STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215336	A. Building B. Wing	01/13/2023

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 16218 Based on medical record review, it was determined that the facility failed to ensure that a resident received written notification prior to the implentation of a room change. This was found to be evident for 2 (Resident #51, Resident #7) out of 86 residents reviewed during the survey. The findings include: Review of Resident #51's medical record revealed that the resident had a room change on 8/5/22. The Notification of Room Change form documented that the change occurred on 8/5/22 at 0000 (midnight) but the form was noted to have a time stamp of 7:16 AM. The scanned version of this form, that was hand signed by the resident, was noted to have been printed on 8/9/22 at 7:18 AM. This was 4 days after the move occurred. On 1/3/23 at 4:50 PM, surveyor reveiwed the concern with the Administrator that the date on the signed notification of room change was 8/9/22, but the room change occurred on 8/5. As of time of survey exit on 1/13/23 at 4:00 PM, no additional documentation or information was provided regarding this concern. The DON and the Administrator were made aware of the concern regarding the failure to ensure resident was made aware of room change prior to the move at time of exit. Cross reference to F 689 37276 2) On 1/3/23 at 3:00 PM, a review of Resident #7's EMR (electronic medical record) revealed documentation that Resident #7 resided in a room on Wing 1, located on the first floor of the facility. On 1/3/23 at 3:30 PM, an observation of the Resident #7's assigned room on Wing 1 revealed the space where the Resident #7's was assigned was empty, and there was no evidence Resident #7 had a bed in the room. At that time, when asked where Resident #7's room was, an employee on Wing 1 indicated the resident had been moved to a room on Wing 2. On 1/3/23 at 3:58 pm, Resident #7 was observed lying in a bed in a room on Wing 2 of the second floor. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Following the observation of the resident in a room on Wing 2, a review of Resident #2's EMR failed to reveal documentation that the resident had changed rooms, or that the resident/representative had received written notice, including the reason for the change prior to the resident's room change. On 1/5/22 at 9:58 AM, the above findings were discussed with Staff #22, Regional Clinical Director. At that time Staff #22 indicated a room transfer assessment should be completed prior to a resident's room change. On 1/12/23 at 4:25 pm the NHA (Nursing Home Administrator), the Corporate NHA, and the Director of Nurses were made aware of all concerns.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45139 Based on record review and interview, it was determined that the facility failed to honor the resident choice in receiving a shower over a bath. This was evident for 1 resident (Resident # 30) reviewed for grievances during a revisit survey. Th findings include: In an interview with Resident #30 on 4/10/23 at 2:05 PM, Resident #30 reported that he/she filed a grievance with the facility for not receiving showers. Resident #30 reported that his/her shower days are Tuesday and Fridays. The Resident also stated that he/she had only been receiving showers on Tuesdays. In an interview with the Director of Social Services on 4/10/23 at 2:18 PM, she indicated that Resident #30 had submitted a grievance form on 3/27/23 indicating that he/she wanted showers instead of bed baths. A review of the form revealed a description of the grievance that was written as Resident #30 wants his/her shower on the schedule shower days every time. A review of Resident #30's GNA task documentation record on 4/11/23 at 7:40 AM, revealed that, the under the heading bathing per resident's choice. the GNAs documented that the resident received a bed bath instead of a Shower on the following dates. Friday 3/17/23, Friday 3/24/23 , Friday 3/31/23, and the resident refused bathing on Friday 4/7/23. Further review of nursing progress notes failed to reveal documentation on why a shower was not provided on the above dates. During an observation on 4/12/23, the first-floor shower schedule revealed that resident #30 was to receive showers every Tuesday and Friday. In an interview on 4/12/23 at 10:03 AM, the first -floor unit manager (staff member #13) stated that she/he could not find any documentation as to why Resident #30 had not been given a shower on 3/17/23, 3/24/23, 3/31/23 and 4/7/23. The first-floor unit manager stated that the expectation was that Resident #30 would be given a shower on Tuesday and Friday.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 45139 Based on a complaint and staff interview, it was determined that the facility failed to ensure that a resident received an unopened package that was addressed to the resident and delivered to the facility. This was evident for 1 Resident (Resident #15) out of 2 resident complaints received during a revisit survey. The Finding include: On 4/10/23 at 12:20 PM, during an interview with Resident #15, a long-term resident of the facility, s/he reported a complaint that the facility staff opened his/her mail without his/her permission. On 4/11/23 at 9:10 AM, The Social Service Assistant staff #8 reported that the facility received a package addressed to resident # 15, while resident #15 was in the hospital, sometime in early March. The facility suspected the package contained pills. The Social Service Assistant and the Director of Social work staff #3 opened that package in the social work office without Resident #15's permission or knowledge. The Social Service Assistant staff #8 reported that it was an error to open the pachage without the resident permission. On 4/11/23 at 12:00 PM, The Social Service Director staff # 15 confirmed that that she and the Social Service assistant opened the package in their office. Social Service Director staff # 15 reported the package contained 2 bottles of pills and the pills were shown to the Medical Director staff # 36. The Social Service Director staff # 15 reported it was an error to open the resident's package without permission.

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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** 31982 Based on record review, interview, and observation, it was determined the facility staff failed to provide a safe, clean, comfortable, and homelike environment for all residents. This was evident for 1 (#83) out of 2 residents reviewed for resident grievances during the survey. The findings include: An observation was made of Resident #83's room [ROOM NUMBER]/11/23 at 12:17 PM, with the resident present. The room contained boxes, bags and belongings stacked approximately 2-3 feet high along the wall to the right of the entrance door, along the wall behind the head of the first bed, through the center of the room between the 2 beds, as well as under the room sink and bathroom sink. Resident #83 confirmed that he/she was not able to pull his/her motorized wheelchair up to either of the sinks to perform personal hygiene including, but not limited to handwashing and brushing his/her teeth, due to the items stacked below them. Built into the wall to the left side of the sink was a shelf with a television identified by Resident #83 as his/hers. Six to eight plastic clothing hangers were hanging on the shelf below the television. Two socks were draped over each hanger. A large dresser was located below the television shelf as well. These items were identified by Resident 83 as also belonging to his/her roommate. Approximately 6-8 flowerpots containing houseplants covered the windowsill of the only window in the room. The window was located beside the second bed. A cubby space approximately 2.5 feet wide by 2.5 feet deep near the foot of the second bed contained plastic totes, cardboard boxes, bags, and loose items stacked from the floor to within a few inches of the ceiling, a curtain hung at the front of the cubby. Upon inquiry at that time, Resident #83 explained that 1 of the 3 closets in the room contained a small dresser and his/her clothing. The other 2 closets as well as 2 large dressers and the cubby contained Resident #20's items. Resident #83 indicated that the second bed, closest to the window, was his/hers and that the items stacked throughout the room belonged to his/her roommate, Resident #20. Resident #83's bedside commode was located between the head of his/her bed and the far wall. A small, wheeled cart with 2-3 shelves that contained snack items was located against the wall beside the foot of the second bed to the left of the window. Resident #38 explained that this was the only place he/she had to store his/her snacks. Resident #83 indicated that Resident #20 placed the houseplants on the windowsill without his/her consent and routinely comes into his/her personal space to water them, that he/she was gradually losing all of his/her personal space to Resident #20. During another observation on 1/12/23 at 12:05 PM, the surveyor observed that 5 covered glass pickle jars containing clear liquid were lined up on the counter to the left of the bedroom sink. Resident #83 indicated that the jars were used by Resident #20 to water the houseplants on the windowsill. One of Resident #83's representatives was also present at that time. The Representative indicated that Resident #20 will wash his/her clothing in the bathroom sink and hang it around the room and in the bathroom to dry. Both Resident #83 and the Representative indicated that Resident #20's belongings were impacting Resident #83's personal space and ability to complete basic hygiene activities such as hand washing and brushing teeth. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/12/21 at 12:25 PM, the Administrator was made aware of the above concerns. Cross reference F 585.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 31982 Based on record review, interview, and observation, it was determined the facility staff failed to develop and implement a process to address and ensure prompt resolution of all grievances, and failed to provide the residents with notice of the grievance resolution as required. This was evident for 2 (Resident #83 and #42) out of 2 residents reviewed for grievances during the survey. The findings include: An observation was made of Resident #83's room on 1/11/23 at 12:17 PM. The resident's room contained numerous boxes, bags and belongings stacked along the walls, through the center of the room between the 2 beds, as well as under the bedroom sink and bathroom sink and in a cubby space. Potted house plants lined the windowsill on the far side of the room. Upon interview at that time, Resident #83 indicated that the second bed was his/hers and that the stacked items observed by the surveyor belonged to his/her roommate. Resident #83 confirmed that he/she was not able to utilize either of the sinks due to the items stored below them. Resident #83 indicated that his/her roommate, Resident #20, had gradually spread their belongings into his/her side of the room leaving Resident #83 with very little personal space. The resident confirmed that he/she had spoken to staff in the past, and the Social Services Assistant #14 within the past week, regarding the clutter. The resident indicated that he/she was previously offered a room change and indicated that he/she did not want to move because he/she got along well with Resident #20 aside from the condition of the room, and was afraid of who he/she would be placed with and that he/she felt they had a right to have personal space within the current room. He/she added that nothing was being done by the facility to address this issue. In an interview on 1/11/23 at 3:28 PM Social Service Assistant #14 indicated that the Director of Social Services #15 was the facility grievance officer however, she was no longer employed in the facility. Staff #14 was not sure who was responsible now. When asked if she was familiar with the grievance process, she then indicated that the grievances were given to her, that she logged them into the grievance book indicating which department head they were forwarded to, that the department had 5 days to give it back to her. When asked who followed up with the resident she stated, usually the nursing staff and sometimes the Unit Manager asks me to go see them then added Whoever looked into it follows up with the resident. She was asked if the residents were given a copy of the resolution and stated No. Review of the facility's grievance/complaint logs revealed 6 entries pertaining to Resident #83 since 7/1/22. Four were related to missing clothing, one was a missing laptop, and one pertained to a dietary concerns. The notes/comments column indicated that the missing items were found and that dietary addressed the dietary concern. There were no entries related to the condition of the resident's room/roommate concerns. In an interview on 1/12/23 at 12:05 PM, one of Resident #83's representatives indicated that the condition of Resident #83's room was brought up by him/her and discussed during Resident #83's care plan meeting. He/she indicated that the treatment team said they would look into it, but he/she had not heard back. The representative also indicated that he/she had also spoken to the ADON (Assistant Director of Nursing) regarding the concerns with the room but received no follow up. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/12/23 at 12:25 PM, the Administrator was made aware of the above concerns that there was no evidence that the facility staff implemented resident grievance protocols to investigate, resolve, provide notification to the resident nor was there a record of the resolution regarding the resident's grievance. The facility's policy/procedure/protocol for grievances was reviewed on 1/12/23 at approximately 12:45 PM. The policy was titled: CommuniCare Family of Companies Policy and Standard Procedures Subject: Resident Grievance. The policy included that it was approved by the Chief Clinical Officer effective 01/12/2017 and renewed on 05/30/2019 however there was no signature nor indication that the policy was reviewed approved and implemented by the facility Administrator. Cross Reference F 584. 42863 2) During a phone interview conducted on 12/27/22 at 09:50 AM, the complainant stated that the key areas of concernwere expressed to for Resident # 42 that the facility were unclean laundry, not repositioned every two hours, was left dirty for extended periods of time, agency staff did not provide adequate care, facility understaffed, residents not provided with water, the kitchen was not up to standards, small meal portions, and the facility smelled of urine. The complainant also stated that he/she had talked to the facility staff and administration multiple times regarding his/her concerns and the facility failed to respond verbally or in written format. On 12/30/22 at 08:29 AM, the surveyor initiated an interview with the administrator regarding the grievance/concern form related to resident #42, dated 08/10/22. The administrator explained that the facility referred to grievances as concerns and maintained a concerns log book. During the review of the grievance form, the Administrator confirmed there was a delay in the initiation of the investigation by nursing. The administrator stated that an investigation was not initiated immediately after the receipt of the grievance in August 2022. On 12/30/22 at approximately 09:00 AM, the surveyor reviewed the electronic progress notes of resident #42. Staff #15, the social services director wrote on 12/17/2022: Concern placed in the concern binder on 08/01/2022 and given to nursing on 08/01/22. Concern was reissued to nursing on 12/07/2022. The grievance form showed that the social service assistant initiated and signed the grievance form on 08/10/22 and the Administrator signed the form on 12/19/22. The Director of Nursing (DON) was assigned to investigate the grievance, however, there was no record of the initiation and/or conclusion of the investigation, and no record that the complainant was informed of the outcome as of 12/30/22. The Administrator stated that he/she could not explain why there was a delay in response to the family member's grievance but stated that the normal turnaround time was within one week. During the continued interview, the Administrator stated that her responsibility was to oversee the facility's grievance process, the Director of Social Services and the Social Service Assistant were responsible for the initiation of the grievance form and forwarding the concern to the appropriate department manager for the investigation of the concern. In this example, the DON was responsible to investigate the grievance related to Resident #42. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/22 at approximately 11:30 AM, the surveyor reviewed the facility's grievance policy. The grievance policy had an effective date of 01/12/2017 and a last review date of 05/30/2019. On page 2 of the grievance policy under procedure 1: Prevent ongoing violations: the grievance official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated , and under Procedure 4: Time Frame a. The grievance review will be completed in a reasonable time frame consistent with type of grievance. On page 3. Procedure #5. Grievance Decision: iii Steps taken to investigate the grievance. the facility did not provide evidence of completing the following processes related to its grievance policy: 6. Resident Notification: the facility failed to document within the concern form nor during the interview with the administrator that the complainant had been notified of the outcome of the investigation. The facility failed to follow its own grievance policy which resulted in a four-month delay in the facility investigation, the application of corrective action with staff related to the complaints, and the timely notification of the resident or family member of the outcome of the grievance investigation.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42863 Based on record review, and interviews of staff and residents, it was determined that the facility failed to ensure that residents were free from abuse. This was found to be evident for 1 (Resident #88) out of 11 residents reviewed for resident to resident abuse and 4 (Resident #20, #38, #16, #8) of 40 residents reviewed for facility reported abuse allegations. As a result, actual harm was identified for the facility's failure to ensure that resident # 88 was free from physical abuse and injury due to another resident's aggressive behavior. The findings include: An FRI (facility reported incident) is a self- report with investigations conducted by nursing home facilities. 1) On 01/05/23 at 08:47 AM, the surveyor interviewed the residents #72 and #74. Resident # 72 stated that, on 01/01/23 at around 10:00 AM, another resident, #73, entered his/her room and grabbed his/her left forearm, scratched the skin, twisted his/her wrist, and left bruising on the left forearm below the elbow. On 01/05/23 at approximately 10:30 AM, the surveyor requested that the Administrator provide a copy of the FRI related to Resident #72 and the surveyor completed the review of the FRI at approximately 2:30 PM on 01/05/23. A review of the medical record revealed documentation by LPN # 4 that, on 01/01/23 at 11:35 AM, Resident #73 entered another resident's room, grabbed their arm and caused discoloration. The Nurse practitioner (NP) on call was made aware and the resident's family members were updated on the situation. The surveyor reviewed the FRI for resident #73 which included an interview completed around 12 noon on 01/01/23 by the facility staff with Resident #88 who stated that he/ she went to their room to sit on the bed. Resident # 73 entered the room and was trying to take things from her roommate in bed #1 and the resident in bed #1 was telling resident #73 to stop. Resident # 73 proceeded to walk to bed # 2 and take something off the bed. Resident #88 told Resident # 73 to not bother the resident in bed 2 and to leave her things alone. Resident # 73 then walked to the window ledge and picked up Resident # 88's bible. Resident #73 proceeded to hit Resident #88 in the face with the bible and then exited the room. Resident # 88 stated that they went to the hallway and saw Licensed Practical Nurse (LPN) # 40 and informed them of the physical altercation. Resident # 88 was physically assessed and noted to have blood present on the bridge of the nose and a bruise on the forehead. Notifications were made to the on-call medical doctor and the nurse practitioner (NP). GNAs were instructed to watch/monitor Resident # 73 prior to a hospital transfer to the emergency room . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the S-BAR, Change in Condition document that was written on 01/01/23 at 11:17 AM by LPN #48, revealed that Resident #73 appeared to be agitated with a diagnosis of dementia and psychosis.The recommendations for nursing were to continue to monitor Resident #73. Primary care provider : Recommendations: monitor. Written by LPN # 48. New Intervention Orders: Removed Resident and de-escalated situation. During a telephone interview with LPN # 48 on 01/13/23 at approximately 2:52 PM, the surveyor asked: What preventive measures were instituted after the first display of aggressive behavior was demonstrated by Resident #73 around 10:00 AM on 01/01/23? LPN # 48 stated that staff (GNAs) were told to monitor Resident #73 and to shut all the other residents' door to discourage Resident #73 from wandering into the other resident's rooms. LPN # 48 also stated I did use de-escalation techniques with Resident # 73. and that All staff were assigned the task of monitoring resident #73 in the hallway. During an interview at 1:24 PM on 01/13/22, the DON stated: The resident should have been placed on 1:1 after the first display of aggressive behavior. The surveyor asked : Has any staff education been provided since related to resident/resident abuse? The DON responded: I provided an in-service to all staff on 01/02/23. During the in-service, I emphasized that any aggressive residents should be placed on 1:1 immediately in order to prevent potential harm to other residents or staff. On 01/12/23 at approximately 2:22 PM, the surveyor reviewed a FRI for a second resident-to-resident physical altercation that occurred on 01/01/23 at approximately 12 noon, that involved the same perpetrator, Resident # 73. The second victim of alleged resident to resident physical abuse was Resident #88. On 01/13/23 at 1:23 PM, the surveyor reviewed the progress notes related to Resident #73, written on 01/01/23 beginning at 12:18 PM. Staff # 50 wrote the following: Diagnosis: Altercations, Change in mental status, possible infection, UTI. Notified that resident has had x2 altercations with 2 other residents. The aggressive resident caused a bruised area to upper extremity during the first altercation, but no skin tears were noted. After the second altercation involving Resident #73, Resident #88 sustained injuries described as blood on the bridge of the nose and bruising to the forehead. Aggressive resident is typically calm and cooperative. She/he was alert and oriented x1 with known aphasia. She/he is currently aggressive toward other residents and now with staff. During video assessment, Resident #73 was verbally aggressive, yelling and charging at staff. Due to significant change in behavior and to provide safety to staff, NP recommended transfer of Resident #73 to the ER. NP felt she/he may be experiencing an infection such as UTI. On 01/13/23 at 1:32 PM, the surveyor reviewed the medical record related to resident #88. A change in progress notes written by LPN #40 at 12:18 PM on 01/01/23 revealed the resident had a skin condition change that involved the top of the scalp with redness and mild bruising to the forehead. Also, there was a second skin assessment signed by LPN #2 on 01/03/23 but dated for 01/01/23. The second skin assessment stated that Resident #88 had a new red colored abrasion that measured 0.2 X 0.2 (LxWxD) on the face/forehead. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/13/23 at 10:30 AM, a review of the electronic medical record revealed that, on 01/01/23, Resident #73 was transferred to Meritus Hospital. The change of condition form included the following information: Reason for transfer: Resident to be evaluated for the changes in mental status and physical aggression displayed towards other residents. The two resident/resident physical abuse allegations were substantiated by the facility. Resident #73 was identified as the aggressor in both facility investigations. In summary, the facility failed to ensure that resident # 88 were free from physical abuse due to resident #73's aggressive behavior. At 1:30 PM on 01/13/23, the Nursing Home Administrator and the DON were interviewed regarding the two FRI's submitted to OHCQ (the Office of Healthcare Quality) related to resident # 73. Additionally, both the Nursing Home Administrator and the DON were notified of the potential harm related to Resident #73, during the exit conference on 01/13/23 at 4:00 PM. 40927 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. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Brief Interview of Mental Status (BIMS) test is used to get a quick snapshot of cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. 2. A medical record review on 12/28/22 at 9:24 AM for Resident #20 revealed the resident had been in the facility for approximately 2 years. A progress note written for a visit conducted on 1/4/22 by Certified Nurse Practitioner (CRNP) #6 revealed that Resident #20 suffered from many health issues to include, but not limited to diabetes, high blood pressure, chronic kidney disease, and bipolar disease. CRNP #6 documented that Resident #20 used a wheelchair to get around the facility. A review of the progress notes and administration records for medication and treatment for 12/21 revealed one documented behavior of medication refusal on 12/26/21. Otherwise, staff had not documented behaviors for this Resident #20. Further review of the medical record revealed that the resident was evaluated by the facility's mental health services on 12/16/21, following a readmission to the facility. The visit was conducted by CRNP #63. She noted that Resident #20 was being seen as a follow up requested by the facility. She documented that nursing staff reported the resident had no recent behavioral or mood concerns, elopement attempts, or episodes of resisting care. The note further read that Resident #20 was cooperative with medication administration and voiced no suicidal ideations or passive death wishes per nursing. Resident had questionable judgement, limited ability to effectively problem solve, and was goal directed. Resident was to continue antipsychotic medication for treatment of bipolar disease. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/28/22 at 9:33 AM, a review of the facility's investigation file for self-reported incident #MD00181051 was conducted. The self-report concluded that Resident #20 had been abused by an agency Licensed Practical Nurse (LPN) #49 on 1/9/22 during the evening shift. The facility provided in-service sign-in sheets as evidence that staff were given education about the different types of abuse and abuse reporting. There were interview sheets for the residents capable of an interview and skin sheets for residents who had not been capable of an interview, and no additional abuse concerns had been identified. A review of the witness statements collectively revealed that, on 1/9/22, the facility was in a COVID 19 outbreak and as residents tested positive for COVID 19 they were being moved to the COVID 19 positive unit referred to as the red zone and there was a plastic barrier between the red zone and the rest of the unit which was considered the green zone. According to the statements, the red zone staff were to stay in the red zone and green zone staff were not to go into the red zone and so forth. However, that day staff had been crossing over into the other zones to move residents and provide care. The Nursing Home Administrator (NHA) provided an undated statement from Resident #20 (but did note the date that the incident occurred was on 1/9/22). The statement described what Resident #20 had observed on 1/9/22 regarding staff not adhering to the red zone and green zone as they moved residents to the COVID 19 positive unit and provided care. It further described that Resident #20 had attempted to address the issues/concerns with staff to which they didn't seem to be listening. As LPN #49 was transporting a resident to the red zone, he tore a hole in the plastic barrier and Resident #20 asked him about it and was told that he would fix the hole. The resident left the unit for an hour and returned to see staff sitting in the nurses' station and LPN #49 had his mask off while talking to the other staff. Resident #20 noted that the hole had not been fixed and s/he became infuriated. Resident #20 started recording on his/her cell phone the hole in the plastic and the staff sitting in the nurses' station not wearing a mask. Resident #20 reports that an argument occurred between them and LPN #49 and they were cussing at each other. LPN #49 proceeded to come out of the nurses' station towards the resident to grab the resident's phone from them. Resident #20 then alleges that LPN #49 started to punch his/her hand so the resident would let go of the phone. Resident #20 then reported that s/he started punching LPN #49. Reportedly, LPN #49 backed off and stated he was going to call the police, but then started back towards the resident. At this point the resident grabbed a pair of scissors and told LPN #49 s/he would stab him if he attacked him/her again. Resident #20 reported that s/he went to the lobby and called the police. The statement provided by LPN #49, dated 1/9/22, read that he asked Resident #20 to stop recording on his/her cell phone because of HIPAA (The Health Insurance Portability and Accountability Act of 1996 a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. www.cdc.gov) and the privacy rights of the staff. LPN #49 reported that when Resident #20 continued to record with the cell phone he went over to the resident and attempted to grab the phone from the resident. Reportedly, when Resident #20 grabbed a pair of scissors and threatened to kill him, LPN #49 walked away to call the Director of Nursing (DON). LPN #49 reported that the DON advised him to call the police. Although it was mentioned in LPN #49's statement that he reported the incident to the DON, review of the investigation file revealed no documentation from the DON regarding the date, time, and content of the conversation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A statement from agency Registered Nurse (RN) #68 confirmed that Resident #20 had been upset regarding the way staff were going from the red zone to the green zone during the shift. She reported as the resident continued to get angry, calling us names, taking pictures, and recording us she had asked LPN #49 to assist because the resident was getting out of control. RN #68's statement confirmed that she had been present and that LPN #49 had attempted to take the resident's phone from his/her hand, however, she did not report that LPN #49 was cussing and arguing with the resident, only that he had been trying to explain things to Resident #20. According to RN #68's statement, During my time at Hagerstown Healthcare Center, I have not seen or heard of any employee abusing residents therefore, she had not identified this incident of a staff member arguing, yelling, and cussing at a resident and attempting to grab a cell phone from the resident's hand as abuse. Nor had she documented she had intervened to separate the abusive staff member from the resident to protect the resident. A statement from agency Geriatric Nursing Assistant (GNA) #69, dated 1/9/22, revealed that she had words with Resident #20 regarding the red zone and green zone and that the resident had been upset. Reportedly, she had been present during the abusive altercation between LPN #49 and Resident #20, by stating that LPN #49 had told Resident #20 to stop recording and a heated argument occurred. Based on GNA #69's statement, she had not attempted to intervene when abuse occurred to protect the resident. An unsigned, undated statement from GNA #66 indicated that on 1/9/22, she had been working on the yellow unit and overheard the arguing. GNA #66 went to see what was going on and heard Resident #20 saying that the staff were trying to give the residents COVID and that s/he had been upset about the hole in the tape. Reportedly, GNA #66 had not heard everything that had been said between Resident #20 and LPN #49 but confirmed that they had been loud and LPN #49 was trying to get his point across. She reported that, when Resident #20 threatened to kill LPN #49, she had intervened to calm the resident down. Based on her statement, she had not attempted to separate LPN #49 from Resident #20 to protect the resident, when in fact she walked away and went back to the yellow unit. She recounted that LPN #49 started to follow her, so he could move another resident. Then an unidentified nurse came in to let LPN #49 know that Resident #20 was further threatening him and that was when LPN #49 called someone who had told him to call the police. GNA #66 failed to recognize this incident as abuse due to a sentence she had in her statement that read, During my time at Hagerstown Healthcare Center, I have not seen or heard of any employee abusing residents. A statement from GNA #32, dated 1/9/22, revealed that she had seen Resident #20 in the lobby holding a pair of scissors. Reportedly, when she asked the resident what s/he had been doing with the scissors, the resident responded that s/he were defending themselves. GNA #32 asked the resident to give the scissors to her and the resident complied. A medical record review on 12/28/22 at 9:24 AM revealed a progress note that Resident #20 had been seen by CRNP #106 on 1/10/22. CRNP #106 documented that the resident was seen on rounds secondary to an incident that occurred over the weekend. Patient said to have become verbally abusive towards staff and then threatened a male staff member with scissors. Resident #20 was calm this morning and stated that he had no intention to hurt anyone. The resident stated that he felt threatened at the time of the incident and was only trying to defend himself. Patient stated that he was not worried about his personal safety. However, there was no mention that Resident #20 had been abused by staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Further review of the medical record revealed a subsequent visit from the facility's psychiatric services provider on 1/11/22 in which Resident #20 was seen by CRNP #63. She documented in the note that resident was being seen following an incident of agitation, aggressive behavior towards staff, and threatening staff with scissors. CRNP #106 doesn't mention or address that Resident #20 had been abused by a staff member. On 12/28/22, a review of LPN #49's employee and education file revealed no behavioral health training. On 12/28/22, a review of RN #68's employee and education file revealed no behavioral health training. On 12/28/22, a review of GNA #66's employee and education file revealed no behavioral health training. During the review of LPN #49, RN#68, and GNA #69's employee files, it was determined that all three staff had worked for the same staffing agency. On 1/5/23 at 12:30 PM, a review of the staffing agency's contract with the facility, dated 5/21/21, revealed that the staffing agency was responsible to ensure that staff had the appropriate training to care for the residents in the facility. However, there was no process for the facility to inform the staffing agency of the training needed to care for their residents. On 12/28/22, a review of GNA #69's employee file revealed she had been employed by the facility. She had completed the online temporary nurses' aide training on 12/17/21. The facility provided no evidence of any training completed by GNA #69, no evaluation of resident care competencies, and no evidence that she had been trained on the behavioral health needs of residents. A review on 1/5/23 at 1:00 PM of the facility's assessment tool, dated 8/20/21, revealed the facility had failed to identify the training/competency needs for the staff to care for their resident population. On 12/28/22 at 11:15 AM, an interview was conducted with LPN #49 and he reported he remembered being asked by the DON to help move residents who were COVID 19 positive to the COVID 19 positive unit. He reported that he had 30 residents on the 2nd floor and had to go to the first floor to move the residents as requested ,which he felt doubled his workload. When asked about the specific events of 1/9/22, LPN #49 stated that due to the legal battle, he did not feel comfortable discussing it with the surveyor. On 1/5/23 at 10:53 AM, surveyor reviewed the concerns with the Director of Nursing and the Regional Director of Clinical Services #22. