (Centers for Disease Control) germs can travel along the catheter and cause an infection in the bladder or kidney that could cause a catheter-associated urinary tract infection if proper infection control practices are not put in place and followed. 1) Observation was made on 9/17/21 at 1:40 PM of Resident #52 lying in bed. Resident #52's foley catheter bag was lying on the floor wedged under the frame of the over the bed tray table. There were 600 cc. of urine in the bag. A second observation was made on 9/17/21 at 2:16 PM and the bag was still in the same position and had not been emptied. Review of Resident #52's medical record on 9/20/21 at 10:40 AM revealed the resident was admitted on [DATE] from an acute care facility with diagnoses that included but were not limited to respiratory failure, sepsis, pneumonia due to COVID-19, and obstructive and reflux uropathy. Obstructive uropathy occurs when urine cannot drain through the urinary tract. Urine backs up into the kidney and causes it to become swollen. Reflux nephropathy is a condition in which the kidneys are damaged by the backward flow of urine into the kidney. Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death. 2) Observation was made on 9/17/21 at 2:16 PM of Resident #51 lying in bed with a foley catheter bag lying on the floor in a covered bag with the top of the covered bag open. Review of Resident #51's medical record on 9/20/21 at 11:55 AM revealed the resident was admitted to the facility on [DATE] from an acute care facility with diagnoses including but not limited to sepsis, type 2 diabetes mellitus, obstructive and reflux uropathy and tubulo-interstitial nephritis. Review of the hospital discharge summary, dated 8/5/21, revealed documentation that a foley catheter was placed in the resident in the emergency department and over 1 liter of urine was removed, and the resident was severely dehydrated and had sepsis. Allowing the urinary catheter bag to lie directly on the floor places the vulnerable resident at risk for infection as germs could travel from the floor along the catheter to the point of entry into the bladder and cause infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nursing Home Administrator was made aware of the findings on 9/21/21 at 9:37 AM. 40601 3) On 9/22/21 at 11:55 AM, Resident #48 was observed exiting their isolation room and walking down the hallway to the 2nd floor nurses station with no mask. Observation of the resident's room at this time revealed a plastic covering over the door with a vertical zipper down the center to isolate the resident's room from the remainder of the hallway. Review of Resident #48's medical record at 12:00 PM revealed that the resident was readmitted to the facility on [DATE] and had refused the COVID-19 vaccination. Resident #48's admission note from 9/16/21 at 6:34 PM specified that resident is to be placed in isolation.

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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. 31145 Based on interview and observation, it was determined the facility failed to have an effective way that a resident could contact nursing staff. This was evident for 1 (#25) of 17 residents interviewed during a complaint survey. The findings include: 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 9/13/21 at 9:53 AM, an interview was conducted with Resident #25. Resident #25 stated that the facility was short staffed and sometimes had to wait 40 minutes for assistance. Resident #25 stated that he/she was waiting for washcloths and towels. The surveyor suggested that the resident put on the call bell to request assistance. Resident #25 showed the surveyor the call bell and stated, the call bell broke and it is missing the middle piece. Observation of the call bell revealed that the middle section, the area that is pushed in to activate the call bell, was missing and was not functional. The surveyor asked Resident #25 if he/she told anyone and the answer was, yes, I told the nurse but no one has come to fix it. Resident #25 stated he/she was in pain and needed to call the nurse. At that time, the surveyor found the Interim Director Of Nursing on 9/13/21 at 10:01 AM and informed her of the broken call bell and the resident's need for pain medication.