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview completed on 1/11/23 at 12:35 PM with the Nursing Home Administrator (NHA) and Corporate Executive Director #29 to review the concerns, it was stated that the facility relied on the staffing agency to send them staff who were able to provide care and services for the residents at the facility. However, they reported that, once a contract was signed with a staffing agency, there was no additional information sent to them regarding changes or updates in the resident population. While discussing the concern that none of the staff intervened to protect the resident and wrote statements indicating that LPN #49 was only trying to get his point across, the NHA reported that when things like that were identified, they provided training to the agency staff who were present on the days that the training had been offered. They had not held additional training to ensure that all agency staff had been trained. When asked the rationale for the facility's determination that physical abuse had not been substantiated, the NHA stated that they had substantiated the verbal abuse because it was recorded on the resident's phone. She stated that, when LPN reached the resident, the recording stopped, but she wanted to review the investigation notes and get back to the surveyor. A subsequent interview with the NHA on 1/11/23 at 2:45 PM revealed that they reviewed and determined that the intention of the staff member (LPN #49) was to remove the phone from the resident to stop him from recording them. However, when asked if it was appropriate for a staff member to grab a phone from a resident's hands, she responded, no it is not. The NHA stated she understood what the surveyor was asking, but they had identified a problem with residents recording things on their cell phones and was concerned about the privacy of the other residents. The NHA could not provide evidence that the facility had provided any guidance to staff on how the facility wanted them to handle an incident involving a resident recording within the facility. She stated that the staff would call management and they would instruct staff on what to do at that time. 3) On 1/4/23 at 9:32 AM, a medical record review for Resident #38 was conducted. A minimum data set with the assessment reference date of 3/22/22 revealed in section C that the resident had a BIMS of 15 which indicated no cognitive impairment and section E had no documentation indicating that this resident had behaviors. Review of the progress notes revealed this resident had a visit with the attending physician on 4/18/22 and she had documented the resident had the following, but not limited to diagnoses: morbid obesity, chronic back pain and now was having bilateral knee pain. His pain was treated with a narcotic and an analgesic for break through pain. A progress note written by Registered Nurse (RN) #71 on 4/21/22 revealed that resident was having uncontrolled pain at an 8/10 over the past 5 days. On 1/3/23 at 9:25 AM, a review of the facility's investigation file regarding self-report #MD00182599 revealed they had determined that, on 4/21/22 at 11:00 AM, RN #70 had abused Resident #38. According to the documentation, it was a witnessed altercation and RN #70 was removed from the area and an investigation was started. According to the statement provided by Resident #38, the resident had been asking RN #70 for pain medication on the morning of 4/21/22. At 10:10 AM, the resident was talking to Unit Nurse Manager (UM) #2 in his/her room. While they were talking, RN #70 came in and said to Resident #38 that he had told him/her he would be with them shortly. The resident reportedly became upset and attempted to get out of bed and that was when UM #2 stepped between them to try to deescalate the situation. A statement from RN #70 read that he thought that Resident #38 had called UM #2 into his/her room to complain about RN #70's delay with getting the pain medication as requested. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A statement from UM #2 read that she had been in Resident #38's room talking with the resident about the situation with the pain medication being delayed when RN #70 came into the room and started yelling at the resident. She stated she had to step between them and was asking RN #70 to leave the room. There were additional statements from other staff who had been on the unit at the time of the incident and reported hearing RN #70 yelling. As a result of the investigation, RN #70 was terminated. The facility reported their interventions were to monitor Resident #38's psychosocial wellbeing and staff from Social Services were to meet with Resident #38 to discuss disrespectful behaviors from staff. 4) A medical record review for Resident #16 was conducted on 1/11/23 at 4:06 PM. A Minimum Data Set, with the assessment reference date 5/29/22 in section C, revealed this resident had a BIMS of 15/15 which indicated no cognitive impairment. According to Certified Nurse Practitioner (CRNP) #5's progress note, dated 9/23/22, Resident #16 was in the facility for management of Chronic Obstructive Pulmonary Disease (COPD - lung disorder that is defined by a person being diagnosed with at least two of the following lung conditions: asthma, chronic bronchitis, and/or emphysema), diabetes type 2, chronic kidney disease, and depression. Review of the record failed to reveal that staff had documented that Resident #16 had behaviors. Further review revealed this resident was locomotive throughout the facility on a motorized scooter. On 12/29/22 at 3:30 PM, a review of the facility's investigation file for the self-report #MD00184946 was conducted. The facility documented on the self-report form that, on 10/26/22 at 9:00 AM, Resident #16 had been waiting at the elevator on the 1st floor with an agency Licensed Practical Nurse (LPN) #71 who proceeded to state to the resident that s/he needed to let the ambulance people go first. An argument occurred and LPN #71 was overheard calling Resident #16 a curse word. A former Unit Manager (UM) #104 and a Geriatric Nursing Assistant (GNA) #105 had witnessed the altercation. Resident #16 and LPN #71 had been separated. Statement taken from UM #104 and GNA #105 confirmed that LPN #71 had called Resident #16 a curse word. The facility had concluded that the abuse was substantiated. As a result of the investigation, the facility reportedly contacted LPN #71's staffing agency and provided evidence that the following trainings were provided for all facility staff regarding Customer Service, 7 Types of Abuse, and Behavior Management. An interview conducted on 1/11/23 at 12:35 PM with the NHA and Corporate Executive Director #29 revealed that, in review of the abuse cases since January 2022, they had not provided any type of behavior management training for staff until recently they reached out to their psychiatric service provider to give a training on how to manage residents with behavior issues. When asked to provide behavior health training that was provided upon hire and annually, they provided training for residents with dementia, however, the residents involved in these incidents had no cognitive impairment. Cross Reference: F607, F609, and F610. 37276 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	5) On 12/21/22 at 1:00 PM, a review of Facility Reported Incident MD00176589 revealed that, on 4/1/22, Resident #8 reported that a housekeeper, Staff #118, gave him/her the middle finger. The facility investigated the allegation and substantiated that the abuse occurred, and the employee was terminated for abuse. The substantiated abuse was discussed with the Director of Nurses (DON) on 1/3/23 at 4:07 PM.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on record review and staff interview, it was determined that the facility failed to provide their residents with an environment that was free of misappropriation of property, as evidenced by facility staff taking cigarettes from one resident and giving them to another resident, while promising to replace the cigarettes borrowed, but were not tracking the cigarettes borrowed to ensure replacement. This was evident for 1 (#16) of 4 residents reviewed for misappropriation of property. The findings include: A medical record review for Resident #16 was conducted on 1/11/23 at 4:06 PM. A Minimum Data Set, with the assessment reference date 5/29/22, in section C revealed the resident had a BIMS of 15/15 which indicated no cognitive impairment. According to Certified Nurse Practitioner (CRNP) #5's progress note dated 9/23/22, Resident #16 was in the facility for management of Chronic Obstructive Pulmonary Disease (COPD - lung disorder that is defined by a person being diagnosed with at least two of the following lung conditions: asthma, chronic bronchitis, and/or emphysema), diabetes type 2, chronic kidney disease, and depression. On 1/11/23 at 3:21 PM, a review of the facility's investigation file for self-report #MD00185631 revealed a self-report form that had documentation that Resident #16 reported to staff that his/her cigarettes were stolen. This was reported to the facility on [DATE]. A statement taken from Resident #16 by the Nursing Home Administrator (NHA) read that, in early summer, the resident had multiple packs of cigarettes with the Activities Department. The resident reported that three staff from the Activities Department, Staff #100, Staff #102, and Staff #103 had been taking cigarettes from him/her to give to other residents with the intentions of returning them except for Staff #100. Review of the staff statements revealed that they had been allowing residents to borrow other resident's cigarettes with the promise to return them. However, when asked how they were tracking the borrowed cigarettes to ensure that they had been returned, staff had reported they had no tracking system and were not sure if the cigarettes borrowed had been replaced. Furthermore, staff reported that this had involved taking cigarettes from Resident #16. The facility failed to interview other residents who smoked to determine the procedure being used by the Activities Department for distributing cigarettes. On 1/13/23 at 8:43 AM, an interview was conducted with the Nursing Home Administrator (NHA), with the Director of Nursing, Director of Clinical Services #22, and Regional Clinical Director #7 present, regarding the rationale for the facility not substantiating the allegation of misappropriation of property. The NHA reported that their rationale for not substantiated misappropriation was because Resident #16 had given permission for the cigarettes to be borrowed. When asked if it was an acceptable practice to borrow cigarettes from one resident to give to another resident with the promise to replace them and then not replace them, the NHA reported she needed to review the investigation and get back to the surveyor. However, the NHA had not come back with the rationale for not determining this incident to be misappropriation of resident property. Cross Reference: F607, F609, and F610.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 40927 Based on record review and interview, it was determined that the facility failed to implement their abuse policies and procedures by 1) failing to maintain an environment that was free of abuse for the residents, 2) failing to report abuse incidents and allegations of abuse to the State Agency within the required timeframe, and 3) failing to conduct a thorough investigation of allegations of abuse. This was evident for 1 of 1 abuse policy and procedure reviewed and has the potential to affect all residents. The findings include: A review of the facility's Abuse, Neglect, and Misappropriation Policy NS 1300-03 was conducted on 12/16/22 at 1:40 PM. The policy was dated 10/7/14 and was last updated on 9/20/22. The policy failed to address the screening of agency staff, how their abuse education would be verified, and reference checks completed. In addition, the staff who perpetrated abuse in self-reported incident #MD00181051, MD00182599, and MD00184946 had not been reported to their state licensing board. Further review of the policy revealed a section regarding the reporting of abuse: VII. 1. a. If the events that cause the allegation involve abuse and/or serious bodily injury the self-report must made immediately, but no later than 2 hours after the allegation is made. Section VII. 1. Although this was in the facility policy it was determined that 10 abuse allegations out of the 40 reviewed that had not been reported to the state agency within the 2 hour timeframe. Furthermore, the abuse policy read in the Investigation of Incidents that statements will be obtained from staff related to the incident, including victims, person reporting, accused perpetrator, and witnesses. This statement should be in writing, signed and dated at the time it was written. Supervisors may write the statement for the a person giving a statement about the incident to them and the person giving the statement must sign and date it or a third party may witness the statements. Also documentation of the facts and findings will be completed in each resident medical record. Witness statements were to include the firsthand knowledge of the incident and a description of what was witness, seen or heard. Review of 40 self-reported incidents revealed that 6 of these incidents had not been fully investigated by obtaining witness statements that were signed and dated, and contained description of what was witnessed, seen, or heard. The facts and findings of each abuse allegation had not been found in the resident's medical record. In addition, the policy read that all investigations of abuse, neglect, and misappropriation will be reviewed by the Quality Assurance Improvement (QAPI) committee. However, the facility had been cited for F600, F602, F607, F609, and F610 during a complaint survey in 11/15/21. The first incident of abuse occurred in 1/22. A month after the facility alleged compliance with these deficiencies. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the concerns was conducted on 1/13/23 at 8:43 AM with the NHA, Director of Nursing, the Regional Clinical Director #7, and Regional Director of Clinical Services #22 present. Cross Reference: F600, F602, F609, and F610.

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Hagerstown Healthcare Center	750 Dual Highway Hagerstown, MD 21740

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37276 Based on record review and staff interview, it was determined that the facility failed to have a process in place to ensure prompt reporting of abuse incidents and allegations to the State Agency within the required timeframes by failing to maintain accurate and complete documentation of the date and time that an incident of abuse was witnessed, an allegation of abuse occurred, if known, and/or when an allegation of abuse had been reported to facility staff. This was evident for 15 (Residents #8, #13, #81, #7, #9, #20, #38, #33, #16, #68, #67, #69, #5, #66, and #64,) out of 40 residents reviewed for abuse allegations and this deficient practice has the potential to affect all residents in the facility. The findings include: 1) On 12/20/22 at 11:00 AM, a review of facility reported incident MD00176589 revealed that Resident #8 reported that an employee gave him the middle finger. The facility's initial self-report, dated 4/1/22 at 1:00 PM, documented the incident occurred in the afternoon on 3/29/22, the resident reported the allegation of abuse on 4/1/22 and local law enforcement were called on 4/1/22 at 12:55 PM. The facility reported the incident to OHCQ on 4/1/22 at 6:18 PM. The facility failed to report the allegation of abuse to the state agency, OHCQ, within 2 hours of the allegation. 2) Review of the facility's investigation related to the facility reported incident MD00176589 conducted on 12/20/22 at 11:00 AM, revealed resident interviews had been conducted. Review of the abuse questionnaires revealed on 4/1/22, during an interview, that 2 residents (Resident #13, #81) reported they had been abused. On 12/21/22 at 4:49 PM, when asked if Resident #13 and Resident #14's allegations of abuse on 4/1/22 had been investigated and reported to OHCQ, the DON (Director of Nurses) indicated she would have to follow up to see if the allegations of abuse had been investigated. On 12/29/22 at 3:30 PM, the NHA (Nursing Home Administrator) confirmed hat the abuse alleged by Resident #13 and Resident #81's on 4/1/22 in the abuse questionnaire had not been investigated at that time. The NHA stated that after becoming aware of the allegations [by the surveyor], Resident #13 and Resident #81 were interviewed and the resident concerns were deemed customer service concerns not abuse, indicating the allegations would not be investigated or reportable to the regulatory office. On 12/29/22 at 3:57 PM, the DON informed the surveyor that the facility would be investigating Resident #13 and Resident #81 abuse allegations. On 12/29/22 at 4:45 PM, the surveyor received a Concern Form, dated 12/22/22, for Resident #13, that documented Resident #13 did not recall the past event, however, the resident reported 2 new allegations of abuse, verbal abuse from a nurse on 11/6/22 and bullying by a nurse on 11/11/22. Also received was a Concern form, dated 12/22/22, for Resident #81 that documented an allegation that an agency nurse verbally abused Resident #81 when the resident asked for medication. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/22 at 12:55 PM, the NHA provided the surveyor with an initial self-report for Resident #13, and an initial self-report for Resident #81, and indicated the self-reports were in response to the allegation of abuse the residents alleged on 4/1/22. The initial self-report for Resident #13, dated 12/30/22 at 10:00 AM, documented that the type of report was abuse, the date and time of the incident was 11/6/22 & 11/22/22; unknown. The facility notified the regulatory office, OHCQ on 12/30/22 at 12:27 PM. The initial self-report for Resident #81, dated 12/30/22, documented the type of report was abuse, and the date and time of the incident were unknown. The facility notified the regulatory office on 12/30/22 at 12:35 PM. The self-reports did not reference the date that the resident initially reported an allegation of abuse on 4/1/22, the date the surveyor made the facility aware of the allegation on 12/21/22, or the date that Resident #13 alleged verbal abuse by an agency nurse as documented on 12/22/22 in a Concern Form. The facility failed to report Resident #13 allegation of abuse and Resident #81's allegation of abuse to the regulatory agency with-in 2 hours of the allegation on 4/1/22, failed to report the allegation of abuse, when again made aware of the allegation on 12/21/22, or in response to Resident #13 and Resident #81's allegation of abuse during an interview on 12/22/22. On 1/12/23 at 4:25 pm, the NHA (Nursing Home Administrator), the Corporate NHA, and the Director of Nurses were made aware of all concerns. 3) On 12/21/8122 at 10:30 AM, a review of facility reported incident MD00183174 revealed that, on 9/6/22, Resident #7 reported to staff that on the 11pm - 7am shift, that a GNA (geriatric nursing assistant) had scratched the resident and yanked the resident's brief during care. The facility's initial self-report, dated 9/6/22 at 9:00 AM, documented the date and time of incident as 9/5/22 - 9/6/22, with time unknown and the local law enforcement was called on 9/6/22 at 9:10 am. The facility reported the incident to the Office of Health Care Quality on 9/6/22 at 3:17 PM. The facility failed to report the allegation of abuse to the state agency, OHCQ, within 2 hours of the allegation. 4) On 12/30/22 at 10:30 AM, review of facility reported incident MD00177644 revealed that, on 5/26/22, Resident #9 was observed in a confrontation with another resident's family member. Initial self-report indicated the incident occurred during the day and was reported to the local law enforcement on 3:24 PM. The facility reported the incident to the State Agency, OHCQ on 5/26/22 at 5:59 PM. The facility failed to report the allegation of abuse to the state agency, OHCQ, within 2 hours of the allegation. The facility submitted the final self-report on 6/1/22 at 5:03 PM which was 6 days, not 5 days. The facility failed to report the final report to the state agency, OHCQ, within 5 days. On 1/12/23 at 4:25 pm the NHA (Nursing Home Administrator), the Corporate NHA, and the Director of Nurses were made aware of all concerns. 40927 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) On 12/28/22 at 9:33 AM a review of the facility's investigation file for the self-report #MD00181051 revealed a self-report form that the facility sent to the State Agency (SA) documenting an incident of abuse perpetrated by LPN #49 against Resident #20. Review of the form revealed that the Nursing Home Administrator (NHA) had completed the form and entered a date of 1/10/22 at 4:00 PM and in the section titled Incident Date and Time she entered 1/10/22 on evening shift. Further review of the investigation revealed that the incident had occurred on 1/9/22 and although it had been a witnessed incident the facility had failed to document the time of the incident. According to the statements the Director of Nursing (DON) was notified by the LPN #49 who had abused Resident #20 and the DON failed to provide documentation of the date, time, and content of her conversation with LPN #49. The witness statements used by the facility had a place for the date the incident occurred, but not for the time. In addition, review of the email confirmation revealed that the incident had not been reported to the State Agency (SA) until 1/10/22 at 5:52 PM which was past the 2-hour timeframe required. 6) On 1/3/23 at 9:25 PM a review of the facility's investigation file for self-report # MD00182599 revealed a self-report form that the facility sent to the SA documenting an incident of abuse perpetrated by Registered Nurse (RN) #70 against Resident #38. The self-report form noted that the incident occurred on 4/21/22 at 11:00 AM. Further review of the investigation file revealed statements written by Resident #38 and staff that reported the incident occurred sometime between 9:40 AM and 10:00 AM, and although it was a witnessed incident facility staff failed to document a time at which it occurred. Furthermore, an email confirmation for when the self-report form had been sent to the SA showed it had been sent on 4/21/22 at 7:40 PM which was past the 2-hour timeframe required. 7) A review of the facility's investigation file for self-report #MD00182899 was conducted on 1/3/22 at 8:00 AM. The self-report form was dated 8/28/22 at 5:00 PM and in the section for the date and time of the incident the report form read 3/29/22 in the afternoon, however in the body of the self-report form it was noted the incident occurred on 8/27/22, but was not reported to facility staff until 8/28/22. Review of the witness statements revealed that Resident #33 reported to staff that during the night shift a Geriatric Nursing Assistant had been rough with him. Staff failed to document which shift the accused GNA had worked and what time the resident had reported the allegation of abuse to facility staff. Further review of the file revealed an email confirmation that showed the initial report had not been sent to the SA until 8/28/22 at 6:40 PM. 8) On 12/29/22 at 3:30 PM a review of the facility's investigation file for self-report #MD00184946 revealed a self-report form that documented a witnessed abuse incident perpetrated by LPN #71 against Resident #16 that occurred on 10/26/22 at 9:00 AM. Further review of the investigation file revealed an email confirmation that showed the facility sent the self-report to the SA on 10/26/22 at 1:09 PM which was past the 2-hour required timeframe. 9) On 1/3/23 at 7:40 AM a review of the facility's investigation file for self-report #MD00182254 which was an allegation of abuse reported by Resident #68 against GNA #72. According to the self-report form Resident #68 reported the incident on 8/12/22, but it had occurred on 8/11/22 during the evening shift. The facility failed to document when and to whom the allegation was reported. An email confirmation documented that the facility had notified the SA on 8/12/22 at 8:30 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10) Additionally, the facility failed to report allegations of abuse within the required 2-hour timeframe for the residents: Resident #67 on 2/11/22, Resident #69 on 3/6/22, Resident #5 on 4/18/22, Resident #66 on 4/29/22, Resident #5 on 5/21/22, Resident #64 on 6/20/22, and Resident #16 on 11/8/22. A review of the facility's Abuse, Neglect, & Misappropriation NS 1300 03. Dated 10/7/2014 and last updated on 9/20/22 was conducted on 12/16/22 at 1:40 PM. The policy stated that staff were expected to report all allegations of abuse to the SA within 2 hours. During an interview with the DON on 1/11/23 at 9:41 AM the surveyor reviewed the concerns and the DON reported that the facility was working on a new process for abuse reporting. A review of the concerns was conducted on 1/13/23 at 8:43 AM with the NHA, Director of Nursing, the Regional Clinical Director #7, and Regional Director of Clinical Services #22 present. Cross Reference: F600, F602, F607, and F610

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 37276 Based on record review and staff interview, it was determined that the facility failed to have a process in place to thoroughly investigate all allegations of abuse to take the appropriate corrective actions; and failed to have evidence that a resident's injury of unknown origin was thoroughly investigated. This was evident for 6 (Resident #13, #81, #16, #20, #33, and #68) of 40 residents reviewed for allegations of abuse, and 1 (Resident #32) of 2 residents reviewed during the survey in relation to facility reports of injury of unknown origin. The findings include: 1) On 12/20/22 at 11:00 AM, a review of facility's investigation of facility reported incident MD00176589, revealed that resident interviews were documented on Abuse Questionnaire forms. Review of the resident interviews revealed that, on 4/1/22, Resident #13's response to the question Has staff, a resident, or anyone else here abused you, was documented Y (yes) and Did you tell staff? was documented as Y, indicating Resident #13 had been abused and had told the staff, and Resident #81's response to the question Has staff, a resident, or anyone else here abused you, was documented Y (yes) and Did you tell staff? was documented as Y, indicating the Resident #81 had been abused and he/she had told the staff, and Resident #81 alleged he/she had been abused and had told the staff. On 12/21/22 at 4:49, when asked if the facility had investigated the allegations of abuse, the DON (Director of Nurses) indicated she would find out if they allegations had been investigated. On 12/29/22 at 3:30 PM, during an interview, the NHA (Nursing Home Administrator) indicated that Resident #13 and Resident #81's allegations of abuse on 4/1/22 had not been investigated at the time that the allegations of abuse were made. The NHA indicated that when Resident #13 and Resident #81 were talked to regarding their abuse allegations, both residents had customer service concerns, not abuse allegations, therefore, an investigation and facility report had not been initiated, and that the interviews with the residents were documented on a concern form. The surveyor requested a copy of the concern forms that documented the resident interviews. On 12/29/22 at 3:57, when the surveyor requested that the DON provide the documentation of the interviews conducted with Resident #13 and Resident #81 in regard to the residents' allegation of abuse on 4/1/22, the DON indicated that the facility would be investigating the allegations. The facility failed to conduct a thorough investigation of an allegation of abuse by 2 residents on 4/1/22 to determine whether alleged abuse had occurred. 2) On 12/29/22 at 4:45 PM, the surveyor received a Concern Form, dated 12/22/22, for Resident #13. In the form, Resident #13 alleged that Staff #43, LPN, agency nurse had verbally abused her/him on 11/6/22 during the evening shift and Staff #44, RN had bullied him/her on 11/11/22 during the late evening. The unsigned concern form did not indicate the time of the interview, who interviewed the resident and did not reference the resident's allegation of abuse on 4/1/22. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/22 at 11:00 AM, during an interview, Staff #14, SSA (social service assistant) stated that he/she conducted the interviews on 12/22/22 with Resident #13 and Resident #81 which were documented on the concern forms. Staff #14 stated that his/her understanding was that no one had followed up on Resident #13 and Resident #81 abuse allegations from the resident interviews on 4/1/22, and he/she was asked to go back and talk to the residents, which he/she did. On 12/30/22 at 12:55 PM, the NHA provided the surveyor with an initial self-report for Resident #13 dated 12/30/22 at 10:00 AM. The report was dated 12/30/22, the report type was abuse, and indicated the date and time was 11/6/22 & 11/22/22; unknown. The report indicated there were 2 perpetrators and documented Resident #13 reported concerns with staff on 11/6/22 and 11/11/22. On 1/12/23, a review of the facility's final self-report for Resident #13's allegation of abuse (facility reported incident MD00187177) and the facility's investigation was conducted. Review of the facility's investigation revealed that the facility interviewed the alleged perpetrators, Staff #43, and Staff #44 and no other staff were interviewed during the investigation. On 1/12/23 at 3:34 PM, during an interview, when asked why the facility's investigation failed to interview other staff members, the NHA stated it was because the resident specifically called them out, so they centered around them and interviewed the resident. At that time, the NHA was made aware of concerns related to failing to thoroughly investigate an allegation of abuse. On 1/12/23 at 4:25 pm the NHA, the Corporate NHA, and the Director of Nurses were made aware of all concerns. 40927 3) On 1/11/23 at 3:21 PM, a review of the facility investigation file for self-report # MD00185631 in which Resident #16 reported that Activity staff #100, 102, and 103 had been borrowing cigarettes from him/her and had not replaced them. During the investigation other resident's had been interviewed in regard to missing property although it may be that residents had not been missing the cigarettes because they had been the one borrowing them. Therefore, the facility failed to conduct a thorough investigation by failing to determine other residents who may have been witness to the staff's smoking procedure and/or been a victim of misappropriation in the same manner. (Cross reference F602) 4) On 12/28/22 at 9:33 AM a review of the facility's investigation file for the self-report #MD00181051 revealed a self-report form that the facility sent to the State Agency (SA) documenting an incident of abuse perpetrated by LPN #49 against Resident #20. Although this incident had been witnessed by 3 staff members no one documented the time the incident occurred and staff failed to sign and date the statements. A review of the witness statements revealed the the Director of Nursing (DON) was notified by the LPN #49 at the time of the incident and the DON failed to provide documentation of the date, time, and content of her conversation with LPN #49. Lastly, the facility failed to determine through the investigation that Resident #20 had been agitated and was addressing staff by cursing at them and staff responded to the resident in a manner that had increased the agitation versus resolving it, as evidenced by Resident #20's statement and staff statements. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) A review of the facility's investigation file for self-report #MD00182899 was conducted on 1/3/22 at 8:00 AM. The review revealed that Resident #33 had reported a GNA had been rough with him/her and squeezed the resident in places that should not have been squeezed. The facility failed to document the date and time the incident occurred and when and to whom Resident #33 reported the incident. Further review of the incident revealed that the facility failed to interview Resident #33 regarding his/her statement which did not describe what had occurred in order to further investigate the abuse allegation. The allegation of abuse was unsubstantiated by the facility; however, a thorough investigation had not been completed. 6) On 1/3/23 at 7:40 AM a review of the facility's investigation file for self-report #MD00182254 which was an allegation of abuse reported by Resident #68 against GNA #72. According to the self-report form Resident #68 reported the incident on 8/12/22, but it had occurred on 8/11/22 during the evening shift. The facility failed to document when and to whom the allegation was reported. Staff failed to obtain statements that were complete, dated and signed. On 12/16/22 at 1:40 PM a review of the facility policy titled Abuse, Neglect, & Misappropriation NS 1300 03, dated 10/7/2014 and last updated on 9/20/22 was conducted. In the section titled, Investigation of Incidents it read that statements would be obtained from staff related to the incident, to include victims, person reporting, accused perpetrator, and witnesses. The statement was to be in writing, signed and dated at the time it was written. Further instructing that supervisors may write the statement for the person giving the statement about the incident to them. If this occurred, the person who gave the statement must sign and date it or a third party must witness the statement. Witness statements were to include the firsthand knowledge of the incident and a description of what was witness, seen or heard. In addition, documentation of the facts and findings was to be completed in each involved resident's medical record. 1/13/23 at 8:43 AM this concern was reviewed with the Nursing Home Administrator, Director of Nursing, Regional Clinical Director #7, and Regional Director of Clinical Services #22. Cross Reference: F600, F602, F607, and F609. 31982 7) . Review of facility reported incident #MD00180899 on 12/27/22 at 10:12 AM revealed that Resident #32 was observed with discoloration on his/her right hand on 1/5/22. The facility's investigative documentation included that the state agency and police were notified. Interviews were conducted with other residents asking if they were abused or had seen others abused. Statements were obtained from Staff #61 and #62, the GNA's (Geriatric Nursing Assistants) who discovered and reported the discoloration to Resident #32's hand. However, no statements were obtained from other staff or Resident #32 in an attempt to determine how or when the injury occurred. The Director of Nursing (DON) was made aware of these findings on 12/27/22 at 11:12 AM and indicated that she would look for additional statements. In another interview on 12/28/22 at 9:56 AM the DON indicated she was not able to find any additional statements.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 16218 Based on medical record review and interview, it was determined that the facility staff was unable to provide historical information for a resident being transferred to the hospital for altered mental status, who also presented with signs and symptoms of trauma. This was found to be evident for one out of 1 (Resident #21) out of 26 residents reviewed related to complaint investigations. The findings include: 1) On 12/29/22, review of Resident #21's medical record revealed that the resident was originally admitted to the facility several years ago and whose diagnoses included, but were not limited to: chronic pain, kidney disease with dependence on dialysis, diabetes, muscle weakness with a history of falling, lung disease and dementia. Review of the medical record revealed a nursing note, dated 12/27/22 at 4:56 AM by Nurse #73,that revealed the resident had a rash to the left side of the body. A telehealth consult with a nurse practitioner (NP) was completed and No orders for treatment at this time just monitor and follow up with on-call today. No documentation was found to indicate the rash was re-assessed during the day or evening shift on 12/27/22. Further review of the medical record revealed a Change in Condition Evaluation, dated 12/28/22 at 3:52 AM revealed the resident was experiencing shortness of breath, unresponsiveness and seemed different than usual; a primary care provider was notified and the recommendation was to send the resident to the hospital for further evaluation. This note was completed by Temp 12 - Temp/Agency Nurse. Review of the corresponding Transfer Form revealed documentation that Nurse #74 was documenting under Temp 12 on 12/28/22. Review of the nurse's note, dated 12/28/22 at 5:00 AM revealed the resident appeared pale and skin was warm to touch all over and legs were red and splotchy; mouth was dry; physician was notified and was picked up at 4:00 AM by EMS (emergency medical services). On 12/29/22 at 3:00 PM interview with EMT #76, revealed that upon arriving at the facility on 12/28/22, the EMT received paperwork from someone in the lobby and then went up to the resident's room. Upon entering the resident's room, no staff were available, although someone got the nurse. The nurse indicated this was the first time working with the resident and was unable to provide information other than the resident attended dialysis. The EMT noted that the left leg was larger than the right, with dark discoloration. When asked, staff were unable to state if this was normal for this resident. Additionally, a skin tear was noted but facility staff were unable to provide information about the skin tear. Review of the documentation on the EMT report for the 12/28/22 date of service supported EMT #76's report that facility staff were unable to provide information regarding resident's baseline status. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 12/28/22 hospital emergency room records revealed the resident presented for evaluation of respiratory distress and The nurse that was caring for this patient had never met the patient before tonight did not do anything about [his/her] medical history, baseline mental status, or any other pertinent medical information related to the patient. She states that she found the patient with apparent difficulty breathing which is what prompted her to call 911. No other staff at the facility was able to give a last known well time. No one there was able to say whether or not this patient experienced a fall. When EMS noted some discoloration of [his/her] leg staff said they were unaware of that. On 1/4/23 at 6:46 AM, interview with Nurse #74 revealed that she was a licensed practical nurse employed by a staffing agency and has been working at the facility a couple days a week, maybe since November or October. She only worked night shifts at this facility. The nurse went on to report that the 12/27/22 night shift was her first time on that side of the floor. In regard to Resident #21, Nurse #74 reported the resident was asleep when she first conducted her rounds. She was alerted by the GNAs #55 and #54 that the resident did not look right; she did not recall the time, but stated maybe around 2:00am. During the 1/4/23 interview, when asked what kind of report she received from the offgoing nurse, Nurse #74 reported: depends on what nurse you get report from. The nurse went on to state: nobody had mentioned anything to me about [him/her] not doing well; or [him/her] being on dialysis; someone said s/he may not be feeling well because just got back from dialysis, so thought that may have been the problem. Nurse #74 was not able to recall who informed her about resident having been at dialysis, and indicated it may be one of the supervisors. Review of Staffing and Assignment Sheets failed to reveal documentation to indicate that a supervisor or community nurse was on duty during the 12/27/22 night shift. An interview with Nurse #52 on 12/30/23 revealed that, when she worked as a community nurse, her role was to be a resource for agency staff. Nurse #74 reported obtaining the resident's vital signs, and due to the resident's mouth looking dry she attempted to give fluids to see if that would help, stating: I was spooning [him/her] fluids. The nurse indicated she worked with the resident for about 30 minutes then called the physician, then 911 and got the paperwork ready to send out. When asked if anything unusual about the resident's skin, the nurse reported: Guess they called the doctor about it the day before, purple bruising on half of his/her body, legs, trunk, don't remember which half. The nurse also reported the resident's legs did look a little swollen, but I never had [him/her] before so I don't know what [his/her] baseline is. When asked if the resident had a skin tear the nurse reported that there looked like an old one that got broke open, not sure if done while changing the resident. Further review of the hospital emergency room record, dated 12/28/22, revealed that, upon physical exam, the resident was found to have significant swelling and bruising involving the left leg compared to the right. And the summary included the following: Essentially no information was able to be obtained from the nursing home that would be helpful in determining a timeline of events, however, the patient also presents with signs of trauma/injury and work- up shows a displaced left intertrochanteric hip fracture. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the hospital emergency room record revealed the resident had symptoms of septic shock, which included a high fever, low blood pressure, high respiratory rate and high heart rate. On 1/5/23 at 10:50 AM, surveyor discussed the concern with the Director of Nursing and the Regional Director of Clinical Services #22, that according to Nurse #74, there was purple bruising on half of Resident #21's body including their leg, that EMT reported no one could tell them if the bruising noted on the leg was a change for the resident or if there had been a fall, and Nurse #74's confirmation that it was the first night she had cared for the resident and did not know the resident's normal status. DON acknowledged that she had reviewed the hospital report.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on medical record review and staff interview, it was determined that the facility failed to ensure that physician orders were obtained for the resident's immediate care at the time of admission. This was evident for 1 (#19) of 26 residents reviewed for complaints. The findings include: On 1/6/23 at 9:00 AM, a review of complaint #MD00185499 was conducted. The complainant reported that, on the morning of 10/16/22, Resident #19 was transferred to the facility from an acute hospital following orthopedic surgery. The complainant reported that, after being in the facility for a couple hours, Resident #19 was in severe pain from his/her broken bones, and when the complainant inquired about getting pain medication for the resident, he/she was told the medication needed to be delivered from another town, and when he/she pressed for more information, it was found out the resident had not been entered into the facility's system, which delayed things even more. On 1/6/23 at 9:00 AM, review of Resident #19's medical record revealed that the resident was admitted to the facility for rehab in mid-October 2022 following an acute hospitalization with diagnoses that included a fractured femur, lumbar fracture, and Type 2 diabetes, and transferred to the hospital on 10/17/22 at approximately 4:21 AM for management of uncontrolled pain. Review of the hospital's discharge instructions revealed a list of 15 medications which included: - Acetaminophen (Tylenol) 500 mg (milligrams) (pain reliever) 2 tabs by mouth every 8 hours - Albuterol (helps breathing difficulties) (Eqv-Proair HFA) 90 mcg/inh (microgram/inhalation) aerosol, 2 puffs inhalation every 6 hours as needed for shortness of breath. - Apixaban (Eliquis) (blood thinner) 5 mg by mouth 2 times a day - Atorvastatin (lowers cholesterol) 40 mg by mouth at bedtime - Calcium-Vitamin D 600 mg-12.5 mcg extended release by mouth once daily - Cholecalciferol (Vitamin D3) 50 mcg (2000 units) by mouth once daily. - Citalopram (antidepressant) 20 mg by mouth once daily - Famotidine (Pepcid) (digestive aid) 40 mg by mouth once daily - Furosemide (Lasix) (water pill) 40 mg by mouth once daily - Levothyroxine (thyroid hormone) 150 mcg by mouth once daily - Ondansetron (Zofran) (prevent nausea/vomiting) 4 mg by mouth once daily (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Polyethylene glycol 3350 (MiraLAX) powder for reconstitution 17 gram by mouth once daily. - Tramadol (narcotic pain medication) 50 mg by mouth every 6 hours as needed Also, handwritten on the discharge medication form, were the orders: - Levemir (Insulin detemir) (injection) 14 Units am, 4 Units pm - Novolog (insulin aspart injection) sliding scale (varies the dose of insulin based on blood glucose level). In an initial progress note on 10/16/22 at 3:43 PM, Staff #27, LPN, agency nurse, documented Resident #19 had been admitted to the facility at approximately 9:30 AM. In an Admission Initial Evaluation, with an effective date 10/16/22 at 5:00 PM, Staff #38, RN, documented Resident #19 was admitted to the facility on [DATE] at 9:00 AM. On 10/16/22 at 6:21 PM, Staff #38, RN documented that orders were verified. This was approximately 8 to 9 hours after Resident #19 was admitted to the facility. On 1/6/23 at approximately 3:00 PM, during an interview, Staff #38, RN, stated when he/she came into work for the evening shift on 10/16/22, Resident #19's admission orders had not yet been confirmed with the physician and indicated that is he/she confirmed the orders and completed the resident's admission assessment. The above findings were discussed with the DON (Director of Nurses) on 1/9/22 at 5:45 PM. During an interview, the DON stated that for new admissions, when the resident arrived at the facility, the expectation was for the resident's admission orders to be confirmed with the physician and transcribed to the resident's medical record promptly. Cross Reference F 684 Cross Reference F 697

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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. 37276 Based on observation, 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 (#9) of 40 residents reviewed for abuse. The findings include: The MDS (minimal data set) is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on these individualized needs, and that the care is provided as planned to meet the needs of each resident. Brief Interview of Mental Status (BIMS) is a standardized test used to get a quick snapshot of the cognitive function and is a required screening tool used in nursing homes to assess cognition. Review of Resident #9's medical record on 12/30/22 revealed an incomplete MDS assessment. Review of Resident #9's quarterly MDS with an ARD (assessment reference date) of 10/24/22 revealed that Section C, Cognitive Patterns and Section D, Mood was not assessed. Section C. Cognitive Patterns, C0100. Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be Conducted? was coded Yes, however, there was no documentation to indicate that Resident #9's BIMS assessment had been completed. C0200-C0500 were not coded as being assessed and the BIMS summary score was blank. C0600, Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? was coded 1, yes, however, C0700 - C1000 were not coded as being assessed. Section D, Mood, D0100. Should Resident Mood Interview be Conducted? Was coded 1, yes, continue to D0200 mood interview, however there was no evidence a mood interview had been conducted. D0200 Resident Mood Interview questions were not coded as being assessed and D.0300 did not document a total severity score. In addition, D0500. Staff Assessment of Resident Mood was not coded as being assessed. Staff #12, RN, MDS Coordinator, was made aware of the above concerns on 1/3/23 at 1:20 PM. At that time, Staff #12 confirmed the findings and indicated that a resident interview had not been conducted within the MDS look-back period, and per the RAI (Resident Assessment Instrument) (MDS user manual) they missed the dates an interview could have been documented the resident's MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31982 Based on review of facility and resident records and interview with staff, it was determined that the facility staff failed to develop and implement a resident's plan of care. This was evident for 3 (Residents #32, #37 and #36) of 86 residents reviewed during the survey. 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. The findings include: 1) Review of a facility reported incident #MD00180369 on 12/27/22 at 12:10 PM revealed that Resident #32 was identified with discoloration to the left eye on 12/18/21. The facility's investigative documentation included that the facility reported the injury of unknown origin to the state agency and police. The investigation summary revealed that the facility was unable to determine the cause of Resident #32's injury and that the resident became combative and resistant to care at times and was made a two person assist with care. Review of Resident #32's medical record on 12/27/22 at 12:42 PM revealed a Plan of Care initiated on 12/21/21 for ADL (Activities of Daily Living) self-care performance deficit, requires assistance with ADLs, cognitive deficit, functional deficit. The plan indicated that Resident #32's goal was to maintain current level of function. The plan did not identify what Resident #32's current level of function was, nor did it include the objectives that the facility staff would measure to determine if the resident was reaching his/her goals. The plan identified several interventions which included that Resident #32 required total assistance with eating, hygiene, toileting, and transfers, however, the plan did not include that the resident was to be provided 2 person assistance during care as indicated in the facility report. In an interview on 12/28/22 at 9:45 AM, The Director of Nursing (DON) indicated that the Geriatric Nursing Assistants (GNA's) do not have access to the resident's plans of care but have access to an electronic Kardex. Review of Resident #32's Kardex failed to indicate that Resident #32 should be a 2 person assist with care. In an interview on 12/28/22 at 10:40 AM, GNA #13 confirmed she was familiar with and was caring for Resident #32 on that day. When asked how many staff were required to provide care for Resident #32, she indicated 1 person assist for ADL's, 2 for transfers using a Hoyer lift. She indicated that the resident was total assist with feeding. When asked if the resident was cooperative with care she stated, not really, he/she can be combative at times, he/she has slapped me before. On 12/28/22 at 11:33 AM, the DON showed the surveyor that an entry was made in the GNA Kardex under personal hygiene on 12/27/21 that Resident #32 should be 2 person assist for care. However, when asked to show the surveyor where it was reflected on the actual Kardex view that the GNA's were able to see, she confirmed that it was not there. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of facility reported incident #MD00182028 on 1/10/23 at 9:42 AM, revealed an altercation occurred on 3/6/22 in which Resident #37 struck Resident #36 with a reaching/grabbing tool. The residents were separated, a room change was made, the physician and resident representatives were notified and the facility reported and investigated the incident. A review of Resident #37's record revealed a plan of care with the focus Resident #37 has a behavior problem disease process, loss of independence, psychosocial issues as witnessed by verbal/physical aggression towards others; refusal of care and medications/treatments, lab, and weight monitoring. This plan was initiated on 2/17/21. The resident's goal was identified as Resident #37 will have fewer episodes of behaviors through the review date. The plan did not identify the objectives to be measured to determine the resident's progress toward reaching his/her goals. The plan was not clear how the treatment team would determine if the resident was having fewer episodes of behaviors. Review of the care plan notes, dated 3/15/22 - 12/22/22, revealed 3 entries which indicated that Resident #37 continued to refuse medications. Other entries indicated Care plan reviewed and updated. However, the facility failed to measure the resident's progress or lack of progress toward reaching his behavior problem or other care plan goals. Review of Resident #36's medical record, on 1/10/23 at 9:42 AM, revealed a plan of care initiated on 3/6/22 with the focus: Resident #36 was involved in a resident to resident altercation. The goal was that the resident would remain safe within the facility. The goal did not include measurable objectives. The interventions included but were not limited to CRNP (Certified Registered Nurse Practitioner) Evaluation and Social Services to evaluate and monitor for psycho-social implications. Further review of the record failed to reveal that CRNP, and Social Service evaluations were completed as per the plan of care. On 1/10/23 at 11:45 AM, Medical Records coordinator #8 confirmed that she was unable to find CRNP and Social Service evaluations completed after the resident to resident altercation as per the resident's plan of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on observation, medical record review and interview, it was determined that the facility failed to ensure that staff used unique identifiers when documenting in the electronic health record, and failed to ensure that staff did not document assessments and administration of medications that were not actually completed as evidenced by documentation of neuro checks and vital signs being completed at a time the resident was not physically in the facility(Resident #51), and documentation of medication administration when the medications were not actually administered to the resident (Residents #91,and #90). This was found to be evident for 3 out of 86 residents reviewed during the survey. The findings include: 1. Review of Resident #51's medical record revealed the resident sustained a fall on 8/5/22 and neuro checks were initiated as per the facility policy. 1a. On 12/30/22, medical record review revealed that the Change in Condition form was completed by Temp 10/ Temp Agency nurse on 8/6/22 at 2:44 AM related to a fall that occurred on 8/5/22. Review of the Pain Observation Tool, with an effective date of 8/5/22 at 7:30 PM, revealed it was signed by Temp 10 on 8/6/22. Within the Pain Observation Tool there [NAME] a section J. Signature 1. Nurse completing this assessment. There is a box provided for staff to type in their name. The box on this Pain Observation Tool is noted to contain a period mark (.) only. No nurse's name was found on this assessment. On 1/3/23, further review of the medical record revealed documentation of neuro checks being initiated on 8/5/22 at 7:30 PM. The neuro checks were documented as completed every 15 minutes x 4, then every hour x 4; then every 4 hours x 1 by Temp 10/ Temp Agency nurse. The last assessment completed by Temp 10 was documented on 8/6/22 at 4:15 AM. As of time of survey exit on 1/13/23, the facility staff was unable to provide surveyor the name of the nursing staff who documented the Change in Condition note and the neuro checks that were documented using Temp 10. Cross reference to F 842 and F 689 1b. Further review of the medical record revealed four daily neuro checks were all documented as being completed by Nurse #106 at 0000 (midnight) on 8/7, 8/8, 8/9 and 8/10/22. All four of these assessments were signed by Nurse #106 on 8/22/22. Further review of the medical record revealed the resident was sent to the hospital and was admitted on [DATE]. Thus the resident was not physically in the facility on 8/10/22 at 0000 when the final neuro check was documented as having been completed Cross reference to F 689 2. On 1/13/23, medication pass observation was completed for Residents #90 and #91. Six of the medication errors identified during these observations included staff documenting the administration of medications that were not actually administered to the residents. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross reference to F 759

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on observation and interview, it was determined the facility staff failed to ensure that a resident unable to carry out activities of daily living received the necessary services to maintain grooming, personal and oral hygiene, bathing, incontinent care and repositioning while in bed. This was evident for 1 (Resident #75) of 26 residents reviewed for complaints, and 1 (Resident #47) out of 6 of residents reviewed for ADL (Activities of Daily Living) for a dependent resident. The findings include: 1) The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on these individualized needs, and that the care is provided as planned to meet the needs of each resident. ADLs (activities of daily living) are activities that people perform every day such as, getting dressed, taking showers or baths, cooking, and eating. On 1/5/23 at 9:00 AM, a review of complaint #MD0077279 was conducted. The complainant reported that Resident #75's hygiene had been poor prior to being discharged from the facility to home. The complainant reported that upon discharge, when Resident #75 arrived home, the resident presented as unshaven, his/her fingernails were long, and there was staining from dried feces on the resident's buttocks. A review of Resident #75's medical record revealed that Resident #75 was admitted to the facility in November 2021, and discharged from the facility in December 2021. The medical record documented that Resident #75's diagnoses included moderate intellectual disabilities, cognitive communication deficits, and required assistance with all ADLs. Review of Resident #75's admission assessment with an ARD (assessment reference date) of 11/15/21 documented the resident had a BIMS (Brief Interview for Mental Status) score of 00, indicating the resident had severe cognitive impairment. The assessment documented that Resident #75 was dependent on staff for ADLs (activities of daily living) and required extensive assistance with 1 person physical assist for dressing, toileting, and personal hygiene and the resident was totally dependent with1 person physical assist for bathing. Review of Resident #75's care plans revealed a care plan, ADL Self Care Performance deficit, requires assistance with ADL Disease Process, Functional Deficit that included the interventions, Resident requires mod (moderate) assistance with hygiene, and Resident requires mod-max (maximum) assistance with bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #75's GNA (geriatric nursing assistant) task documentation, for November and December 2021, printed from the EMR, revealed Documentation Survey Report forms that included an intervention/task for Bathing per residents' choice, which was followed by space for the GNA to document the resident's bathing self-performance, bathing support provided, and the type of bath/shower given every shift on Monday, Wednesday and Fridays. The GNA task documentation form also included an intervention/task for personal hygiene, which included all personal hygiene tasks, except for bathing and showers, followed by a space for the GNA to document a resident's personal hygiene self-performance, the personal hygiene support provided to the resident every shift. Review of Resident #75's November 2021 Documentation Survey Report intervention/task for bathing per residents' choice indicated the resident revealed that, from 11/10/21 to 11/30/21, there was no documentation to indicate Resident #75 had been bathed on 8 of 9 scheduled bath days. Review of Resident #75's November 2021 Documentation Survey Report intervention/task for personal hygiene revealed that from 11/10/21 to 11/30/21, there was no documentation to indicate that Resident #75 received personal hygiene care of 11 of 21 day shifts, on 16 of 21 evening shifts and 11 of 21 night shifts. Review of Resident #75's December 2021 Documentation Survey Report intervention/task for bathing per residents' choice indicated the resident revealed that from 12/1/21 to 12/8/22, there was no documentation to indicate Resident #75 had been bathed on 1 of 4 scheduled bath days. Review of Resident #75's December 2021 Documentation Survey Report intervention/task for personal hygiene revealed that from 12/1/21 to 12/9/21, there was no documentation to indicate that Resident #75 received personal hygiene care of 1 of 9 day shifts, on 3 of 8 evening shifts and 5 of 9 night shifts. On 1/11/23 at 10:50 AM, the Director of Nurses was made aware of the above concerns and the GNA documentation failed to support evidence that Resident #75's bathing and the personal hygiene needs were met while a resident in the facility. At that time, the DON indicated residents were assigned to showers on the unit and no other comments were offered. 42863 2) ADL (Activities of Daily Living) is used as an indicator of a person's functional status. The inability to perform ADLs results in the dependence of other individuals and/or mechanical devices. The inability to accomplish essential activities of daily living may lead to unsafe conditions and poor quality of life. Measurement of an individual's ADL is important as these are predictors of admission to nursing homes. The outcome of a treatment program can also be assessed by reviewing a patient's ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted by a surveyor on 12/22/22 at 1:10 PM, the complainant stated his brother did not have his sheets changed nor was he bathed for the first eight days. Additionally, the complainant stated the resident's back wound became infected resulting in a transfer to Meritus Hospital on December 24, 2021. Upon discharge from the hospital , the recommended follow-up instructions were for the resident's legs to be repositioned in bed every two hours to aid in the healing of a stage three right heal wound and these instructions were not followed per the complainant. A (pressure ulcer scale for healing) PUSH score tool monitors the pressure ulcer healing . The PUSH score monitors three parameters: surface area of the wound, wound exudate (pus), and type of wound tissue. The scores are rated 0 to 10 according to the size of the wound. Zero indicates healed. Total score range is from 0 to 17. On 01/11/23 at 10:53 AM, the surveyor reviewed the copies of the ADL documentation related to Resident #47 from dates of service from November 23, 2021, through and including March 8, 2022. On the following dates, there was missing documentation of staff providing specific care for Resident #47 such as repositioning the resident, and/or evidence of the resident being provided personal hygiene or being bathed/groomed as part of the ADL process. The surveyor found that (geriatric nursing aides) GNAs either did not document performing the tasks, entered XX in the space, or entered N/A inappropriately for tasks related to bathing, repositioning, and or personal hygiene on the following dates, 11/25/21, 11/27/21, 11/30/21, 12/11/21, 12/12/21, 12/14/21, 12/15/21,12/16 /21, 12/19/21,12/21/21, 1/06/22, 1/8, 1/9/22, 1/14/22, 02/11/22, 02/14/22,02/15/22, 02/19/22,02/20/22, 02/22/22, and 02/27/22. There were twenty- two examples in the nursing forms that revealed that the facility did not document that the resident #47 received personal hygiene, bathing, right heel elevation, and/or bed mobility/repositioning. Review of the electronic medical record by surveyor was initiated at 10:20 AM on 01/09/22. The quarterly MDS (Minimum Data Set) had a submission date of 02/28/22 and a completion date of March 14, 2022. Review of Section G showed the resident's functional status described in section: G:0110-ADL Assistance as: The resident required extensive assistance (3) with bed mobility and transfer from bed to chair, dressing was extensive assistance, toileting (3), personal hygiene, extensive assistance (3). At 12:01 on 01/09/23, the surveyor continued the electronic medical record review of Resident #47. The wound care evaluation on 11/29/21 for (wound # 64215) on the right buttock was measured as 2.0 cm in length, 3.42 cm in width, 0.10 cm in depth, and tissue coloring is red for 4.5 centimeters of the wound bed. The right buttock wound was 80% slough/eschar and acquired on admission. The recommendation by the nurse practitioner were for Pressure Reduction/Offloading: Ensure compliance with turning protocol, wheelchair cushion, specialty bed, hydrogel dressing, as well as a secondary dressing of bordered foam and a PUSH score of 10.The 11/29/21 at 1:13 PM the (certified registered nurse practitioner) CRNP #60 documented the skin assessment and wound care treatment. On 12/20/21 at 09:58 AM, Wound ID: 64213 was identified as located on the right hand with wound status of healed and zero PUSH score. The evaluation was completed by CRNP #60. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the medical record review, on 01/11/23 at 11:03 AM, the surveyor found physician orders dated for 12/09/21. The physician orders instructed nursing staff to off load (elevate) the Resident # 47's right heel. The right heel was described as a right heel pressure ulcer with suspected (deep tissue injury) DTI. Nursing staff were instructed to use wedge/foam cushion to elevate the right heel and to provide wound treatment to right heel every shift. The surveyor did not find documentation that the right heel elevation was performed on every shift as required by the physician order. Further review of the medical record revealed that, on 12/23/21, the resident was transferred to the ER for evaluation of sacral wound and surgical wound debridement. Also, on 12/23/22, an Urgent surgical consult was written requesting a sacral debridement of a stage IV sacral decubitus as the reason for the hospital transfer. Continued review of the medical record on 01/11/23, the MDS Section GG, revealed that Resident #47 was described as dependent for showering and bathing and required maximum assistance with dressing. Section GG.0170 Mobility documented that Resident #47 was dependent for rolling from back to left and right side and return to his back while in the bed. Section M0100. Determination of Pressure Ulcer or Injury showed the following information: Yes, there was a pressure ulcer over a bony prominence. Under the functional status, section G of the MDS 3.0 MDS dated [DATE]: The resident was evaluated as requiring extensive assistance for bed mobility. Section G. Resident requires extensive assistance, H. Eating (1) requires supervision, I. Toileting: (3) Extensive assistance required. J. Personal Hygiene (3) Extensive Assistance. G0120. Bathing. (4) Total dependence. DON interview was initiated 01/11/23 at 10:45 AM regarding the ADL documentation related to bed mobility and bathing for resident # 47 for the months of November, December 2021, January 1 through January 31, 2022, February 1 through February 29, 2022 , March 1 through March 8, 2022. The surveyor reviewed the documentation of those dates in which the GNA's either documented N/A or did not document at all on specific dates for the ADLs of bathing and bed mobility with the DON. The DON stated that it is considered an error if the GNA used the code N/A inappropriately and it was not acceptable for the GNA to not document on each resident, each day whether ADL care, such as bathing, and bed mobility, were provided. The DON was advised that this concern regarding compliance with documentation of ADL's correctly would be reviewed further by the surveyor. Based on the lack of documentation in the medical record, the facility failed to provide ADL services to a dependent resident. The deficient practices related to documentation of the provision ADL activities for a dependent resident such as repositioning, bathing and/personal hygiene for resident # 47 were identified and discussed with the DON on 01/11/23 at 10:45 AM.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on medical record review and interview, it was determined that the facility 1) failed to ensure that a newly developed rash was reported to the primary care physician and followed up on as indicated by the on call physician; 2) failed to ensure that a report of severe pain and inability to participate in therapy was reported to the primary care physician in a timely manner, and 3) failed to accurately transcribe and act upon physician orders for a newly admitted resident resulting in delayed treatment, placing the resident at risk for further discomfort and decline. This was found to be evident for 3 (Resident #21, #51, #19) out of 26 residents reviewed related to complaint investigations. The findings include: 1) On 12/29/22, review of Resident #21's medical record revealed that the resident was originally admitted to the facility several years ago with diagnoses that included, but were not limited to: chronic pain, kidney disease with dependence on dialysis, diabetes, muscle weakness with a history of falling, lung disease and dementia. Review of the medical record revealed a nursing note, dated 12/27/22 at 4:56 AM, by Nurse #73 revealed the resident had a rash to the left side of the body. A telehealth consult with a nurse practitioner (NP) was completed and No orders for treatment at this time just monitor and follow up with on-call today. Review of the corresponding NP note revealed the following: Nurse to mark borders of rash and notify PCP Telehealth should the patient develop pain, pruritus (itching), or enlarging rash. OK to go to dialysis today. Further review of the medical record revealed that the resident attended dialysis on 12/27/22. Review of the Pre Dialysis Evaluation form, dated 12/27/22 at 2:50 AM, revealed a notation about the rash to the left side of the body. A Post Dialysis Evaluation was completed by the day nurse on 12/27/22 at 2:49 PM, and no mention of the rash was found in this evaluation. Review of the Treatment Administration Record revealed documentation to indicate that a weekly skin assessment was completed during the day shift on 12/27/22. However, review of the corresponding Weekly Skin Check assessment form revealed that it had an effective date and time of 12/25/22 at 7:54 PM, although it was signed by Temp 12/Agency nurse on 12/27/22. This assessment documented No in regard to any skin conditions or changes, ulcers or injuries. [Cross reference to F 842 regarding identification of Temp ## in the electronic health record]. Further review of the medical record revealed a Change in Condition Evaluation, dated 12/28/22 at 3:52 PM, that revealed the resident was experiencing shortness of breath, unresponsiveness and seemed different than usual; a primary care provider was notified and the recommendation was to send the resident to the hospital for further evaluation. This note was completed by Temp 12 - Temp/Agency Nurse. Review of the corresponding Transfer Form revealed thatNurse #74 was documenting using Temp 12 on 12/28/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse's note, dated 12/28/22 at 5:00 AM revealed that the resident appeared pale and skin was warm to touch all over and legs were red and splotchy; mouth was dry; physician was notified and was picked up at 4:00 AM by EMS (emergency medical services). On 1/4/23 at 6:46 AM, interview with Nurse #74 revealed she was a licensed practical nurse employed by a staffing agency and has been working at this facility a couple days a week, maybe since November or October 2022. She only worked night shifts at this facility. The nurse went on to report that the 12/27/22 night shift was her first time on that side of the floor, and indicated that she had not previously been assigned to care for Resident #21. In regard to Resident #21, nurse #74 reported that the resident was asleep when she first conducted her rounds. She was alerted by the GNAs that the resident did not look right; she did not recall the time, but stated maybe around 2:00am. During the 1/4/23 interview, when asked what kind of report she received from offgoing nurse, Nurse #74 reported: depends on what nurse you get report from; nobody had mentioned anything to me about [him/her] not doing well; or [him/her] being on dialysis; someone said s/he may not be feeling well because just got back from dialysis, so thought that may have been the problem. Nurse #74 was not able to recall who informed her about resident having been at dialysis, and indicated it may be one of the supervisors. Nurse #74 reported obtaining the resident's vital signs, and due to the resident's mouth looking dry she attempted to give fluids to see if that would help, stating: I was spooning [him/her] fluids. The nurse indicated that she worked with the resident for about 30 minutes then called the physician, then 911 and got the paperwork ready to send out. When asked if anything unusual about the resident's skin, the nurse reported: Guess they called the doctor about it the day before, purple bruising on half of his/her body, legs, trunk, don't remember which half. The nurse also reported the resident's legs did look a little swollen, but I never had [him/her] before so I don't know what [his/her] baseline is. When asked if the resident had a skin tear the nurse reported that there looked like an old one that got broke open, not sure if done while changing the resident. Further review of the medical record failed to reveal documentation to indicate that the area of the rash was assessed during the day or evening shift of 12/27/22. No documentation was found to indicate that the primary care provider or the facility nurse practitioner was notified of the rash during the day or evening shift on 12/27/22. On 1/5/23 at 3:00 PM, the Director of Nursing confirmed there was no follow up to the rash. Review of the hospital admission records revealed the resident was admitted to the hospital with a fever of 103 and signs of septic shock. Cross reference to F 622 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 12/28/22, review of Resident #51's medical record revealed the resident was originally admitted to the facility in July 2022 after a hospitalization for a broken hip sustained from a fall at home. Resident's diagnoses included, but were not limited to cancer involving the blood and kidneys; diabetes; and high blood pressure. Review of the 7/15/22 Minimum Data Set (MDS) assessment revealed the resident had cognitive impairment as evidenced by a BIMS (Brief Interview for Mental Status) score of 4 out of 15, the resident required two person physical assist for bed mobility, dressing, toilet use and personal hygiene, was totally dependent on staff for bathing, and the resident had lower extremity (leg) impairment on one side. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Brief Interview of Mental Status (BIMS) test is used to get a quick snapshot of cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. Review of Resident #51's Physical Therapy Treatment Notes signed by Physical Therapy Assistant (PTA) #117 on 8/5/22 at 10:49 AM revealed the resident ambulated 3 x in parallel bars with care giver assist for balancing and left knee buckling at times; completed trunk-core activities and exercises to increase bilateral lower extremity strength and endurance. On 12/28/22 review of the medical record revealed a Change in Condition Evaluation with an effective date of 8/5/22 at 5:15 PM. This note included the following summarization: Resident found on the the floor as per GNA report,stated they where trying to transfer from the bed to the wheelchair, GNA picked up resident and transferred back to the wheel chair and conducted room change. The note was signed as completed on 8/6/22 by Temp #10. Further review of the progress notes revealed a note written by the nurse practitioner #108 on 8/5/22 at 9:45 PM that includes: s/p [status post] unwitnessed fall with no injuries per RN [registered nurse]. Neuro checks started. Further review of the medical record and interviews failed to reveal documentation to indicate that an RN conducted the post fall assessment. The facility was unable to provide documentation to indicate that an investigation was completed regarding the circumstances of the fall. Post fall assessments were not completed two times a day for 3 days as indicated in the facility policy. Cross reference to F 689. An interview was conducted with the Director of Nursing (DON) on 12/28/22 at 3:33 PM. The DON indicated that either a nurse practitioner or a physician, and therapy would assess a resident the day of the fall. Further review of the medical record failed to reveal documentation that a NP, MD or physical therapist completed an assessment the day of or for several days after the fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As of time of survey exit on 1/13/23 at 4:00 PM, the facility had not provided documentation to indicate the name of the nurse who had written the Change in Condition and Neuro Check assessments that were documented under Temp 10 on 8/6/22. No documentation was found to indicate an RN had assessed the resident at the time of the fall. Further review of the medical record failed to reveal documentation of additional Fall Follow Up assessments after 8/6/22. Per the facility policy the Fall Follow Up assessments should of been completed twice daily for three days. Further review of the medical record did reveal Skilled Documentation UDAs with effective dates of 8/7/22 at 6:23 AM, and 8/8/22 at 6:23 AM. However there is no documentation in these assessments that the resident had sustained a fall on 8/5. Once a day neuro checks were documented as being completed by Nurse #106 at 0000 (midnight) on 8/7, 8/8, 8/9 and 8/10. All four of these assessments were signed by Nurse #106 on 8/22/22. Further review of the medical record revealed the resident was sent to the hospital and was admitted on [DATE]. Thus the resident was not physically in the facility on 8/10/22 at 0000 when the final neuro check was documented as having been completed. Review of the physical therapy treatment note, signed by PTA #117 on 8/8/22 at 3:57 PM revealed the resident reported [s/he] had fallen, with nursing initially not noting any fall. Resident was having a complaint of left lower extremity pain rated 8 out of 10 with swelling and warm to the touch with slight yellow discoloration noted to the front of the resident's knee. The resident was transferred with no weight bearing on left lower extremity (leg). The note indicates the Physical Therapist was aware of the fall and that the nursing was made aware of the findings in the note. The resident was noted to be limited that day by LLE (left lower extremity] pain. Further review of the medical record failed to reveal documentation to indicate the primary care provider was informed of the resident's pain or that it was causing a limitation in therapy on 8/8/22. On 1/4/23 at 10:04 AM PTA #117 reported, after review of the 8/8/22 note, that on Monday the resident told him something had happened Friday night. The PTA stated: I went to the the nurse who said no, nothing happened. The PTA does not recall which nurse he spoke to, stating: so many agency. The PTA said that the nurse said he did not believe the resident had fallen. But the PTA reports he did not believe this because you do not get that kind of change in status just laying in bed and that the resident was fine on Friday morning. Further review of the physical therapy treatment notes revealed that on 8/9/22 the resident's left lower extremity was swollen and painful with palpation. The resident's pain was documented as 9 out of 10. The provider was notified of the change in condition with the resident limited by knee pain and an order was received for stat x-ray of the left knee. Further review of the medical record revealed a corresponding progress note, written by NP #5 on 8/9/22 at 11:20 AM, which indicated the resident was assessed in the therapy area sitting in a wheelchair. The note also revealed the physical therapist stated that the patient fell on Friday and was unable to perform activities; therapist stated that patient was not their usual. The note documents left knee pain and tenderness and that an x-ray was ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed that an x-ray was obtained. On 8/9/22 at 8:55 PM, the Physician Assistant #78 documented: X-ray of L knee showing acute comminuted displaced fracture of the distal femur. Will sent to ED [emergency department] for evaluation. On 1/3/23 at 4:00 PM, surveyor reviewed with the DON the concern that review of the therapy notes revealed documentation that the resident was having pain of 8 out of 10 on 8/8/22, but no documentation was found to indicate that nursing or a primary care provider was made aware until 8/9/22. 37276 3) On 1/6/23 at 9:00 AM, a review of complaint #MD00185499 was conducted. The complainant reported Resident #19 was transferred to the facility from an acute hospital following orthopedic surgery on the morning of 10/16/22. The complainant reported that, after being in the facility for a couple hours, Resident #19 was in severe pain from broken bones, and when the complainant inquired about getting pain medication for the resident, they were told the medication needed to be delivered from another town, and when they pressed for more information, they found out the resident had not been entered into the facility's system, which delayed things even more. Review of Resident #19's medical record revealed thathe resident was admitted to the facility for rehab in mid-October 2022 following an acute hospitalization with diagnoses that included a fractured femur, lumbar fracture, and Type 2 diabetes, and was transferred to the hospital on 10/17/22 at approximately 4:21 AM for management of uncontrolled pain. Review of the hospital's discharge instructions revealed a list of medications which included: - Acetaminophen (Tylenol) 500 mg (milligrams) (pain reliever) 2 tabs by mouth every 8 hours Also, handwritten on the discharge medication form, were the orders: - Levemir (Insulin detemir) (injection) 14 Units am, 4 Units pm - Novolog (insulin aspart injection) sliding scale (varies the dose of insulin based on blood glucose level). In an Admission Initial Evaluation, with an effective date 10/16/22 at 5:00 PM, Staff #27, RN, documented Resident #19 was admitted to the facility on [DATE] at 9:00 AM. In the note, the nurse documented the resident was to receive routine pain medication, Acetaminophen (Tylenol) 500 mg (milligrams) 2 tabs every 8 hours and Tramadol (narcotic pain medication) 50 mg as needed. 1a) Review of Resident #19's October 2022 MAR (medication administration record) revealed an order for Acetaminophen 500 mg, 2 tablets by mouth 3 times a day, AM (6:00 AM to 11:00 AM), afternoon (12 pm to 3 pm), and HS (hour of sleep) (8:00 PM to 11:00 PM) for pain, transcribed to start on 10/17/22. There was no documentation in the medical record to indicate why the order for routine order for Acetaminophen every 8 hours had not been transcribed to start on 10/16/22, the day the resident was admitted to the facility, or why the order was entered with liberalized administration times, not every 8 hours as prescribed, and there was no documentation to indicate why the Acetaminophen was not administered to Resident #19 on 10/16/22 despite the resident's complaint of pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/11/23 at 4:00 PM, the DON (Director of Nurses) was made aware the Resident #19's hospital discharge order for Acetaminophen 500 mg, 2 tablets by mouth every 8 hours was not transcribed into eMar (electronic medical record) as prescribed, and instead transcribed to be administered with liberalized med administration times. At that time, the DON stated that the Acetaminophen order should have been transcribed to be administered every 8 hours as prescribed, not with a liberalized administration time and the order should have been transcribed to start on the day the resident was admitted to the facility. The DON also stated Acetaminophen 500 mg tablets were available in the facility as a stock medication and should have been administered to the resident as prescribed. Cross Reference F 697 1b) Resident #19's hospital discharge orders indicated that Resident #19 was to be administered insulin every morning and every evening. On 10/16/22 at 6:21 PM, Staff #38, RN documented that the orders were verified, that the orders for Levemir (Insulin detemir) were not clear, that the nurse spoke with the resident and family and the resident received 14 units in the am and 4 units in the pm. Review of Resident #19's October 2022 MAR revealed an order for Insulin Glargine 4 units subcutaneously at bedtime for DM2 (Diabetes Mellitus 2) that was entered in eMar to start on 10/17/22. There was no documentation in the medical record to indicate why the order was not transcribed for Resident #19 to receive insulin at bedtime on 10/16/22 as prescribed, or that the physician had changed the order. On 1/11/23 at 4:30 PM, the DON was made aware of the above findings and indicated that, if the insulin was in the Omnicell, (automated medication dispensing unit) it should have been transcribed to start on 10/16/22 and administered to the resident at bedtime. A review of the Omnicell's inventory list revealed that the Insulin Glargine 100 units/1ml, 3ml pen was available in the Omnicell, and on 1/11/23 at 4:43 pm, the DON was made aware that per the Omnicell inventory list, the insulin was available in the facility. Cross Reference F635, F697

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 16218 Based on medical record review and interview, it was determined that the facility failed to provide necessary treatment and services to prevent the development and infection of a pressure ulcer. This was found to be evident for ## 1(Resident #51) out of 26 residents reviewed related to complaint investigations. The findings include: On 12/28/22, review of Resident #51's medical record revealed the resident was originally admitted in July 2022 with diagnoses that included, but were not limited to, cancer involving the blood and kidneys; diabetes; and high blood pressure. The resident had a brief rehospitalization in August for a left femur fracture. The resident was readmitted with a knee immobilizer and orders to be non-weightbearing on the left lower extremity. Review of the Minimum Data Set (MDS) assessments, dated 8/18/22 and 9/24/22, revealed the resident required extensive assist for bed mobility, dressing , toilet use and personal hygiene; and was totally dependent on staff for bathing; the resident did not have any pressure, arterial or venous skin ulcers, or other identified skin problems. The 9/24/22 assessment revealed a functional limitation in range of motion for both lower extremities that interfered with daily function or placed the resident at risk for injury. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of the Geriatric Nursing Assessment (GNA) documentation regarding bed mobility revealed areas for staff to document how the resident moves to and from lying position, turns side to side and positions body while in bed or alternate sleep furniture. Staff are able to document 0 for Independent if no help or oversight was provided; 1 for Supervision in which oversight, encouragement or cueing was provided; 2 for limited assistance in which the resident is highly involved in the activity and staff provide guided maneuvering of limbs or other non-weight bearing assistance; 3 for Extensive assistance in which the resident is involved in the activity but staff provide weight bearing support; or 4 for Total Dependence on staff for full performance. There was a second question in which staff could document the amount of assistance provided and a third that asked: how many times did this level of activity occur this shift? The instructions indicated a number between 1-10 must be entered in response to the third question. Additionally, there was a notation at the bottom of the print out of this documentation which stated: System Response that is available for all questions include: RX for resident not available; RR for resident refused; and NA for not applicable. Review of the GNA documentation for bed mobility for the 78 shifts between November 1st thru November 26 failed to reveal documentation of physical assistance having been provided on 23 of the 78 shifts as evidenced by 8 shifts with blanks, 3 shifts with NA and 12 shifts documented 0 indicating no help or oversight was provided. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed that, on 4 shifts when staff documented that limited assistance was provided, they also documented NA in response to how many times this level of activity occurred. Review of the Treatment Administration Record (TAR) revealed that nursing staff documented the completion of weekly skin assessments on Tuesday 9/6, 9/13, 9/20 and 9/27/22. This documentation consisted of a check mark in a box to indicate the assessment was completed. The TAR stated: Documentation to be completed on Weekly Skin Assessment every evening shift every Tue [Tuesday] for Skin Assessment. Further review of the medical record revealed Weekly Skin Check assessment forms were completed on three dates in September: 9/3, 9/17 and 9/27. No documentation was found to indicate that staff completed assessments as indicated by their sign off on the TAR on 9/6, 9/13 or 9/20. Review of the 9/17/22 Weekly Skin Check documentation revealed there were no skin conditions or changes, ulcers or injuries. Review of the 9/27/22 Weekly Skin Check assessment revealed that yes, there was a skin condition. The instructions stated If Yes, Review prior weekly skin check and/or most recent patient nursing evaluation to determine: Is this new since the last documented skin check? Staff documented No, but no other documentation was found to indicate the presence of this ulcer prior to 9/27/22. The nurse (LPN #40) did include in the comment section: unstageable pressure to sacral area. Further review of the medical record revealed that LPN #39 completed a Skin Grid Pressure assessment on 9/27/22. Review of this assessment revealed the pressure ulcer was acquired while in the facility, and the resident's risk factors included: dependent with care, unable to turn and reposition independently and impaired mobility. There is documentation that the wound was located on the sacrum and that eschar was present, but failed to include measurements. The note also documented that new treatment orders were in place. Eschar is dead tissue that will eventually come off. Staff are unable to determine the stage of a pressure ulcer when eschar is present. On 12/28/22 at 3:33 PM, the Director of Nursing (DON) reported that the weekly skin assessments are to be completed the same day every week, for example every Tuesday day shift. Surveyor reviewed the concern that only 3 weekly skin assessments were found for September and that there was more than a week between the 9/17 and 9/27 assessment when the sacral wound was identified. Further review of the GNA documentation for bed mobility from November 27 until October 7 failed to reveal documentation of physical assistance having been provided on 8 out of the 33 shifts reviewed as evidenced by 4 shifts with blanks and 4 shifts marked NA. Further review of the medical record revealed that the resident was seen by the primary care nurse practitioner on 10/3/22. This note addressed the presence of the unstageable sacral ulcer. The note indicated pressure reduction and turning precautions were discussed with staff including heel protection and pressure reduction to bony prominences. Further review of the orders and progress notes failed to reveal documentation to indicate that a heel protector was ordered or utilized for this resident between 10/3/22 and time of discharge. The resident was also seen by the wound specialist on 10/3/22 with an update to the dressing change orders which was implemented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the TAR revealed staff continued to document daily dressing changes to the sacral wound. On 10/8/22, the resident was sent to the emergency room due to being found unresponsive with a rapid respirator rate. Review of the hospital medical record's initial physical exam revealed the resident had a large stage 4 sacral decubitus ulcer, as well as a hemorrhagic bulla on the right heel. A Stage 4 ulcer indicates there is full thickness tissue loss with exposed bone, tendon or muscle. A hemorrhagic bulla is a fluid filled blister. Further review of the hospital medical record revealed the resident was admitted for septic shock, and required antibiotics. Wound, blood and urine cultures were found to be growing Proteus. Proteus is found abundantly in soil and water, and although it is part of the normal human intestinal flora it has been known to cause serious infections in humans. The concern regarding the failure to prevent the development of pressure ulcers was addressed with the DON and the Nursing Home Administrator on 1/13/23 at 4:00 PM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on review of medical records and other pertinent documentation and interviews, it was determined that the facility failed to ensure that the circumstances of a resident fall were investigated; that an assessment was completed by a registered nurse after the fall occurred; and that neuro checks and post fall assessments were completed as indicated by facility policy. This was found to be evident for 1 (Resident #51, 90, and) out of 26 residents reviewed related to complaint investigations. 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. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Brief Interview of Mental Status (BIMS) test is used to get a quick snapshot of cognitive function and is a required screening tool used in nursing homes to assess cognition. A score of 13-15 points indicates an intact cognition, 8-12 points indicates moderately impaired cognition, and 0-7 points indicates severely impaired cognition. 1) On 12/28/22, review of Resident #51's medical record revealed that the resident was originally admitted to the facility in July 2022 after a hospitalization for a broken hip sustained from a fall. Resident's diagnoses included, but were not limited to, cancer involving the blood and kidneys; diabetes; and high blood pressure. Review of the 7/15/22 Minimum Data Set (MDS) assessment revealed that the resident had cognitive impairment as evidenced by a BIMS (Brief Interview for Mental Status) score of 4 out of 15, the resident required two person physical assist for bed mobility, dressing, toilet use and personal hygiene, was totally dependent on staff for bathing, and the resident had lower extremity (leg) impairment on one side. A care plan was initiated in July 2022 to address the resident's risk for falls. Interventions included, but were not limited to ensuring the resident's room was free of accident hazards and to place call bell within reach and remind the resident to call for assistance. Review of complaint MD00184382 revealed an allegation that the resident had fallen while trying to go to the bathroom on his/her own because the nurses wouldn't come for hours. On 12/28/22, review of the medical record revealed a Change in Condition Evaluation with an effective date of 8/5/22 at 5:15 PM. This note was signed Temp 10 Temp/Agency Nurse on 8/6/22. This note included the following summarization: Resident found on the the floor as per GNA report, stated they where trying to transfer from the bed to the wheelchair, GNA picked up resident and transferred back to the wheel chair and conducted room change. The note revealed the primary care clinician was notified at 9:00 PM and that the family was notified on 8/6/22 at 2:00 AM via a call back voice mail. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes revealed a note written by the nurse practitioner #108 on 8/5/22 at 9:45 PM that includes: s/p [status post] unwitnessed fall with no injuries per RN [registered nurse]. Neuro checks started. Further review of the medical record revealed the resident did have a room change on 8/5/22. The Notification of Room Change form documented that the change occurred on 8/5/22 at 0000 (midnight) but the form was noted to have a time stamp of 7:16 AM. An interview was conducted with the Director of Nursing (DON) on 12/28/22 at 3:33 PM. When asked to explain the process after a resident falls, the DON reported: we get witness statements, question the resident if able and the roommates if able, and the aides. She also reported that a head to toe assessment would be completed to make sure that there was no injury, and if the fall was unwitnessed, or if resident was observed to hit their head, then neuro checks would be initiated, and the on call physician would be notified. Surveyor then reviewed the documentation regarding the fall with the DON. The DON confirmed that the NP note was a telehealth visit and it referenced an RN assessment. Surveyor reviewed that the Change in Condition note was documented by an agency nurse with temp credentials, and requested clarification. The DON indicated she would have to investigate to determine if the agency nurse that completed the assessment was an RN. RNs are registered nurses. LPNs are liscensed practical nurses. The educational and training requirements are more extensive for RNs than for LPNs. Review of the Fall Prevention and Management policy, with a revised date of 6/1/22, revealed the Investigation: Once the resident is safely transferred, a fall investigation should begin. Ask the resident what they were doing when they fell (this should be asked even if the resident has dementia). Identify if there were any witnesses to the fall. Ask them what they saw and have them write a statement if possible (immediately written statements provide much more detail than asking later). The policy also revealed that the Interdisciplinary Team should review all information for all falls at the next Daily Clinical Meeting. The team should discuss the fall, potential causes of the fall, interventions put into place and if they are effective. A deep root cause investigation should be discussed. On 12/29/22 at 9:30 AM the DON reported she was unable to find any of the witness statements related to the 8/5/22 fall. The DON went on to report that the agency nurse that completed the assessment note was an RN; and that the resident was seen by a physician on 8/9/22. On 12/30/22 at approximately 10:10 AM, when asked, the DON again reported she was unable find the investigation for the fall. Surveyor then requested the 8/5/22 assignment sheets and the name of Temp Nurse #10 who wrote the assessment evaluation related to the fall on 8/5/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/22 on 11:15 AM, the Unit Nurse Manager #2 was interviewed in regard to the process after a resident has a fall. She reported their was a physical assessment completed by the nurse, either an LPN or a RN depending on who was assigned to care for the resident. After the assessment, if physically ok, staff would pick up the resident and put them in the chair or the bed, notify the NP or MD and call the family, and obtain statements if witnessed, or unwitnessed. If unwitnessed, they automatically initiate neuro checks. After the statements are obtained, they notify the on-call manager and the DON is notified. She indicated the statements are uploaded to their email, she makes a physical copy to keep one for herself and gives a copy to the DON. She reported that she remembered Resident #51 did have a report of a fall, surveyor requested any witness statements or other investigation documentation she had regarding this fall. On 12/30/22 at 1:00 PM, surveyor informed the Nursing Home Administrator (NHA) that surveyor was told by DON that they could not locate the investigation of the fall for Resident #51. Interview with the unit manager revealed that witness statements are uploaded, emailed and copies are made. Surveyor requested clarification in regard to if an investigation was conducted. Also reviewed that the initial nursing note indicated the resident was found on the floor, but then it was stated that they were attempting to transfer the resident at the time. In response to the request for Temp Nurse #10's name, on 12/30/22 the facility provided Nurse #109's name and phone number. During an interview with Nurse #109 on 12/30/22 at 2:15 PM, the nurse reported she was a LPN, but there was always an RN in the building and if there was a fall, she and the RN would conduct the assessment together. During this interview, the nurse could not recall the resident. On 12/30/22 at 2:39pm, Nurse #109 called surveyor back and reported that after looking at her time sheets she remembered the incident. She reported that it was her second day working at the facility, that she had worked from 6:25 AM until 12:30 AM. She reported that a GNA found the resident at the change of shift. She reported that she did not assess the resident, that they sent the GNA to do vital signs. She reiterated several times that she did not go back to see the resident and that she did not assess the resident. She was not sure of the name of the GNA who found the resident. She also denied having written a witness statement for this fall. On 12/30/22 at 3:15 PM, surveyor reviewed with the NHA, corporate administrator #1 and Regional Director of Clinical Services #22 that, upon interview, Nurse #109 denied having completed the assessment of Resident #51. Also, the nurse stated she left for the day at 12:30 AM. The Change in Condition note was locked after 2:00 AM and referenced a call to the family at 2:00 AM. Surveyor again requested identification of the nurse that completed the assessment after the fall. On 1/3/23 at 12:25 PM, surveyor asked the Administrator if she had any additional information regarding Resident #51's fall, she indicated she would ask the DON. On 1/3/23 at 12:44 PM, the DON, corporate administrator #1 and Regional Director of Clinical Services #22 met with the survey team to discuss Resident #51's fall. The DON reported that, on 8/5/22, a Change in Condition was imitated at 1715 (5:15 PM) by Nurse #109. She reported the nurse was working a double shift, 16 hours, that day. She reported the oncall provider put their notes in themselves and that was documented at 2145 (9:45 PM). She went on to report that on 8/9/22, the resident was seen by the inhouse provider who ordered an x-ray of the left knee which came back with a fracture, the oncall provider was notified and the resident was sent out for further evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked who found the resident on the floor, the DON reported: the GNA. When asked which GNA? the DON did not provide an answer to this question. The DON reported the resident was found in room [new room number]. Surveyor then discussed the concern that nursing note indicated the room change was conducted after the resident was found on the floor. On 1/3/23, further review of the medical record revealed revealed documentation of neuro checks being initiated on 8/5/22 at 7:30 PM. The neuro checks were documented as completed every 15 minutes x 4, then every hour x 4; then every 4 hours x 1 by Temp 10/ Temp Agency nurse. The last assessment completed by Temp 10 was documented on 8/6/22 at 4:15 AM. This was almost 4 hours after Nurse #109 had left the facility after having worked a double shift. Further review of the medical record revealed a Care Plan Note, written by the Unit Nurse Manager #2 on 8/8/22 at 4:39 PM, that stated the resident fell attempting to transfer self from bed to w/c [wheelchair]. No documentation was found in this note to indicate who reported that the resident fell while attempting to transfer, or what the circumstances were at the time of the fall. On 1/3/23 at 1:00 PM, after review of the Care Plan note, Unit Nurse Manager #2 reported that she had interviewed the resident herself, she confirmed this took place on the 8th and that the resident was trying to get self into a wheelchair. She reports she did conduct an investigation and obtained statements, but confirmed that the facility staff were unable to locate any of them at this time. She went on to state that she did not remember a whole lot about it, and was not at the facility when the resident was found on the floor. On 1/3/23 at 4:00 PM, the DON reported that she was attempting to reach RN #114 to determine if she was Temp 10 on 8/5/22. The DON confirmed that she previously reported it was LPN #109 since that was the nurse assigned to the resident's new room on the evening shift of 8/5/22. On 1/5/23 at 10:26 AM, the Regional Director of Clinical Services #22 reported they had identified the nurse that assessed the resident after the fall as Nurse #112 and that she was identified through the call to the nurse practitioner. A phone interview was completed by the surveyor with the DON, the corporate nurse and Nurse #112. Nurse #112 reported it was an evening shift, one of the GNAs found the resident, pretty sure it was the GNA assigned to the resident but did not recall the GNA's name. Nurse #112 reported that she had assessed the resident, took the vitals, and called the telehealth. She indicated she did some documentation, thought it was a Change in Condition but could not remember. She was unable to recall what the resident told her after the fall. Review of the Weekly Time Card Report for 7/31/22 - 8/6/22 for Nurse #112 revealed she worked from 6:00 AM until 11:00 PM on 8/5/22. No documentation was found to indicate Nurse #112 worked on 8/6/22. The Change of Condition and the Neuro Check assessments were both documented on after Nurse #112 had left the facility. Review of the assignment sheet for Resident #51's unit for the 8/5/22 evening 3-11 shift revealed the Unit Nurse Manager #2 was listed as the supervisor, the resident census was 64 and there were three nurses (LPN #109, RN # 114, and LPN #112) and four GNAs working on the unit. Nurse #112 was not assigned to either the resident's original room, or the room s/he was moved to on 8/5/22. All three nurses working on the unit were agency staff. Three of the four GNAs were agency staff. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/5/23 at 10:56 AM, surveyor reviewed the concern with the DON and Regional Director of Clinical Services #22 regarding the lack of an RN assessment prior to the resident being moved after being found on the floor. During the interview, it was determined that more than one staff person could document using the same temp agency number during the course of the day. Cross reference to F 842. On 1/13/23 at 11:00 AM, the DON provided a copy of a written statement, signed by GNA #111 on 1/4/23. This statement revealed GNA #111 had assisted the resident in the move between rooms and that the resident was observed in the hallway in a wheelchair prior to being found on the floor by GNA #111. Further review of the assignment sheets revealed thatGNA #111's assignment did not include either the resident's first room or the room the resident was moved to. As of time of survey exit on 1/13/23 at 4:00 PM, the facility had not provided documentation to indicate the name of the nurse who had documented the Change in Condition and Neuro Check assessments that were documented under Temp 10 on 8/6/22. No documentation was found to indicate that an RN had assessed the resident at the time of the fall. 1b) Failed to ensure follow up post fall as per facility policy. Review of the Fall Prevention and Management policy, with a revised date of 6/1/22, revealed Documentation: .If the resident hit their head or the fall was unwitnessed, complete Neuro Checks per policy . Complete the Fall Follow Up UDA at least twice each day x 3 days unless the resident's condition is such that it should be continued longer. A UDA is a user defined assessment. Review of the facility policy for Neurological Checks (NS1323-01) revealed neurological checks are to be performed when there is a fall with unknown head injury, and for stable or unchanging neuro-checks the following schedule should be used: every 15 minutes times 4; every 60 minutes times 4; every 4 hours times 4 and daily times 4. On 1/3/23, further review of the medical record revealed revealed documentation that neuro checks were initiated on 8/5/22 at 7:30 PM. The neuro checks were documented as completed every 15 minutes x 4, then every hour x 4; then every 4 hours x 1 by Temp 10/ Temp Agency nurse. The last assessment completed by Temp 10 was documented on 8/6/22 at 4:15 AM. This was almost 4 hours after Nurse #109 had left the facility after having worked a double shift. A second 4 hour neuro check was documented by LPN #40, but the date and time was documented as 8/6/2022 at 0000. Nurse #40 also completed a Fall Follow Up assessment on 8/6/22 at 7:30 AM. The third 4 hour neuro check was documented by Temp 13/Temp Agency nurse on 8/6/22 at 4:00 PM. Temp 13 also documented a Fall Follow Up assessment on 8/6/22 at 7:30 PM. Further review of the medical record failed to reveal documentation of additional Fall Follow Up assessments after 8/6/22. Per the facility policy the Fall Follow Up assessments should have been completed twice daily for three days. Further review of the medical record did reveal Skilled Documentation UDAs with effective dates of 8/7/22 at 6:23 AM, and 8/8/22 at 6:23 AM. However, there was no documentation in these assessments to indicate that the resident had sustained a fall on 8/5/22. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The four daily neuro checks were all documented as being completed by Nurse #106 at 0000 (midnight) on 8/7, 8/8, 8/9 and 8/10/22. All four of these assessments were signed by Nurse #106 on 8/22/22. Further review of the medical record revealed the resident was sent to the hospital and was admitted on [DATE]. Thus, the resident was not physically in the facility on 8/10/22 at 0000 when the final neuro check was documented as having been completed. Cross reference to F 622, F 684, F 842, F 658, F 726 and F 836

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37276 Based on medical record review, and staff interviews, it was determined that 1) the facility failed to ensure that pain management was provided to residents who require such services, resulting in an increased level of pain and the resident's eventual transfer to the hospital for pain management, and 2) the facility failed to ensureb that regularly scheduled narcotic pain medication was administered as ordered to a resident with chronic pain. This was found to be evident for 2 (#19, #21) of 26 residents reviewed as part of complaint investigations. As a result of this failure actual harm was identified for Resident #19. The findings include: 1) On 1/6/23 at 9:00 AM, a review of complaint #MD00185499 was conducted. The complainant reported that Resident #19 arrived at the facility on 10:00 AM on 10/16/22 following hospitalization for surgical repair of a left distal femur fracture (bottom part of the thigh bone) sustained from a recent fall, and also had L-1 and L-2 (first and second vertebra of the lumbar spine) compression fractures and a fracture of the sacrum (large triangular bone at the bottom of the spine) from a previous fall. The complainant indicated that the resident received pain medication prior to leaving the hospital, and a couple of hours after arriving at the facility, the resident was in severe pain from his/her broken bones. The complainant indicated that when he/she inquired about Resident #19 receiving pain medication, he/she was told the medication needed to be delivered from a town that was not local, and when he/she pressed for more information, found out the resident had not been entered into the facility's system, which delayed things even more. The complainant indicated that between 10:00 PM and 2:00 AM, the resident was writhing in pain, at one point yelling out for help, and the staff were unresponsive. The complainant wrote that he/she must have gone to the nurse's station a dozen times, and they could not give the resident anything to ease his/her pain. The complainant wrote that, by 4:00 AM, the nurse called an ambulance to send the resident to the hospital to get the resident's pain under control. Review of Resident #19's medical record revealed that, on 10/16/22 at 3:43 PM, in an initial progress note, that the nurse documented that Resident #19 was admitted to the facility at approximately 9:30 AM and was s/p fall with a left femur fracture ORIF (open reduction, internal fixation) (surgery to fix severely broken bone). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/22 at 5:00 PM in an Admission Note, the nurse wrote Admission: 10/16/22 9:00 AM. In the note, the nurse wrote that Resident #19 exhibited verbal/nonverbal pain upon admission. An Admission Initial Evaluation assessment for Resident #19, with an effective date of 10/16/22 at 5:00 PM, documented that the resident's date and time of admission was 10/16/22 at 9:00 AM, and Resident #19's chief complaint was fracture distal end left femur. The nurse documented that Resident #19 verbalized and/or exhibited non-verbal pain, the pain was the distal end left femoral fracture, the pain was worse in the evening, and the feeling of pain was internal, external, and chronic. The nurse documented that based on the assessment, the resident's severity level of pain (0-10) was a pain level 5 (hurts even more/moderate significant pain) and the admission evaluation form indicated the physician was to be notified if the resident scores 3-4 or higher on the severity scale. The evaluation revealed documentation that the resident explained their pain felt like an ache, was tender and throbbing, and the pain affected Resident #19's ability to rest/sleep and the pain increased with movement. The nurse documented that the resident was to receive routine pain medication, Acetaminophen (Tylenol) 500 mg (milligrams) 2 tabs every 8 hours and Tramadol (narcotic pain medication) 50 mg as needed. The resident's 48 hour baseline care plan, included in the admission evaluation, documented that Resident #19 verbalized and/or exhibited non-verbal pain upon admission. Review of Resident #19's October 2022 MAR (medication administration record) revealed an order for Acetaminophen 500 mg, 2 tablets by mouth 3 times a day for pain, that was initiated to start on 10/17/22 with no documentation to indicate the resident received Acetaminophen for pain on 10/16/22 while residing in the facility. Resident #19's October 2022 MAR also documented an order for Tramadol 50 mg by mouth every 6 hours as needed for pain, was documented as given one time on 10/16/22 at 9:28 PM for pain level 9 (severe excruciating pain, the worst pain that can be imagined), and documented as given on 10/17/22 at 3:20 AM for pain level 10. There was no other documentation found in the MAR to indicate that Resident #19 received any other medication for pain while residing at the facility. In a progress note on 10/17/22 at 12:36 AM, the nurse documented that Resident #19 ' s family member reported the resident was in a lot of pain and could not get comfortable. In an eMar (electronic medication administration note), on 10/17/22 at 1:18 AM, the nurse indicated the Tramadol that was given to Resident #19 on 10/16/22 at 9:28 PM was ineffective for controlling the resident's pain and Resident #19's follow-up pain scale was 5. Following Resident #19's repeated complaints of pain, no documentation was found in the medical record to indicate that the physician had been notified when the resident ' s medication for pain was ineffective. On 10/17/22 at 3:20 AM, in a nurses note, the nurse wrote that Resident #19 reported pain level 10 out of 10 and Tramadol was given to the resident. On 10/17/22 at 3:51 AM, in an eMar note, the nurse documented the PRN administration of Tramadol was ineffective and the resident's follow-up pain scale was 10. On 10/17/22 at 3:55 AM, in a nurses note, the nurse wrote that resident's family member requested that the resident be transferred to the hospital because the pain medication Resident #19 received was not effective in managing the resident's pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/22 at 4:02 AM, in a nurses note, the nurse wrote that the NP (nurse practitioner) was made aware of the resident' s continuing pain 10/10 after medication and the family member's request for the resident to be transferred to the hospital and the NP would put in the order. On 10/17/22 at 4:05 AM, in a convergence consultation note, Staff #115, NP, wrote Resident #19's diagnosis was complaint of severe uncontrolled pain despite Tramadol and Tylenol. The NP indicated that Resident #19 had severe pain to the area of the leg fracture that extended into the resident's back, and Tramadol and Tylenol were not working to control the resident's pain since the resident arrived at the facility yesterday morning. The NP wrote that a family member with Resident #19 requested an ER (emergency room) evaluation, that the resident was diaphoretic (sweating heavily), visibly in distress from pain with a pain level 10/10 and the plan was to send Resident #19 to the ER for uncontrolled pain and suffering. On 10/17/22 at 4:21 AM, in a nurse's note, Staff #26, LPN, agency nurse documented that report was given to EMS (emergency medical system) and indicated that Resident #19 was leaving the facility in their care at that time. On 10/17/22 at 10:12 AM, in a convergence post transport note, Staff #116, Clinical NP, wrote that Resident #19 was sent to the emergency department for evaluation and management of uncontrolled pain, back and lower extremity and, per the ED, the resident was admitted for diagnosis of intractable pain (pain that can't be controlled with standard medical care). On 1/6/23 at approximately 3:00 PM during an interview, Staff #38, RN, stated he/she worked the 2nd shift on 10/16/22 and indicated that his/her assignment included caring for Resident #19. Staff #38 stated that, when he/she came into work on 10/16/22, nothing had been done related to Resident #19's admission to the facility, that Resident #19 had not been assessed, the resident's orders had not been confirmed with the physician and the resident had not been added to the electronic medical record. Staff #38 indicated that he/she completed Resident #19's admission assessment and confirmed the resident ' s orders with the physician. When asked wy Resident #19 was not administered medication for a pain level 5, Staff #38 indicated it was because he/she had to wait for the orders to go in the EMR before the medication could be given. Staff #38 stated that, before Resident #19's orders could be entered in the EMR, the resident ' s ADT (admission, discharge or transfer) information needed to be entered in the EMR, the orders confirmed with the physician, and the confirmed order sheet faxed to the Admission line (admission order entry department). Once the orders were entered, the orders pop-up in the resident's EMR, and the nurse activated the order. Staff #38 stated that he/she did recall that the Tramadol was hard to get. Staff #38 stated he/she thought that a written prescription for the Tramadol had not come with the resident from the hospital and Staff #38 had to call the doctor to get a written prescription to fax to the pharmacy. The facility identified the nurses who cared for Resident #19 on 10/16/22 dayshift (Staff #27) and night shift (Staff #26) as agency nurses and phone numbers provided. Phone calls were placed to both Staff #26 and Staff #27, with messages left to return the surveyor's call, and no return calls were received. On 1/9/23 at 1:35 PM, Staff #77, Staffing Coordinator, was made aware of the need to talk to Staff #26 and #27. At that time, Staff #77 stated that Staff #26 was out of the country and Staff #27 no longer worked for the agency or the facility. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above findings were discussed with the DON (Director of Nurses) on 1/9/22 at 5:45 PM. During an interview, the DON stated that for new admissions, when the resident arrived at the facility, the expectation was for the resident's admission orders to be confirmed with the physician and transcribed to the resident ' s medical record promptly. The DON also indicated that he/she would have expected the resident's order for Acetaminophen by mouth for pain as needed, to have been transcribed to start on 10/16/22 and administered to the resident for pain as Acetaminophen was a house stocked item. On 1/12/23 at 4:25 pm, the NHA (Nursing Home Administrator), the Corporate NHA, and the Director of Nurses were made aware of all concerns. 16218 2. On 12/29/22, review of Resident #21's medical record revealed the resident was originally admitted to the facility several years ago and whose diagnoses included, but were not limited to: chronic pain, kidney disease with dependence on dialysis, diabetes, muscle weakness with a history of falling, lung disease and dementia. On 1/4/23, review of Resident #21's medical record revealed an order, in effect in December 2022 until it was discontinued on 12/28/22, for Tramadol 50 mg tablet give 0.5 tablet by mouth in the morning for chronic pain. Review of the Medication Administration Record (MAR) revealed an area for nursing staff to document the resident's pain level at the time of administration. Further review of the medical record revealed an order for acetaminophen 500 mg every 6 hours as needed for pain that was in effect in December 2022. Pain level scale ranges from 0-no pain to 10-worse pain possible. Review of the drug control sheet for the resident's Tramadol 50 mg half tablets revealed that, on 12/5/22, the resident had 7 doses of Tramadol available. a) Review of the MAR revealed that, on 12/6/22, the nurse failed to document a pain level for the resident as evidenced by an X in the area of the MAR to document a pain level associated with the Tramadol order. Further review revealed the medication was not administered to the resident on 12/6/22 as evidenced by a 9 being documented rather than a check mark. The 9 indicated there was a related nursing note. Review of the 12/6/22 nursing note associated with this order revealed: Medication on route. Review of the drug control sheet revealed that one dose of the Tramadol was removed from the supply on 12/6/22, however, no documentation was found on the MAR, or the nursing notes, to indicate the dose was administered to the resident. b) Further review of the MAR revealed that, on 12/7/22, the nurse documented the resident's pain level as a 7 and that the medication was not administered as evidenced by a 9 rather than a check mark. Review of the associated nursing note, dated 12/7/22, revealed Medication on route. Review of the drug control sheet failed to reveal documentation to indicate a dose of the tramadol was removed on 12/7/22. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record failed to reveal documentation to indicate that the nurse offered non-pharmacological interventions, or other pain medications, when the nurse documented the resident had pain at a level of 7 and that the regularly scheduled pain medication was not available (on route). On 1/11/23 at 10:50 AM, when asked what it means when a nurse documents medication on route, the Director of Nursing reported this meant the nurse has called the pharmacy and they had been told it's on the way; and that the nurse should call to pull it from the interim supply. Surveyor then reviewed the concern regarding the staff documenting medication on route but it was available; and reviewed the drug control sheet with DON who acknowledged the medication was available on 12/6/22 and 12/7/22. Both the 12/6/22 and 12/7/22 notes were documented by Temp 01 Nursing-Temp/Agency Nurse. On 1/11/23, the Director of Nursing identified the Temp 01 nurse for both of these dates as Nurse #64. The DON reported Nurse #64 no longer worked with the facility, but did provide a phone number. Surveyor attempted to contact Nurse #64 on 1/11/23 but with no response. c) Further review of the MAR revealed the Tramadol was not administered when due on 12/8/22 as evidenced by the nurse documenting 9. Review of the corresponding nursing note revealed a notation of At dialysis. Review of the drug control sheet for the Tramadol failed to reveal documentation to indicate a dose of the Tramadol was removed from the supply on 12/8/22, although there were doses available on that day. Cross reference to F 698. d) Further review of the MAR revealed that an agency nurse documented a pain level of 7 on 12/18/23 and that the Tramadol was administered, however, no documentation was found to indicate that the Tramadol was pulled from the supply on 12/18/22. On 1/11/23 at 10:50 AM, the surveyor reviewed this information with the DON. The surveyor and DON then reviewed the drug control sheets and the DON ackowledged the Tramadol was signed out on 12/17/22 and the next date documented was 12/19/22. The 12/18/22 tramadol was documented as administered by Temp 13 Nursing -Temp/Agency Nurse. On 1/11/23, the Director of Nursing identified Nurse #65 as the nurse who documented the tramadol on 12/18/22. On 1/11/23 at approximately 5:00 PM an interview was conducted with Nurse #65 who did not recall the specific resident. Nurse #65 reported the EMAR (electronic Medication Administration Record) always get done and that the nurse to patient ratio is kind of hectic. When the concern regarding the documentation of the Tramadol without documentation to indicate the medication had been pulled from the supply the nurse responded: I don't know what happened - could be human error. Further review of the medical record, including the MAR and the progress notes, failed to reveal documentation to indicate the resident was offered or received any non-pharmacological interventions for pain relief or the as needed acetaminophen on 12/6/22, 12/7/22, 12/8/22 or 12/18/22. The concern regarding the failure to ensure regularly scheduled narcotic pain medication was administered as ordered was reviewed with the DON and the Nursing Home Administrator on 1/13/23 at 4:00 PM.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on record review and interview, it was determined that the facility failed: to have a process in place to ensure that a contract was developed between the facility and the dialysis center to ensure communication and collaboration for residents receiving dialysis treatments, to ensure that staff had dialysis orders and appropriately assessed the resident before and after treatment, and failed to have an effective system in place to ensure that resident attending dialysis received their daily medications on scheduled dialysis days. This was evident for 4 (Residents #21, #44,#5, and #26) of 5 residents reviewed for dialysis services. The findings include: End-Stage Renal Disease (ESRD) - The stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life. (42 CFR, Part 405 - S405. 2102) Dialysis - A process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane. The two types of dialysis that are currently in common use are hemodialysis (HD) and peritoneal dialysis (PD). (S405.2102) Dialysis facility - means an entity that provides outpatient maintenance dialysis services or home dialysis training and support services, or both. (S494.10 Definitions) On 12/20/22 at 9:44 AM, a review of the facility's policy for Hemodialysis Care and Monitoring NS 1167-01 revealed that the facility was to have a written agreement between them and the dialysis centers that they utilized. The expectation was that facility staff would complete a pre-dialysis assessment and send it with the resident to the dialysis center. The form contained a section for the dialysis center nurse to complete and send back with the resident as a form of communication to let the facility know what had occurred during treatment. When the resident arrived back to the facility the staff were to complete a post-dialysis assessment form. In section II Physician orders, it read that the expectation was that the physician will write orders for medication management on days of hemodialysis (as hemodialysis will affect the way that medications are absorbed) and the monitoring of weights and blood pressure will be established. A sample list of orders were attached to the policy which included orders, but was not limited to the following: orders for the days a resident will go for the dialysis treatment, dialysis weights, dialysis log vital signs and weights, dialysis log daily site care of the access site, orders for flushing the access site when required, and when a pressure dressing that may be applied to the dialysis access site may be removed. In section II, the policy discusses the general access sites for hemodialysis and how to monitor and manage the sites. Section VIII discusses the expectations of staff pre-dialysis treatments that includes obtaining an accurate weight, vital signs, and making sure the resident either takes their medications or the medications are held. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post-dialysis treatment, the staff were expected to review the notes from the dialysis center to check how the resident tolerated the treatment, if they had received a blood transfusion during treatment, check the labs, and if the resident had any medications during the treatment. Staff were expected to do a post-dialysis assessment of the resident and check their access site, pulse in the access site limb, monitor access site for bleeding/swelling/abnormalities, vital signs, talk to the resident about any unusual occurrences during the treatment. Section IX reads that there was an expectation of 24 hour a day communication between the facility and the dialysis center to communicate the resident's clinical status. A review of 3 residents receiving dialysis treatments was conducted. 1) On 12/20/22 at 7:59 AM, a medical record review for Resident #21 was conducted because the Director of Nursing had reported that this resident was receiving dialysis treatments. A review of the physician orders for December 2022 revealed that Resident #21 had no orders for dialysis treatments, no orders for medication management on dialysis days, no orders for monitoring resident weights and blood pressure. A review of the resident's care plan revealed that they had a right arm arteriovenous fistula for the dialysis access port, however, had no orders to monitor the site. A review of the resident's dialysis notebook, the dialysis treatment dates, and the post-dialysis forms in the assessment section on 1/10/23 at 1:38 PM revealed that Resident #21 had 17 treatments between 11/1/22 - 12/15/22. Of those 17 treatment days, facility staff completed the pre-dialysis form and placed in notebook on 11 days, the dialysis center completed their part during the treatment on 4 of the 17 days, and staff completed a post-dialysis assessment on 2 of the 17 days. Additional pre-dialysis assessments were completed in the electronic medical record, but had not been included in the resident's dialysis notebook that they carry back and forth to the dialysis center. A review of the progress notes revealed no documentation that facility staff contacted the dialysis center regarding how the resident tolerated the treatment, whether the resident had a blood transfusion or received medications during the treatment, the lab values, and weights obtained. 1b) On 12/29/22, further review of Resident #21's medical record revealed the resident was originally admitted to the facility several years ago and whose diagnoses included, but were not limited to: chronic pain, kidney disease with dependence on dialysis, diabetes, muscle weakness with a history of falling, lung disease and dementia. In December 2022, the resident had orders for the following medications to be administered in the mornings: vitamin B 12; escitalopram (an antidepressant); furosemide (a diuretic); pantoprazole (used to treat gastroesphogeal reflux disease (GERD)); tramadol (narcotic pain medication); Vitamin C; Eliquis (an anticoagulant); and fluticasone aerosol inhaler. The resident's regularly scheduled dialysis days were Tuesday, Thursday and Saturday. The schedule indicated that the resident's start time was 10:15 AM and should be ready to go one hour before scheduled start time. Review of the Medication Administration Record revealed that, on Thursday 12/8/22, Temp nurse #06 documented 9 for all of the resident's morning medications. Review of the corresponding nursing note revealed that, on 12/8/22 at 1:04 PM, the nurse documented: At dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the drug control sheet for the tramadol failed to reveal documentation to indicate that a dose of the tramadol was removed from the supply on 12/8/22, although there were doses available on that day. Further review of the medical record failed to reveal documentation to hold regularly scheduled medications on dialysis days. On 1/12/23 at 4:06 PM surveyor requested if the facility had a policy regarding medications for residents on dialysis. The DON indicated she would have to check to see if there was a policy, and reported that the residents get their morning medications before they go to dialysis. Surveyor then reviewed the concern that the resident did not recieve morning medications on 12/8/22 and that the scheudle indicated the resident was to be ready to leave in the mornings around 9:00 AM. The DON confirmed there would be time to get medications prior to leaving for dialysis. As of time of exit on 1/13/23 no policy was provided regarding the administration of medications for residents on days they attend dialysis. On 1/13/23 at 4:00 PM surveyor reviewed the concern with the DON and the Administrator regarding the failure to have a process in place to ensure medications were administered on days resident's attend dialysis. 2) A medical record review, on 12/27/22 at 1:48 PM, for Resident #44 was conducted because the resident was identified by the DON as a resident on dialysis. A review of the physician orders for December 2022 revealed that the resident had no orders to monitor weight and blood pressure and no order regarding management of medications on dialysis days. A review of the resident's dialysis notebook, the dialysis treatment dates, and post-dialysis assessments in the electronic medical record, on 1/10/23 at 1:42 PM, revealed that the resident had 11 treatments between 11/1/22 and 12/13/22. Of these 11 treatment days facility staff completed 9 pre-dialysis assessments, the dialysis staff completed their portion of the assessment on 1 of the 11 days, and facility staff completed a post-dialysis assessment on 4 of the 11 days. A review of the progress notes revealed no documentation that facility staff contacted the dialysis center regarding how the resident tolerated the treatment, whether the resident had a blood transfusion or received medications during the treatment, the lab values, and weights obtained. 3) A medical record review for Resident #5 on 12/19/22 at 2:11 PM revealed a care plan, initiated 6/18/21, that read the resident had the need for hemodialysis treatments due to chronic kidney disease. A review of the physician orders for 10/22, 11/22, and 12/22 revealed no orders for dialysis treatments, no orders for medication management on dialysis days, no orders for monitoring resident weights and blood pressure. On 1/10/23 at 1:40 PM, a review of the treatment dates and assessments revealed that between 11/1/22 and 12/10/22 Resident #5 had 17 dialysis treatments and of those 17 treatments staff completed a pre-dialysis assessment on 15 days, the dialysis center completed the form on 5 days, and staff completed a post-dialysis assessment on 3 of the days. A review of the progress notes revealed no documentation that facility staff contacted the dialysis center regarding how the resident tolerated the treatment, whether the resident had a blood transfusion or received medications during the treatment, the lab values, and weights obtained. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/20/22 at 6:53 AM an interview with agency Registered Nurse (RN) #110 revealed that the pre-dialysis assessment was primarily completed by the night shift nurse and printed to give to the oncoming dayshift nurse. Staff were aware of dialysis residents as this information was posted at the nurses' station. An interview with the Unit Nurse Manager (UM) #2 on 12/20/22 at 7:40 AM revealed that she managed the care of the dialysis residents on 1st and 2nd floor. UM #2 reported that she had been reminding staff in a morning huddle which residents had dialysis and to make sure that the pre-dialysis assessment had been completed. When she found a missing pre-dialysis form, she would have the nurse complete the form at that time. UM #2 reported that she was aware that the dialysis staff had not been completing their portion of the dialysis form and stated that she called the center when she was asked for resident weights before and after treatments. UM #2 reported that the Director of Nursing (DON) had been aware of the communication concerns with the dialysis centers. When reviewing the post-dialysis assessments, she reported that she was not on duty when the residents returned from dialysis and was unable to remind staff to do the post-dialysis assessments. An interview with the DON on 12/20/22 at 8:28 AM revealed that the transferring hospital had already set up the dialysis treatment and that information was sent with the residents at the time of admission. The facility enters a set of dialysis orders and ensured that the resident was assessed before and after treatment and had a ride to treatment. During a subsequent interview on 12/20/22 at 9:34 AM, when the DON brought in the Dialysis policy, she reported she was not aware of a contract between the facility and the dialysis center, but would check with the Nursing Home Administrator (NHA). An interview was held with the DON on 12/20/22 at 1:27 PM to discuss the fact that the dialysis center had not been reporting back to the facility how the residents tolerated the treatment, if there had been any medications or blood transfusions given during treatment, the vital signs and weights. She reported that when there was something that the dialysis center needed to tell the facility, they would call. However, there was no documentation in the medical records for the 3 residents reviewed to support this information and this was not in line with the Dialysis policy. The DON reported that she had not contacted the dialysis centers regarding the lack of reporting even though she had been aware of the issue. On 12/20/22 at 10:04 PM, the NHA reported that she was unaware of a contract between the facility and the dialysis center but would check with the corporate office. On 12/27/22 at 2:00 PM, the Regional Clinical Director #7 reported that there was no contract between the facility and the dialysis centers as stated in the facility's policy. On 1/13/23 at 8:43 AM, this concern was reviewed with the Nursing Home Administrator, Director of Nursing, Regional Clinical Director #7, and Regional Director of Clinical Services #22. 16218 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b) On 12/29/22, further review of Resident #21's medical record revealed the resident was originally admitted to the facility several years ago and whose diagnoses included, but were not limited to: chronic pain, kidney disease with dependence on dialysis, diabetes, muscle weakness with a history of falling, lung disease and dementia. In December 2022, the resident had orders for the following medications to be administered in the mornings: vitamin B 12; escitalopram (an antidepressant); furosemide (a diuretic); pantoprazole (used to treat gastroesphogeal reflux disease (GERD)); tramadol (narcotic pain medication); Vitamin C; Eliquis (an anticoagulant); and fluticasone aerosol inhaler. The resident's regularly scheduled dialysis days were Tuesday, Thursday and Saturday. The schedule indicated that the resident's start time was 10:15 AM and should be ready to go one hour before scheduled start time. Review of the Medication Administration Record revealed that, on Thursday 12/8/22, Temp nurse #06 documented 9 for all of the resident's morning medications. Review of the corresponding nursing note revealed that, on 12/8/22 at 1:04 PM, the nurse documented: At dialysis. Review of the drug control sheet for the tramadol failed to reveal documentation to indicate that a dose of the tramadol was removed from the supply on 12/8/22, although there were doses available on that day. Further review of the medical record failed to reveal documentation to hold regularly scheduled medications on dialysis days. On 1/12/23 at 4:06 PM surveyor requested if the facility had a policy regarding medications for residents on dialysis. The DON indicated she would have to check to see if there was a policy, and reported that the residents get their morning medications before they go to dialysis. Surveyor then reviewed the concern that the resident did not recieve morning medications on 12/8/22 and that the scheudle indicated the resident was to be ready to leave in the mornings around 9:00 AM. The DON confirmed there would be time to get medications prior to leaving for dialysis. As of time of exit on 1/13/23 no policy was provided regarding the administration of medications for residents on days they attend dialysis. On 1/13/23 at 4:00 PM surveyor reviewed the concern with the DON and the Administrator regarding the failure to have a process in place to ensure medications were administered on days resident's attend dialysis. 18819 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Resident #26 was admitted to the facility on [DATE] with diagnoses that include but are not limited to congestive heart failure, diabetes, atrial fibrillation, liver cirrhosis, and anasarca. Resident #26 was again hospitalized and readmitted from the hospital on 10/13/2020 with diagnoses that now also included acute kidney failure, chronic kidney disease stage 4, and now required hemodialysis. While in the hospital in October 2020, Resident #26 had a right-sided permacath placed to receive hemodialysis. Resident #26's physician gave orders instructing the nursing staff to have Resident #26 receive hemodialysis three times a week (Tuesday, Thursday, and Saturday). The facility does not have the ability to provide hemodialysis onsite. Resident #26 had to be transferred to an outside hemodialysis center to receive this service. On 10/14/2020 and 11/18/2020, Resident #26's physician also instructed the nursing staff to obtain weekly weights x 4 weeks. Further review of Resident #26's closed record revealed the following documented weights: 09/11/2020 - 130. 5 pounds. 09/16/2020 - 141.4 pounds. 09/22/2020 - 144.2 pounds. 09/25/2020 - 146.8 pounds. 09/28/2020 - 141.4 pounds. 10/14/2020 - 131.0 pounds. 10/15/2020 - 129.7 pounds. 10/21/2020 - 130.0 pounds. 01/05/2021 - 81.4 pounds. This weight was struck out and labeled as incorrect documentation. 01/06/2021 - 78.8 pounds. A review of the facility policy, Hemodialysis Care and Monitoring, on 12/29/2022, revealed that under section 8, Pre-Dialysis, within four hours of transportation to the dialysis center the nursing staff should obtain an accurate weight, a set of vital signs, receive medications or withhold medications, provide a meal or snack prior to leaving, and send a copy of the nursing evaluation and emergency contact information with the resident to the dialysis center. Upon transfer back from the dialysis center, the charge nurse is to review notes from the dialysis center, review the medications that may have been given at the dialysis center, and lab results, and observe and inspect the dialysis site for bleeding, swelling, or other abnormalities. Under section 11, Shared Communication, a 24-hour-per-day communication method is established to communicate a resident's clinical status between the dialysis center and the facility that may not be limited to telephone communication, providing a pre and post-dialysis assessment of the resident response, and medication administration timing, changes, and new orders. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #26's care plan, dated 11/06/2020, revealed a goal for dialysis was that Resident #26 would not develop complications from dialysis. Nursing interventions included: checking the dialysis site for infection, monitoring for fluid and electrolyte imbalance, monitoring lab results, monitoring for peripheral edema and ascites, observing for abdominal distension, monitoring abdominal girth, and providing education to Resident #26 about dialysis. A review of the nursing documented weights, including pre or post-dialysis assessments, for Resident #26 between 10/21/2020 and 01/05/2021 only revealed the following documented weights: 11/05/2020 - 105 pounds. In a post-dialysis note. 11/21/2020 - 130 pounds, pre-dialysis weight, and 95.9 pounds in a post-dialysis note. 11/23/2020 - 95 pounds. In a post-dialysis note. 12/14/2020 - 95.2 pounds. In a post-dialysis note. 12/29/2020 - 130 pounds. In a pre-dialysis note. No dialysis facility documentation, regarding Resident #26 dialysis treatments, was identified in Resident #26's closed medical record on 12/29/2022. In an interview with Resident #26's family member on 12/30/2022 at 3:40 PM, Resident #26's family member indicated that Resident #26 lost a lot of weight and only weighed 70 pounds when Resident #26 took him/herself out of the facility in January 2021. In an interview with the facility dietician covering Resident #26's nutritional needs in 2020 and early 2021, on 01/07/2023 at 10:56 AM, the facility dietician stated that s/he was only working part-time, 3 days a week, when Resident #26 resided in the facility. The facility dietician stated that s/he was hired in April 2020 to be the dietician in the facility. The facility dietician stated that it was difficult obtaining the weights of residents from the nursing staff. Resident weights were just not done. The facility dietician also stated residents were not receiving supplements and this was one of the reasons s/he resigned from the dietician position in January 2021. On 01/04/2023, the facility was able to provide the nurse surveyor with the dialysis documentation listing the pre and post-dialysis weights for Resident #26. Resident #26 was first seen at the dialysis center for a hemodialysis treatment on 10/15/2020. 10/15/2020 - 57.7/60.9 Kg. 134/126.9 pounds. 10/22/2020 - 54.2/53 Kg. 119.2/116.6 pounds. 10/29/2020 - 57/56.6 Kg. 125.4/124.5 pounds. 11/7/2020 - 48.2/47.4 Kg. 106/104.2 pounds. 11/23/202 - 43.4/43 Kg. 95.5/94.6 pounds. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/1/2020 - 40.7/39.9 Kg. 89.5/87.7 pounds. NO DOCUMENTATION between 12/9-12/21/2020. 12/22/2020 - 36.8/36.2 Kg. 81/79.6 pounds. 12/31/2020 - 37.4/36.5 Kg. 82.2/80.3 pounds. 1/3/2020 - 37.9/37.2 Kg. 83.3/81.8 pounds. 1/5/2020 - 37.3/36.1 Kg. 82.0/79.4 pounds. 1/7/2020 - 36.9/35.9 Kg. 81.1/79 pounds. 1/9/2020 - 37.9/36.2 Kg. 83.4/79.6 pounds. The facility nursing staff failed to 1) follow Resident #26's physician's orders and obtain a weekly weight between 10/28/2020 and 01/05/2021, and 2) communicate and document Resident #26's information including pre and post-weights, to and from the dialysis center.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37276 Based on medical record review, staff interview, a review of facility staffing sheets, it was determined the facility failed to have sufficient nursing staff as evidenced by the failure to ensure newly admitted resident's were assessed and ordered were implemented in a timely manner. This was evident for 2 (#19, #68) of 86 residents The findings include: 1) On 1/6/23 at 9:00 AM, a review of complaint #MD00185499 was conducted. The complainant reported on the morning of 10/16/22, Resident #19 was transferred to the facility from an acute hospital following orthopedic surgery for left femur (thigh bone) fracture. The complainant reported that after being in the facility for a couple hours, Resident #19 was in severe pain from his/her broken bones, and when the complainant inquired about getting pain medication for the resident, he/she was told the medication needed to be delivered from another town, and when he/she pressed for more information, found out the resident had not been entered into the facility's system, which delayed things even more. Review of Resident #19's medical record revealed the initial progress note written since the resident was admitted was on 10/16/22 at 3:43 PM. In the progress note, the nurse documented that Resident #19 was admitted to the facility at approximately 9:30 AM. On 10/16/22 at 5:00 PM, the nurse wrote Admission: 10/16/22 9:00 AM. An Admission Initial Evaluation assessment for Resident #19 with an effective date of 10/16/22 at 5:00 PM documented the resident's date and time of admission was 10/16/22 at 9:00 AM. In the assessment the nurse documented Resident #19 verbalized and/or exhibited non-verbal pain, the pain was the distal end left femoral fracture, and a pain level 5 (hurts even more/moderate significant pain) On 10/16/22 at 6:21 PM, Staff #38, RN (Registered Nurse) documented that Resident #19's orders were verified. This was approximately 8 to 9 hours after Resident #19 was admitted to the facility. Review of Resident #19's October 2022 MAR (medication administration record revealed the first time Resident #19 was medicated for pain was on 10/16/22 at 9:28 PM when the resident received Tramadol by mouth for pain level 9 (severe, excruciating pain). This was approximately 12 hours after arriving in the facility. During an interview on 1/6/23 at 3:00 PM, Staff #38, RN, indicated when he/she came into work the evening shift on 10/16/22, none of Resident #19 had not been entered into the electronic medical record, the resident's admission orders had not been confirmed with the physician, and the admission assessment was not done. Staff #38 stated that he/she confirmed the orders and completed the resident's admission assessment. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the staffing and assignment sheets for 10/16/22 revealed for the day shift, no supervisor was identified, there was no RN in the building and there was not a Community Nurse on duty. The facility had two agency LPNs (licensed practical nurse) on the first floor; with three GNAs (geriatric nursing assistant) (two of whom were agency staff). The second floor had two LPNs, (one of whom was agency), one med tech and four GNAs (three of which were agency). Additionally there were two Community GNAs who were on 1:1 assignment. Cross Reference F635, F697 40927 2) A medical record review for Resident #68 on 1/11/23 at 10:17 AM revealed a discharge summary from the acute care hospital dated 8/6/22 that read Resident #68 had been brought to the emergency department following a fall at home for nausea, dizziness, and generalized weakness. According to the document Resident #68 was a fall precaution, had depression and was discharged to the facility. According to the progress notes the resident was at the facility for physical and occupation therapy and was to be discharged to the Assisted Living facility. According to the Admission Assessment the resident was admitted to the facility on [DATE] at 4:46 PM and arrived in a wheelchair. There was a fall report that Resident #68 fell from the wheelchair on 8/11/22 at 8:45 PM and the resident reported s/he was trying to get her nightgown. There was no evidence in the medical record that Resident #68 had an admission assessment until after s/he fell at 8:45 PM. The admission assessment was signed off by temp agency nurse #14. The nurse assigned to Resident #68 was called but unable to leave a message, so an email was sent on 1/11/23 at 3:04 PM and there was no response. On 1/13/23 at 8:43 AM this concern was reviewed with the Nursing Home Administrator, Director of Nursing, Regional Clinical Director #7, and Regional Director of Clinical Services #22.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on review of medical records, staffing sheets, assignment sheets, policies and other relevant documentation, observations and interviews, it was determined that the facility failed to ensure staff provided nursing and related services to ensure resident safety and attain or maintain the highest level of well being possible; and failed to have an effective system in place to ensure that agency staff, who were providing a high percentage of resident care, were sufficiently oriented and supervised. This was found to be evident for 5 (Resident #21, #51,# 89, #90 and #91) out of 26 residents reviewed as part of complaint investigations but has the potential to affect all residents. The findings include: 1) On 12/29/22, review of Resident #21's medical record revealed the resident was originally admitted to the facility several years ago and whose diagnois included, but were not limited to: chronic pain, kidney disease with dependence on dialysis, diabetes, muscle weakness with a history of falling, lung disease and dementia. The resident was sent to the hospital via 911 in the early morning hours of 12/28/22. The agency nurse #74 was unable to provide historical information to the EMTs who arrived to transport the resident to the hospital due to the it being the first night she was assigned to care for Resident #21. No other personnel on duty were able to provide requested information. Review of Staffing and Assignment Sheets failed to reveal documentation to indicate that a supervisor or community nurse was on duty during the 12/27/22 night shift. Review of the Assignment sheets revealed documentation that two LPNs and two GNAs (#55 and #54) were working on Resident #21's unit on the 12/27/22 night shift. The resident census was listed as 62 residents. Although not listed on the assignment sheet, based on review of Staffing Sheets, interview with the DON, and review of timesheet data on 1/9/23, revealed that agency RN #56 was working on Resident 21's floor during the 12/27/22 night shift, but was not assigned to Resident #21's room. Further review of the medical record failed to reveal documentation to indicate that an RN was consulted or assessed Resident #21 when a change in condition was first noted around 2:00 AM. On 12/30/22, after completing a night shift, RN #56 reported that it (the 12/29 night shift) was only his fourth day working at the facility and denied any knowledge of Resident #21. On 1/4/23 at 6:46 AM, interview with nurse #74 revealed she was a licensed practical nurse employed by a staffing agency and had been working at this facility a couple days a week, maybe since November or October. The nurse went on to report that the 12/27/22 night shift was her first time on that side of the floor, indicating it was the first time she had cared for Resident #21. In regard to Resident #21, Nurse #74 reported she was alerted by GNAs #55 and #54 that the resident did not look right. On 1/5/23 at 6:30 AM, during the interview with agency GNA #55 and #54 neither GNA remembered caring for Resident #21 the week prior. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/5/23, an interview was conducted at 9:36 AM with the Director of Nursing (DON), Nursing Home Administrator (NHA), Regional Director of Clinical Services #22 and Corporate Executive Director #29. During this interview, the DON confirmed there were some occasions when all the nurses and GNAs on a unit were agency. When asked about assignments for agency staff, the DON reported that they do try to be consistent for continuity of care. On 12/30/22 at 6:54 at AM, agency RN #56 was interviewed. The RN reported this was his fourth day working at this facility. He reported he had the even rooms on the second floor last night; that some nights he was assigned the even, some the odds, and that there was wrap around assignement he had one night. He was unable to recall which assignment he had when. On 1/5/23 at 6:30 AM, interview with GNAs #55 and #54 confirmed that they were both employed by a staffing agency. When asked about a specific resident by name (Resident #21), neither GNA recalled the resident. They then asked for the resident's room number, reporting they didn't know the names of the residents, that they knew them by room number. Even after the room number was provided, neither GNA recalled caring for the resident. On 1/6/23 at 2:45 PM, agency GNA #83 reported they move their assignments around a lot, stating they were not given a permanent assignment. Reported she received a verbal report at the start of her shift. On 1/9/23 at 9:33 AM, Resident #13 expressed concerns to the surveyors regarding the number of agency staff, stating: they know nothing about any of us. Cross reference to F 622 3) On 12/28/22, review of Resident #51's medical record revealed the resident was found on the floor during the evening shift of Friday 8/5/22. Review of the staffing and assignment sheets revealed three nurses and four GNAs were working on the unit at the time the resident was found. All three nurses, and three out of the four GNAs working on the unit, were agency staff. One of the nurses was an RN. The Unit Nurse Manager #2 was listed as supervisor, but during an interview on 1/3/23 at 1:00 PM, the Unit Manager #2 reported she was not at the facility at the time of the fall. As of time of exit on 1/13/23, the facility was unable to definitively identify which agency nurse completed the post fall change in condition documentation and the corresponding neurochecks. On 1/5/23, LPN #112 reported to the surveyor that she had assessed the resident after the fall, contacted the provider (Nurse Practitioner) and indicated that she initiated the documentation, however, the documentation was signed off as completed after LPN #112 had left for the day. The Annotated Code of Maryland Health Occupations Article, Title 8, is the Nurse Practice Act and contains the laws and regulations which licensed nurses must follow and defines their scope of practice. Licensed nurses are governed by the Maryland Board of Nursing. Review of .04 Prohibited Acts. revealed the following: The LPN may not: C. Perform the comprehensive nursing assessment, and F. Analyze client data in order to determine client outcome identification and formulation of a nursing diagnosis. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Despite NP #108's progress note, dated 8/5/22 at 9:45 PM, stating s/p [status post] unwitnessed fall with no injuries per RN [registered nurse]. Neuro checks started. there was no documentation found, or report provided, to indicate that a registered nurse had assessed the resident prior to being moved from the floor. On 1/5/23 at 10:56 AM, the surveyor reviewed the concern with the DON and corporate nurse #22 that no RN completed the assessment prior to the resident being moved, after being found on the floor. Cross reference to F 689, F 842, F 684 and F 658. 4) Multiple medication errors were identified during medication administration observations for Residents #89, #90 and #91. Observations were made of three different nurses on two different units. Errors were identified during all three observations. All three nurses (#46, #57 and #58) were agency nurses. On 1/12/23, during the medication administration observation, Nurse # 57 reported this was his first day working at the facility. Nurse #57 had to request assistance from other staff in obtaining 3 of the regularly scheduled medications due to the medications not being available in the medication cart. =One of the medications was available in the interim supply that the agency nurse did not have access to. The other two medications were not found on his medication cart but were located and provided by other nurses. Cross reference to F 759 Review of the staffing sheets from Saturday December 3, 2022 through Sunday [DATE] revealed multiple agency GNAs and nurses were working during every shift. On some dates, more than 50% of the staff working were agency. During the 1/5/23 interview at 9:36 AM with the Director of Nursing (DON), Nursing Home Administrator (NHA), Regional Director of Clinical Services #22 and Corporate Executive Director #29, The NHA reported there was an orientation packet for both GNAs and nurses. On 1/5/23 at 3:30 PM, the DON presented an Orientation Checklist for nurses and one for aides; as well as an Agency Nurse Orientation booklet, and Instructions for Use Agency Nurse Orientation Booklet. On 1/6/23 at 10:35 AM during an interview, the DON reported that the facility started using the checklist last week. The Staff Developer Nurse #104 confirmed this, and stated: I will have to assign it if I am not here. They also indicated that they were in the process of completing the checklist with agency staff who had been working there for awhile. On 1/6/22 at 11:25 AM, the DON reported that corporate initiated the checklist in February of 2022. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Instructions for Use Agency Nurse Orientation Booklet revealed: Orientation to the unit is required for each agency (vendor) nurse. This orientation packet is a step-by-step guide to be completed prior to resident care. This is not busy-work; this is a mandatory requirement. The executive leadership will provide oversight and direction for compliance The booklet should be completed with a nurse at the facility at the same level or higher than the Agency nurse. Ideally, a Unit Manager or Director of Nurisng would complete this with the nurse and serve as a Facilitator .The facilitator will provide the Agency Nurse with: . Provide an adequate resident nursing report for each resident that the Agency Nurse will be responsible for, including current code status. Complete the competency at the end of the booklet, obtain signatures, provide a copy to the Agency Nurse and place the original in the Agency Nurse file at the facility. Cross reference to F 835 On 1/11/23, interview with agency nurse #82 revealed that one of two nurses who provided report during a recent shift only provided the residents' names. At the end of report, the nurse asked about code status, antibiotics and who had diabetes, this information could not be provided by the off going nurse, although the nurse was able to obtain this information after reviewing the medical record. After requesting, the nurse was provided a printout of the residents, however, several were listed in the wrong room. Cross reference to F 559 [Sherls writing]. During the 1/5/23 interview conducted at 9:36 AM with the Director of Nursing (DON), Nursing Home Administrator (NHA), Regional Director of Clinical Services #22 and Corporate Executive Director #29, the DON reported that the staff developer nurse or the scheduler gives the agency person a tour, orients them to the crash cart and medication cart and gives them their computer log ins. On weekends, the staff would conduct the tour or the manager on call would conduct the tour during the 4 hour period they would be in the building. The DON also reported there was a Manager on Duty, which could be any discipline, who could also assist with the tour. When asked for further clarification as to who conducts the orientations on the weekends, and if that individual had an assignment, the DON responded : we assign them as community nurse. When asked if there was a job description for what the community nurse was supposed to do, Corporate Executive Director #29 stated: we will look into that. As of time of exit no official job description was provided for the community nurse assignement. On 1/9/23, the staffing coordinator #77 reported that they were utilizing 9- 12 staffing agencies, but there were 5-6 that they usually used. Indicated they were typically able to cover with the 5-6 agencies that were regularly sending staff to them. On 1/9/23, interview with the staffing coordinator #77, revealed the facility was actively looking for an RN for night shift to have 24 hour coverage. She confirmed that they did not currenlty have a night shift supervisor, so she had 5 nurses working on night shift, two on each floor and a community nurse. If they were short staffed, then the community nurse would have an assignement. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Staffing Sheet for 12/29/22 revealed that LPN #52 was listed as Community for the 10:15 PM to 6:45 AM shift (night shift). On 12/30/22 at approximately 6:40 AM, LPN #52 was interviewed. She reported she was assigned as the Community Nurse because there is so many agency [staff]. She reports she is a resource person and helps with paperwork or any incidents, dialysis paperwork, whoever needs help. When asked about who is the current supervisor, LPN #52 confirmed that she was not the supervisor, and reported Unit Nurse Manager #2 is on call. She also reported Nurse #56 is the current RN in the building. Review of staffing sheets confirmed Nurse #56 was scheduled for the 12/29 night shift. Interview with RN #56 on 12/30/22, prior to his leaving the facility at the end of his shift, revealed this was the 4th day he worked at the facility. Further review of the staffing sheets revealed an assignment category titled Community. This position was filled with a variety of staff including: LPNs (licensed practical nurse) both agency and regular staff, GNAs both agency and facility employees who were designated to be providing one on one supervision to specific residents; and sometimes with RNs who were facility employees. Review of the Assignment Sheets often listed Unit Nurse Manager #2 as the Supervisor for day shift for both the first and second floors. Unit Nurse Manager #2 is an LPN. The Annotated Code of Maryland Health Occupations Article, Title 8 is the Nurse Practice Act and contains the laws and regulations in which licensed nurses must follow and defines their scope of practice. Licensed nurses are governed by the Maryland Board of Nursing. Review of .04 Prohibited Acts. The LPN may not: E. Supervise the nursing practice of RNs and other LPNs. Cross reference to F 836

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16218 Based on review of staffing sheets and interview, it was determined that the facility failed to ensure a registered nurse was working at least 8 hours a day; and failed to ensure the DON was working in that capacity on a full time basis due to currently being assigned the duties of the infection preventionist in addition to being the Director of Nursing. These practices have the potential to affect all residents. The findings include: 1) Review of the staffing sheets for Saturday December 3, 2022 through Sunday January 1, 2023 failed to reveal documentation to indicate that an RN was working during the following shifts: Sunday 12/18 - day shift Sunday 12/18 - evening shift Sunday 12/18 - night shift Additionally, review of State regulations require an RN to be on duty 24 hours per day 7 days per week. Further review of the staffing sheets failed to reveal documentation to indicate an RN was working during the following shifts: Saturday 12/3 - day shift Sunday 12/4 - day shift Thursday 12/15 - night shift Tuesday 12/20 - night shift Wednesday 12/21 - night shift Saturday 12/31 - night shift On 1/9/23, interview with the staffing coordinator #77 revealed the facility was actively looking for an RN for night shift to have 24 coverage. 2) On 1/5/23 during an interview at 9:36 AM, the Nursing Home Administrator reported that the Assistant Director of Nursing (Nurse #107) had submitted his resignation. On 1/9/23 at 3:00 PM, the Director of Nursing (DON) reported that the Assistant Director of Nursing (ADON) had been the infection preventionist (IP). The Regional Director of Clinical Services #22 then stated that the DON [NAME] now responsible for that role, but that corporate would be consultative. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/23 at 1:21 PM, the DON reported that she hads the IP certification, but confirmed that she had not previously held that position. Review of state regulations revealed that the infection preventionist position shall be staffed at a ratio of 1.0 Full Time Equivalents for every 200 beds. The faciltiy is licensed for 140 beds. This would mean the infection preventionist responsibilities should occupy 70% of the DONs time.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 40927 Based on record review and interview, it was determined that the facility failed to have staff who were competent and had the skill set to work with residents with mental and psychosocial disorders. This was found to be evident during the review of one (Resident #20) out of 40 residents reviewed for facility reported incidents involving allegations of physical or verbal abuse of residents' by staff, but had the potential to affect any of the residents with psychosocial disorders. The findings include: A medical record review, on 12/28/22 at 9:24 AM, for Resident #20 revealed that the resident had been in the facility for approximately 2 years. A progress note, written for a visit conducted on 1/4/22, by Certified Nurse Practitioner (CRNP) #6 revealed that Resident #20 suffered from many health issues to include, but not limited to bipolar disorder (formerly called manic-depressive illness or manic depression is a mental illness that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks. www.Nih.gov) Further review of the medical record revealed that the resident was evaluated by the facility's mental health services on 12/16/21, following a readmission to the facility. The visit was conducted by CRNP #63. She noted that Resident #20 was being seen as a follow up requested by the facility. She reported that nursing staff reported the resident had no recent behavioral or mood concerns, elopement attempts, or resisting care. The note further read that Resident #20 was cooperative with medication administration and voiced no suicidal ideations or passive death wishes per nursing. Resident had questionable judgement, limited ability to effectively problem solve, and was goal directed. Resident was to continue antipsychotic medication for treatment of bipolar disorder. On 12/28/22 at 9:33 AM, a review of the facility's investigation file for self-reported incident #MD00181051 was conducted. The self-report concluded that Resident #20 had been abused by an agency Licensed Practical Nurse (LPN) #49 on 1/9/22 during the evening shift. A review of the witness statements collectively revealed that, on 1/9/22, the facility was in a COVID 19 outbreak, and as residents tested positive for COVID 19, they were being moved to the COVID 19 positive unit referred to as the red zone and there was a plastic barrier between the red zone and the rest of the unit which was considered the green zone. According to the statements, the red zone staff were to stay in the red zone and green zone staff were not to go into the red zone and so forth. However, day staff had been crossing over into the other zones to move residents and provide care. A witness statement from LPN #67 read that Resident #20 had been upset with her because she had not started with the green zone and was telling her she did not know how to do her job and cussing at her. LPN #67 had been assigned to day shift on 1/9/22. She reported she told Resident #20, How about you mind your P's and Q's while we're giving report? To which the resident responded to negatively. LPN #67 reported she finished her report and just left. No attempt had been made to address Resident #20's behaviors and the fact that s/he had been upset. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A statement given by Resident #20 read that on 1/9/22, the resident had observed staff not adhering to the red zone and green zone as they moved residents to the COVID 19 positive unit and provided care. It further described that Resident #20 had attempted to address the issues/concerns with staff to which they didn't seem to be listening. As LPN #49 was transporting a resident to the red zone, she/he tore a hole in the plastic barrier and Resident #20 asked him about it and was told that he would fix the hole. The resident left the unit for an hour and returned to see staff sitting in the nurses' station and LPN #49 had his mask off while talking to the other staff. Resident #20 noted that the hole had not been fixed and s/he became infuriated. Resident #20 started recording on his/her cell phone the hole in the plastic and the staff sitting in the nurses' station not wearing a mask. Resident #20 reported that an argument occurred between them and both had cussed at each other. LPN #49 proceeded to come out of the nurses' station towards the resident to grab the resident's phone from them. Resident #20 then alleged that LPN #49 started to punch his/her hand so the resident would let go of the phone. Resident #20 then reported that s/he started punching LPN #49. Reportedly, LPN #49 backed off and stated he was going to call the police, but then started back towards the resident. At this point, the resident grabbed a pair of scissors and told LPN #49 s/he would stab him if he attacked him/her again. Resident #20 reported that s/he went to the lobby and called the police. The statement provided by LPN #49, dated 1/9/22, denied that he had argued and cussed at the resident. LPN #49 did admit that he had tried to grab the phone from Resident #20. A statement from agency Registered Nurse (RN) #68 confirmed that Resident #20 had been upset regarding the way staff were going from the red zone to the green zone during the shift. She reported that, as the resident continued to get angry, calling names, taking pictures, and recording us. RN #68 called LPN #49 to assist because the resident was getting out of control. A statement from agency Geriatric Nursing Assistant (GNA) #69, dated 1/9/22, revealed that she had words with Resident #20 regarding the red zone and green zone and that the resident had been upset. Reportedly, she stated that when LPN #49 tore the hole in the plastic and Resident #20 asked him about it, LPN #49 responded to resident, you act like I did it on purpose. On 12/28/22, a review of LPN #49, RN #68, and GNA #66 employee and education files had been reviewed and found that all 3 staff had not had behavioral health training and they worked for the same staffing agency. Review of the Resident Census and Condition of Residents report, provided on 1/9/23, revealed that 57 residents of the 117 residents in the facility had documented psychiatric diagnosis, excluding dementias and depression. An interview on 1/11/23 at 12:35 PM with the Administrator and Corporate Executive Director #29 to review the concerns revealed the facility relied on the staffing agency to send them staff who were able to provide care and services for the residents at the facility. However, they reported that, once a contract was signed with a staffing agency, there was no continuing contact regarding the education the staffing agency needed to provide to the staff that they sent to the facility. On 1/13/23 at 8:43 AM, this concern was reviewed with the Administrator, Director of Nursing, Regional Clinical Director #7, and Regional Director of Clinical Services #22.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 16218 Based on medical record review and interview, it was determined that the facility failed to have an effective system in place to identify and investigate potential narcotic diversion as evidenced by failure to identify and investigate multiple instances of staff removal of narcotics without documentation of the need for or administration to the resident; and faiure to identify drug control sheets that failed to account for the removal of all of the delivered doses. This was found to be evident for 3 (Resident #12, #11, and #51) out of 3 residents reviewed for narcotics. The findings include: 1a) On 12/21/22, review of Resident #12's medical record revealed the resident had resided at the facility for more than one year and whose diagnoses included but were not limited to chronic pain. The resident's pain is frequently treated with the use of oxycodone, a narcotic pain medication. Oxycodone is a narcotic pain medication. Narcotic pain medications are potent and effective at managing moderate to severe pain but have significant side effects and the potential for abuse. As a result, it is a standard of nursing practice to administer narcotic medication only from sources that can be both accounted for and reconciled. This practice discourages the diversion of abusable medication and ensures that narcotic medication is tracked according to federally mandated standards. On 12/21/22 at approximately 2:20 PM, the Unit Nurse Manager #2 reported that the control drug sheets were kept on a resident's paper chart. Review of Resident #12's paper chart with the Unit Nurse Manager revealed several controlled drug sheets, surveyor requested copies of the sheets to account for October thru present. On 12/22/22 review of the Medication Administration Records and the controlled drug sheets provided failed to reveal documentation for doses documented as administered after 11/7 at 10:10 AM and prior to 11/28/22 at 8:21 PM. The DON was informed on 12/22/22 at 12:50 that the controlled drug sheets for these doses were not included in the copies provided on 12/21/22. The controlled drug sheet for these doses were provided later in the survey. Review of the Chain of Custody for Controlled Substances policy and procedure, (NS 1197-01 with an approval date of 10/3/22) revealed; II. General: c. Keep orders with multiple count sheets together in the binder on the cart, i. Do not separate sheets, ii. Doses must be accounted for at all times. On 12/22/22 further review of the medical record revealed an order in effect in October 2022 for Oxycodone 5 mg give 1 capsule every 6 hours as needed for moderate to severe pain. Review of the controlled drug sheet for oxycodone 5 mg, dated 10/28/22, revealed 24 doses were delivered and that by 11/7/22 all 24 doses were removed from the supply. Review of the Medication Administration Record (MAR) revealed documentation of 19 of these doses being administered to the resident. On 12/22/22 at 12:50 PM the DON was informed of this concern and surveyor reviewed the five specific dates when the narcotic was documented as removed, but no documentation was found on the MAR regarding the administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/27/22 at 10:56 AM when asked about doses removed but not documented as administered, the DON reported: they [staff] are not signing on the narc [controlled drug sheet] sheet or not signing on the MAR. When asked if there is any documentation in the medical record to indicate the resident needed or requested the doses, the DON responded that many were agency nurses that have not returned and that she was unable to provide additional documentation. The DON went on to report that the staff is suppose to be signing on the control drug sheet and the MAR and that they have started education of staff. On 12/27/22 additional drug control sheets for the as needed oxycodone 5 mg for Resident #12 were provided for review. Multiple examples were found of oxycodone being removed from the supply without corresponding documentation on the MAR to indicate the medication was administered to the resident, or documentation that it was required or requested by the resident. These examples included: The drug control sheet dated 9/20/22 had 5 doses removed that were not documented on the MAR. The drug control sheet dated 10/12/22 had 4 doses removed that were not documented on the MAR. The drug control sheet dated 11/4/22 had 2 doses removed that were not documented on the MAR. The drug control sheet dated 11/16/22 had 2 doses removed that were not documented on the MAR. The drug control sheet dated 11/28/22 had 6 doses removed that were not documented on the MAR. On 12/27/22 at 11:45 AM surveyor reveiwed the concern with the DON and the Administrator that additional doses of the oxycodone being removed from the supply without documentation of being administered to the resident was being identified. 12/27/22 reviewed with the Administrator and the DON the concern that the same issue was identifed during the survey November 2021 survey. 1b) On 12/21/22 review of Resident #11's medical record revealed that the resident has resided at the facility for more than a year and whose diagnosies includes but is not limited to chronic pain. The resident has order for regularly scheduled and prn (as needed) narcotic pain medication. The current prn order, which has been in effect for several months is for oxycodone 10 mg 1 tablet every 6 hours as needed for moderate pain. On 12/22/22 review of the drug control sheets for the prn 10 mg oxycodone and the corresponding MARs for November and December 2022 revealed multiple examples of the narcotic being removed from the supply without corresponding documentation on the MAR to indicate the medication was needed, was actually administered to the resident, or if admininstered was effective. These examples include: The drug control sheet dated 10/21/22 revealed 13 doses were removed between 11/1 and 11/5, 4 of these doses were not documented on the MAR. The drug control sheet dated 10/30/22 had 7 doses removed that were not documented on the MAR. The drug control sheet dated 11/16/22 had 7 doses removed that were not documented on the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The drug control sheet dated 11/23/22 had 8 doses removed that were not documented on the MAR. The drug control sheet for doses from 12/7/22 - 12/17/22 were not provided for review. Review of the MAR revealed 21 doses were administered during this time period but no control drug sheets were provided. The drug control sheet dated 12/17/22 had 2 doses removed that were not documented on the MAR. On 12/22/22 at 12:50 PM surveyor reveiwed the above examples of the oxycodone being removed without documentation on the MAR, and the need for the control sheet for the doses from 12/7 -12/17/22 with the Director of Nursing. 1c) On 12/28/22 review of Resident #51's medical record revealed an order in effect in September 2022 for oxycodone 5 mg give 1 tablet every 6 hours as needed for pain. Review of the corresponding drug control sheet revealed 30 doses were received on 8/19/22. Doses were documented as removed on the following dates : 9/14 at 9:30 (unable to determine AM or PM) 9/15 at 11:30 AM 9/15 at 10:00 PM 9/20 at 12:00 (unable to determine AM or PM but there was a dose documented as removed and administered on 9/20 at 4:00 AM) 9/20 at 4:05 PM 9/22 at 10:30 (no AM or PM designated) Review of the MAR failed to reveal documentation regarding these 6 doses of oxycodone. Further review of the medical record failed to reveal documentation to indicate the resident required or requested these doses of pain medication. On 12/28/22 at 3:30 PM, surveyor reviewed the concern with the DON that 6 doses of oxycondone was removed from Resident #51's supply but was not documented on the MAR. Further review of Chain of Custody for Controlled Substances policy and procedure, revealed the following statement: Failure to document controlled substances on the MAR is a medication error and must be investigated; and III. Administration of Controlled Substances: e. Nurse will sign both the MAR and the Drug Count sheet when administering a controlled substance to a resident. No documentation was provided during the survey to indicate the facility had identified the current issue of staff removing narcotics without documenting their administration on the MAR prior to surveyor report of the concern. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The concern regarding the failure to ensure narcotics removed from the supply were documented as administered on the MAR was reviewed with the DON and the Administrator on 1/13/23 at 4:00 PM. 2) On 12/22/22 further review of Resident #11's drug control sheet for the prn 10 mg Oxycodone, dated 11/16/22, revealed one tablet of the Oxycodone remained. The area to document the disposition of the unused narcotic was noted to be blank. On 12/22/22 at 12:50 PM, surveyor reviewed the concern with the DON regarding the 1 unaccounted for narcotic on the 11/16/22 drug control sheet for Resident #11. On 12/27/22 at 10:00 AM, the DON reported, regarding the 11/16/22 drug control sheet with one pill remaining, that the nurse did document the administration on the MAR and provided a written statement from the nurse. When asked why this was not picked up during the narcotic count, the DON indicated the nurse removed the empty card and subtracted it from the total and removed the sheet from the book, so it was not included in the count. 2b) On 12/27/22, further review of Resident #12's medical record revealed an order for Oxycontin 10 mg give one tablet every 12 hours. This order was in effect in August and September 2022. Further review of the drug control sheets provided for Resident #12 revealed a controlled drug sheet for Oxycontin 10 mg that indicated a supply of 30 was received on 8/24/22. This sheet indicated that on 9/9 there was one remaining 10 mg tablet. On 12/27/22 at 11:00 AM, this information was brought to the DON's attention. The facility initiated an investigation on 12/27/22 and determined the dose was administered to the resident as evidenced by documentation of the adminisntration on the MAR of the second dose due on 9/9/22 and interview with the resident who denied any issues with not receiving scheduled pain medication. No documentation was provided during the survey to indicate the facility had identified either of these examples of incomplete drug control sheet documentation prior to surveyor alerting the facility to the concern. The concern regarding the failure to have an effective system in place to identify and investigate potential narcotic diversion was addressed with the DON and the Administrator on 1/13/23 at 4:00 PM.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 31982 Based on observation, interview, and record review, it was determined the facility staff failed to ensure that each resident's drug regimen was free from unnecessary drugs by administering as needed pain medication without adequate indication for use. This was evident for 1 (Resident#91) of 3 residents observed during medication administration review and 2 (12 and 11, 51) out of 3 resident's reviewed for narcotic use. The findings include: 1) An observation was conducted, on 1/13/23 at 8:36 AM, of agency LPN (Licensed Practical Nurse) #46 as she prepared and administered morning medications to Resident #91 who then requested medication for pain and nausea. He/she initially indicated a pain level of 7. Pain level scale ranges from 0-no pain to 10-worse pain possible. Nurse #46 returned to the medication cart checked the eMAR (electronic Medication Administration Record) and removed 1 tablet of Oxycodone (a narcotic pain medication) 5 mg and 1 tablet of Zofran (an anti-nausea medication) 4 mg. When asked how she knew that it was okay to give the Oxycodone, nurse #46 stated I checked to see when it was last given, if it's too soon, it would pop up to let me know and would not let me give it. Upon recheck, Resident #91 indicated his/her pain level was an 8. Nurse#46 proceeded to administer the medications to Resident #91. Resident #91's physician orders and eMAR were reviewed on 1/13/23 at approximately 9:30 AM. The physician orders revealed an order written 6/11/22 for Tylenol Extra Strength tablet 500 mg give 2 tablet by mouth every 8 hours as needed for pain, and an order written 1/12/23 for Oxycodone HCl Oral Tablet 5 mg give 1 tablet by mouth every 6 hours as needed for breakthrough pain. The physician orders failed to include parameters or clear indication of how staff were to determine which of the two medications they should administer if the resident complained of pain. Review of the eMAR revealed that Resident #91 received the Oxycodone 26 times between 1/1/23 and 1/13/23 for pain levels documented as 0, 2, 4, 5, 6, 7, 8, 9 and 10. The Extra Strength Tylenol was not signed off as administered during the same time period. There was no clear indication how staff determined that they should administer Oxycodone rather than Tylenol. The Director of Nursing was made aware of these findings on 1/13/23 at 1:20 PM. 16218 2) On 12/21/22, review of Resident #12's medical record revealed that the resident had resided at the facility for more than one year and whose diagnoses included but were not limited to chronic pain. The resident's pain was frequently treated with the use of oxycodone, a narcotic pain medication. Oxycodone is a narcotic pain medication. Narcotic pain medications are potent and effective at managing moderate to severe pain but have significant side effects and the potential for abuse. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/22/22, further review of the medical record revealed an order in effect in October 2022 for Oxycodone 5 mg: give 1 capsule every 6 hours as needed for moderate to severe pain. Review of the Medication Administration Record (MAR) for the as needed pain medication revealed areas to document the pain level at the time of the administration, and if the dose was effective or ineffective. Review of the controlled drug sheet for oxycodone 5 mg, dated 10/28/22, revealed that 24 doses were delivered and that by 11/7/22, all 24 doses were removed from the supply. Review of the Medication Administration Record (MAR) revealed documentation of 19 of these doses being administered to the resident. On 12/22/22 at 12:50 PM, the DON was informed of this concern and surveyor reviewed the five specific dates when the narcotic was documented as removed, but no documentation was found on the MAR regarding the administration. Review of the Chain of Custody for Controlled Substances policy and procedure, (NS 1197-01 with an approval date of 10/3/22) revealed III. Administration of Controlled Substances: c. Nurse will verify the need for the controlled substance using the pain scale assessment, i. Use of non-pharmacologic interventions are used, where appropriate.; e. Nurse will sign both the MAR and the Drug Count sheet when administering a controlled substance to a resident. On 12/27/22 at 10:56 AM, when asked about doses removed, but not documented as administered, the DON reported: they [staff] are not signing on the narc [controlled drug sheet] sheet or not signing on the MAR. When asked if there was any documentation in the medical record to indicate that the resident needed or requested the doses, the DON responded that many were agency nurses that had not returned and that she was unable to provide additional documentation. The DON went on to report that the staff was supposed to be signing on the control drug sheet and the MAR and that they have started education of staff. On 12/27/22, additional drug control sheets for the as needed oxycodone 5 mg for Resident #12 were provided for review. Multiple examples were found of the oxycodone being removed from the supply without corresponding documentation on the MAR to indicate the resident's pain level at the time the medication was removed from the supply, the actual time it was administered or destroyed, and if the medication was effective or not. These examples included: The drug control sheet, dated 9/20/22, had 5 doses removed that were not documented on the MAR. The drug control sheet, dated 10/12/22, had 4 doses removed that were not documented on the MAR. The drug control sheet, dated 11/4/22, had 2 doses removed that were not documented on the MAR. The drug control sheet, dated 11/16/22, had 2 doses removed that were not documented on the MAR. The drug control sheet, dated 11/28/22, had 6 doses removed that were not documented on the MAR. On 12/27/22 at 11:45 AM, surveyor reveiwed the concern with the DON and the Administrator that additional doses of the oxycodone being removed from the supply without documentation on the MAR, were identified. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b) On 12/21/22, review of Resident #11's medical record revealed the resident had resided at the facility for more than a year and whose diagnoses included but was not limited to chronic pain. The resident had order for regularly scheduled and prn (as needed) narcotic pain medication. The current prn order, which has been in effect for several months is for oxycodone 10 mg 1 tablet every 6 hours as needed for moderate pain. On 12/22/22 review of the drug control sheets for the prn 10 mg oxycodone and the corresponding MARs for November and December 2022 revealed multiple examples of the narcotic being removed from the supply without corresponding documentation on the MAR. These examples include: The drug control sheet, dated 10/21/22, revealed 13 doses were removed between 11/1 and 11/5, 4 of these doses were not documented on the MAR. The drug control sheet, dated 10/30/22, had 7 doses removed that were not documented on the MAR. The drug control sheet, dated 11/16/22, had 7 doses removed that were not documented on the MAR. The drug control sheet, dated 11/23/22, had 8 doses removed that were not documented on the MAR. The drug control sheet for doses, from 12/7/22 - 12/17/22, were not provided for review. Review of the MAR revealed 21 doses were administered during this time period, but no control drug sheets were provided. The drug control sheet, dated 12/17/22, had 2 doses removed that were not documented on the MAR. On 12/22/22 at 12:50 PM, surveyor reveiwed the above examples of the oxycodone being removed without documentation on the MAR, and the need for the control sheet for the doses from 12/7 -12/17/22 with the Director of Nursing. Further review of the medical record failed to reveal documentation of the need for, or the effectiveness of, more than 25 doses of narcotic removed from the resident's supply over a two month period. 2c) On 12/28/22, review of Resident #51's medical record revealed an order in effect in August and September 2022 for oxycodone 5 mg give 1 tablet every 6 hours as needed for pain. Review of the corresponding drug control sheet revealed 30 doses were received on 8/19/22. Doses were documented as removed on the following dates : 9/14/22 at 9:30 (unable to determine AM or PM) 9/15/22 at 11:30 AM 9/15/22 at 10:00 PM 9/20/22 at 12:00 (unable to determine AM or PM) but there was a dose documented as removed and administered on 9/20/22 at 4:00 AM) (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/20/22 at 4:05 PM 9/22/22 at 10:30 (no AM or PM designated) Review of the MAR failed to reveal documentation regarding these 6 doses of oxycodone. Further review of the medical record failed to reveal documentation to indicate that the resident required or requested these doses of pain medication. According to the drug control sheet, a dose was removed at noon on 9/20/22 and then again at 4:05pm. If administered to the resident at 4:05 PM as indicated by the drug control sheet, would constitute a medication error in regard to administering the medication 2 hours before it was allowed to be given per the every 6 hours order. On 12/28/22 at 3:30 PM, surveyor reviewed the concern with the DON that 6 doses of oxycondone was removed from Resident #51's supply but was not documented on the MAR On 1/13/23 at 4:00 PM surveyor reviewed the concern with the DON and Administrator regarding the failure to ensure documentation of the need for prn (as needed) narcotic pain medication and it's effectiveness.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 16218 Based on observation, interview and medical record review, it was determined the facility failed to ensure a medication error rate of less than 5%. This was found to be evident based on errors identified during medication observations of three residents (Resident #89, #90 and #91) out of three residents observed. The observations were made on each of the two nursing units and involved three different agency nurses. The findings include: 1) On 1/12/23 at 10:33am, surveyor met Nurse #57 at a medication cart on the 2nd floor. Nurse #57 reported he was late and was preparing medications for Resident #89. The nurse was observed removing one tablet of Atenolol from a punch card and placing it in a medication cup. Atenolol is a beta blocker and is given for the treatment of high blood pressure. The nurse reported he would put this medication aside until after the resident's blood pressure was obtained. The nurse was then asked by another staff person to assist with a resident being prepared for transport in another room. The nurse locked the cup with the Atenolol in the medication cart. A few minutes later the nurse returned to the medication cart. The nurse was then observed to obtain the following medication from the medication cart: 2 Senna Plus 1 tizanidine 4 mg 1 cymbalta 30 mg 1 Eliquis 5 mg 1 Ferrous Sulfate 325 mg 1 Allergy tablet 10 mg and placed these 6 medications in a medicine cup. The nurse also obtained a container of Deep Sea Nasal Spray. At this point, the nurse reported that he was looking for potassium chloride, did not see it in the medication cart and that he would have to check the Pyxis. A Pyxis is an automated medication dispensing machine. This machine contains a variety of commonly used medications. It allows staff (who have access to it) to obtain ordered medications for a resident whose regular supply is not available on the medication cart. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse #57 then found Nurse #40 and informed her of the need for the potassium chloride. Nurse #57 and Nurse #40 then proceeded to a medication room where Nurse #40 accessed the Pyxis and obtained two Potassium chloride 20 meq tablets. After returning to the medication cart, surveyor observed Nurse #57 proceeded to pull another Atenolol and place it in the cup with the first Atenolol tablet. When surveyor stated: so it is two Atenolol, the nurse reported the first tablet was amlodipine. Amlodipine is calcium channel blocker also prescribed for the treatment of high blood pressure, but works differently than atenolol. Surveyor looked again at the two white pills in the medication cup and asked that the nurse pull the Amlodipine card from the cart to compare it to what was in the cup. After surveyor and nurse #57 observed that the Amlodipine in the punch card was larger than the two pills in the cup and with a different number on it, Nurse #57 disposed of the second Atenolol and proceeded to place one dose of the Amlodipine in the cup with the remaining tablet of Atenolol. The nurse then proceeded to attempt to obtain the resident's blood pressure using an automated machine. The cuff was put on the resident's lower arm, rather than above the elbow as is the normal standard of practice when obtaining a blood pressure. At 11:00 AM, the machine produced a very high reading, at this point the nurse stated the pressure needed to be checked again, manually. He then reported this was his first day at this facility. The nurse then went to the nurse's station to obtain a manual blood pressure cuff. Prior to obtaining the blood pressure from the resident with the manual cuff, Nurse #18 (another agency nurse) presented with a larger blood pressure cuff. Nurse #57 was then able to apply the properly sized cuff above the resident's elbow and obtain the resident's blood pressure using the automated blood pressure machine. After obtaining the blood pressure, the resident adminstered the medications previously prepared. The resident then reported that s/he take a Tylenol and another pain pill, nurse reported he would check. Nurse #57 is now at the medication cart, states he is looking for the diflocan gel and that it may be on the treatment cart. Diclofenac gel is used to releive joint pain. Nurse #57 then proceeded to look for the Diclofenac gel, asking other nurses on the unit for assistance. At 11:16 Nurse #57 reported he can call the pharmacy in regard to the Diclofenac gel. At this point, nurse #18 presents with Diclofenac gel 1%, which the nurse #57 proceeds to apply to each of the resident's shoulders. The resident is now asking for tramadol (a narcotic pain reliever) and tylenol. Nurse #57 signs out a dose of the Tramadol from the resident's supply but is unable to find the Tylenol dose required in the medication cart, he informs the resident he has her Tramadol but is looking for the Tylenol. At 11:23 AM, Nurse #57 informs Nurse #40 of the need for 325 mg Tylenol. Nurse #40 is able to provide the 325 mg Tylenol from a different medication cart. At 11:28 AM, the resident receives the Tylenol and the tramadol. Nurse #57 confirmed this is his first day in the facility. Reports he was shown around by Nurse #18. Denied having signed off on any orientation documentation prior to start of shift. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/23, review of the medical record revealed that the Diclofenac gel was ordered to be given three times a day and was scheduled to be given at 8:00 AM, 12:00 noon, and 5:00 PM. It was observed to be administered after 11:15 AM. The nurse documented that it was administered at 8:00 AM and again at 12:00 noon. This constitutes an error of a missed 8:00 AM dose, since it was not administered until after 11:15 AM which would fall in the time frame for the dose due at 12:00 Noon. These observations on 1/12/23 represents 2 errors out of 13 opportunities for error. Review of the facility's Medication Administration policy (NS-1197-05) revealed Medications will be administered within the time frame of one hour before up to one hour after time ordered. Further review of the Medication Administration Record (MAR) revealed that 9 of the 10 other regularly scheduled medications that were observed to administered on 1/12/23 after 10:30 AM were scheduled to be given at either 8:00 or 9:00 AM. 2) On 1/13/23 at approximately 8:10 AM, surveyor began a medication administration observation with Nurse #58 who was preparing medications for Resident #90. The nurse was observed putting the following medications into a medicine cup: Tylenol 325 two tabs Aspirin 81 mg 1 tab Eliquis 5 mg 1 tab Ferrous sulfate 325 one tab Finastride 5 mg 1 tab Fluxotine 10 mg 1 tab Furosemide (Lasix) 20 mg Metoprolol 25 mg er Pantoprazole 40 mg 1 tab Tamusoline 1 capsule Vit B 12 500 mcg 1 tab Wixela Inhal 500-50 - one inhalation When Nurse #58 documented the medications, surveyor requested that the nurse read off the medications as she documented. No discrepencies were identified, all meds read off were included in above list. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After the nurse documented the medications, surveyor asked if the resident's blood pressure had been obtained today? Nurse #58 responded: not yet. After the observation was completed, review of the medical record revealed there were orders to hold the Metoprolol if the resident's SBP (systolic blood pressure - the top number) was less than 110 or if the pulse was less than 60. Further review of the medical record revealed the most recent blood pressure was recorded on 1/12/23 at 9:05 PM. Further review of the medical record revealed an order for Cholecalciferol 1000 units. This medication was not observed during the medication pass, however, the nurse did document that it was administered. These observations on 1/13/23 represent 2 errors out of 13 opportunities for error. On 1/13/23 at 9:18 AM, surveyor reviewed with the Director of Nursing the observations from 1/12/23 medication pass with Nurse #57, including the the medication errors involving the atenolol/amliodipine. Surveyor also reviewed 1/13/23 observations made during the 1/13/23 medication observation with Nurse #58, including the error of omission of the Cholecalciferol and failure to obtain the blood pressure prior to administration of a medication with ordered parameters. The total medication error rate for the three medication pass observations was over 5%. This was reviewed with the Administrator and Director of Nursing at the time of survey exit on 1/13/23 at 4:00 PM. 31982 3) On 1/13/23 at 8:36 AM, the surveyor observed the morning medication administration on the first floor. Agency LPN (Licensed Practical Nurse) #46 entered Resident #91's room and attempted to assess the resident's blood pressure. The resident refused. Nurse #46 educated the resident that the rationale for his/her blood pressure was as per the parameters to administer his/her Amlodipine (blood pressure medication). The resident again refused and also refused the Amlodipine dose. Staff #46 then sanitized her hands prior to preparing the medications for Resident #91. She removed tablets and capsules from cardboard punch cards as well as from plastic jars placing them into a medication cup and then handed the bottle or punch card to the surveyor to observe. As she placed the second medication tablet into the medication cup, she stated Multivitamin and handed the bottle to the surveyor. The bottle was labeled Vitamin D, 25 mcg (micrograms). The surveyor asked nurse #46 what she had just put into the medication cup. She stated Multivitamin then looked at the medication bottle and stated oh, that's Vitamin D. She then took a plastic spoon from the medication cart, removed a tablet from the cup and threw it into the trash. She proceeded to take a bottle labeled Multivitamin with Minerals from the medication cart and placed 1 tablet into the medication cup. During the observation, nurse #46 was observed by the surveyor to have placed the following medications into the medication cup: 1 tablet Morphine sulfate, 15 mg (milligrams), a narcotic pain medication, 1 tablet of Clopidrogel 75 mg, a blood thinner, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 tablet of Furosemide (Lasix) 20 mg, a fluid pill, 1 capsule of Gabapentin 300 mg, for nerve pain, 1 capsule of Prazosin 2 mg, for blood pressure 1 tablet of Senna-Plus 8.6-50 mg., a stool softener, and 1 tablet of Cyanocobalamin (Vitamin B12) 1000 mcg, for supplement, along with the tablet of Multivitamin with Minerals. The surveyor asked nurse #46 to confirm the number of tablets/capsules in the medication cup. She verified that there were 8. When nurse #46 took the medications to Resident #91, the resident refused the Senna-Plus, removed it from the medication cup and stated, I don't want that orange poop pill. He/She then requested PRN (as needed) Oxycodone 5 mg for pain and Zofran 4 mg for nausea which the nurse administered at 9:06 AM and 9:12 AM respectively. A review of Resident #91's physician orders, at approximately 10:15 AM, revealed the 8 scheduled medications nurse #46 removed from the cart and administered to Resident #91. The review also revealed, however, that the resident was scheduled to receive 5 additional medications at that time as well: 1 tablet of Pantroprazole Sodium 40 mg for GERD (acid reflux), 1 capsule of Duloxetine HCl delayed release 30 mg for depression, 1 tablet of Fenofibrate 145 mg for high cholesterol, 1 tablet of Cholecalciferol 1000 Units for supplement, and 1 puff of a Combivent Respimat Aerosol inhaler for COPD (Chronic Obstructive Pulmonary Disease). Nurse #46 was not observed providing these 5 medications to Resident #91 with his/her other morning medications. Review of the eMAR (electronic Medication Administration Record) on 1/13/23 at approximately 12:20 PM revealed that nurse #46 signed off all of the morning medications as well as the 2 PRN medications as administered, and documented that the Amlodipine and Senna were refused. An observation of the medication cart, on 1/13/23 at 12:45pm, revealed that the 5 medications that were signed off, but not administered, were available in the medication cart. The Director of Nursing was made aware of these findings on 1/13/23 at 1:20 PM. These observations of Resident 91's medication pass represent 6 errors out of 16 opportunities for error.

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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. 31982 Based on surveyor observation and interview with staff, it was determined that the facility failed to ensure that all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles. This was evident by the facility's failure store medications in their original labeled packaging in 1 of 3 medication carts observed during medication administration observation. The findings include: An observation was made on 1/13/23 at 12:45 PM of a medication cart on first floor. The top drawer of the cart contained multiple medications in 6 plastic medication cups. Five of the cups were labeled with a last name written in black marker. The 1st cup contained 3 medications, the 2nd cup contained 13-14 medications, the 3rd cup contained 9 medications, the 4th cup contained 10 medications and the 5th cup contained 1 large pink tablet, 2 white tablets and 1/2 of a small white tablet. The 6th cup contained 5 medications and was not labeled. All of the medications were out of their original packaging and loose in the cups. Nurse #46 who was present during this observation, was asked to identify the 6th cup of medication. She initially stated that they were for 221 then 117. She was asked why the medications were out of their labeled packaging and indicated that when she took the medications to the residents, the residents indicated that they did not want them and that she wanted to reattempt to administer them so she placed them in the medication cart. Nurse #46 was asked if it was her normal practice to pre-pour medications and store them in the cart. She stated, I didn't pre-pour them but could not account for why multiple medications for 6 different residents were not administered to the residents at the time they were opened or properly discarded. When asked if she could identify the medications in the 6 medication cups, she stated, I can pull the cards and identify them if needed. The Director of Nursing was made aware of these findings on 1/13/23 at 1:20 PM.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 16218 Based on review of medical records, policies and other pertinent documentation and interviews, it was determined that the facility failed to ensure that corporate policies and procedures were being implemented. This was found to be evident for facility policies related to the use of agency staff and contracts with dialysis centers but has the potential to affect all residents. The findings include: 1) Failure to ensure that the facility's corporate policy was implemented regarding orientation of agency staff. On 1/5/23, it was revealed that there was a Staffing Agency Policy, an Agency Nurse Orientation Packet and an Orientation Checklist for both nurses and GNAs. On 1/6/23, the DON and the Nurse Educator #104 confirmed they started using the Orientation Checklist last week. The DON later reported the checklist was in effect since February of 2022. Review of the Instructions for Use Agency Nurse Orientation Booklet revealed: Orientation to the unit is required for each agency (vendor) nurse. This orientation packet is a step-by-step guide to be completed prior to resident care. This is not busy-work; this is a mandatory requirement. The executive leadership will provide oversight and direction for compliance . During the survey multiple deficiencies were identified that involved agency staff. Cross reference to F 726 2) Failure to ensure that corporate policy and procedures were followed regarding assigning and monitoring electronic health record temporary accounts for use by agency staff. During the survey, it was determined that the facility was unable to accurately identify the name of agency staff that corresponded to documentation with signatures by Temp ##s. On 1/6/22 at 10:00 AM, Regional Director of Clinical Services #22 reported : we have a corporate policy on how to manage the log ins. Regional Director of Clinical Services #22 presented with Nurse PCC Temp Account Process document which outlined a process for assigning and tracking temp account numbers. He indicated this process had been emailed to the facility in 2022 and confirmed the facility was not following the process. On 1/11/23 at 2:45 PM, the Nursing Home Administrator reported she was made aware of corporate policies via calls and that emails are sent notifying us of the policies. She indicated she would have to check to see when she was made aware of the policies regarding the orientation of agency staff as well as the corporate policy regarding the electronic health record temporary account process. On 1/12/23 at 4:22 PM, the NHA reported that she could not remember when she was notified verbally about these policies, but that she had an email dated 2/18/22 that included both of them. Cross reference to F 842 and F 689 (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) Failed to ensure there were contracts with dialysis centers providing service to residents as indicated in the facility's policy. On 12/20/22 at 9:44 AM, a review of the facility's policy, Hemodialysis Care and Monitoring NS 1167-01 revealed that the facility was to have a written agreement between them and the dialysis centers that they utilized. On 12/20/22 at 10:04 PM, the NHA reported that she was unaware of a contract between the facility and the dialysis center but would check with the corporate office. On 12/27/22 at 2:00 PM, the Regional Clinical Director #7 reported that there was no contract between the facility and the dialysis centers as stated in the facility's policy. Cross reference to F 698

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 40927 Based on interview and record review, it was determined that facility staff failed to follow state licensing laws as evidenced by a Licensed Practical Nurse (LPN) who was in a Clinical Manager position which included duties that were outside the scope of practice. This was evident for 1 (Staff #2) of 1 unit nurse managers. The findings include: The Annotated Code of Maryland Health Occupations Article, Title 8 is the Nurse Practice Act and contains the laws and regulations in which licensed nurses must follow and defines their scope of practice. Licensed nurses are governed by the Maryland Board of Nursing. On 12/20/22 at 7:40 AM, an interview was conducted with Unit Manager #2. During the interview, she was asked to define her role as a Unit Manager in which she reported that she provided oversight for all the care provided to the residents by reviewing the care each day and determining the needs of the residents and delegating tasks to Geriatric Nursing Assistants (GNAs) and nurses to ensure the care was provided. UM #2 reported that her job included initiating and updating care plans for residents, reviewing newly admitted residents to ensure everything had been completed for the new admission. When asked if she had supervisory duties, she reported that she supervised the GNA, LPNs, and RNs to ensure that they were completing their assignments and that the residents were receiving quality care and services. RNs are registered nurses. The educational and training requirements are more extensive for RNs than for LPNs. A review of Unit Manager #2's employee file on 12/20/22 at 1:09 PM revealed she was a Licensed Practical Nurse and was offered the position of Clinical Manager LPN. A review of the Position Description revealed that the position 1) provides leadership to nursing staff to assure that care standards were met and the highest degree of quality resident care -including the performance of nursing personnel was provided at all times, 2) the position functioned as a team member, team leader, and supervisor to ensure that work was accomplished and quality of care delivered, 3) monitored job performance to assure staff were performing their work assignments within acceptable nursing standards, 4) participation in the development of written preliminary and comprehensive assessments of the nursing needs of each resident was required, 5) ensure that all staff involved in providing care to the resident were utilizing the care plan to provide daily care to the resident, and 6) monitor job performance to assure that staff were performing their work assignments within acceptable nursing standards. The qualifications for this position were noted as with an RN or LPN could hold the position. According to the Nurse Practice Act Title 10 Maryland Department of Health Subtitle 27: Board of Nursing Chapter 10: Standards of Practice for Licensed Practical Nurses: (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.01 Definitions - 6. a. Comprehensive nursing assessment means an assessment performed by a registered nurse which is the foundation for the analysis of the assessment data to determine the nursing diagnosis, expected client outcomes and the client's plan of care. .04 Prohibited Acts. The LPN may not: C. Perform the comprehensive nursing assessment, D. serve as a case manager for client care, E. Supervise the nursing practice of RNs and other LPNs, F. Analyze client data in order to determine client outcome identification and formulation of a nursing diagnosis. On 12/20/22 at 1:27 PM, an interview with the Director of Nursing (DON) confirmed that care plans were initiated by herself and/or Unit Manager #2. On 12/30/22 at approximately 6:40 AM, LPN #52, who was on the schedule as the community nurse for the 12/29/22 night shift, reported that, as the community nurse, she was a resource for the agency staff, and denied that she was the supervisor. When asked who the supervisor for the night shift was, Nurse #52 reported UM #2 was on call. On 1/5/23 at 9:35 AM, an interview with the Nursing Home Administrator, DON, Regional Director of Clinical Services #22, and Corporate Executive Director #29 revealed they had not been aware that an LPN cannot supervise other LPNs, however, were aware that an LPN cannot supervise or evaluate the care provided by a RN.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. 31982 Based on record review and interview with facility staff, it was determined that the facility staff failed to ensure that psychiatric consults were completed as ordered by the physician and reflected the problem for which it was ordered. This was evident for 2 (Resident #34 & #35) of 11 residents reviewed for resident to resident abuse. The findings include: Review of a facility reported incident #MD00181132 on 12/29/22 at 1:26 PM revealed that Resident #34 and Resident #35 were involved in a resident to resident incident on 3/23/22. Review of Resident #35's medical record on 1/9/23 at 9:30 AM revealed a Change in Condition progress note, dated 3/23/22 5:46 PM, which indicated that the primary care physician was notified and recommended: a room change and psychiatric (psych) evaluation. The record revealed a physician order, written 3/24/22 at 16:11 (4:11 PM), for Psych eval, test and treat - Resident to resident altercation. A progress note entry by the Director of Nursing (DON) on 3/23/22 included Psych eval placed. Will continue to monitor. A plan of care was initiated on 3/24/22 for the problem: resident to resident altercation. The interventions included but were not limited to (name of provider) psych eval. Further review of the record failed to reveal a psychiatric consult report. The DON was made aware and indicated she would look into it. In an interview on 1/11/23 at 8:15 AM, the Medical Records coordinator #8 reported that she contacted the contracted psych services provider to inquire about the missing consult report. She indicated they reported to her that Resident #35 was scheduled to be seen on 4/8/22 but was taken off of the schedule. She said that the psych service provider explained to her that the consult was not cancelled by the facility, but by them. She was not sure why it was cancelled. She was asked if there was any follow up by the facility with the psych service provider to determine why the consult was cancelled, to reschedule, or to notify Resident #35's attending physician? She indicated that she would check with the DON. Resident #34's medical record was also reviewed on 1/9/23 at 9:30 AM. A nursing progress note late entry by the DON, with an effective date of 3/23/22 15:12 (3:12 PM) included that the resident was in a resident to resident altercation, the residents were separated, the resident was not injured, the Nurse Practitioner (NP) and Resident's responsible party were notified and Psych eval. A physicians order was written 3/24/22 at 16:17 (4:17 PM) for psych eval, indicating Resident to Resident. A plan of care was initiated on 3/24/22 for resident to resident altercation. The interventions included but were not limited to Behavioral health consults as needed. A psychiatry note indicating date of service 4/4/22 indicated: chief complaint/nature of presenting problem: Follow up mood, cognition, psychotropics, behavior. The Assessment/Plan/Orders/Recommendations section of the note indicated that the resident was seen for follow up visit. That the resident's behavior has improved and stabilized, he/she is more cooperative, and moods are better controlled. He/She is able to demonstrate an ability for improved patience with a reduction in impulsive agitation noted. The progress note did not include that the evaluation was requested after a resident to resident altercation on 3/23/22 nor did it include the resident's recent behaviors. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 1/11/23 at 10:31 AM, the DON was made aware of these concerns and explained the facility's process for psych consult referrals was to print the physicians order and the resident's face sheet, scan and email them to the contracted psych services provider. The printed copies are placed in a binder at the front desk. Once done, the consult notes are placed in the resident's medical record for the provider to review. She was asked if the facility had any follow up procedures to ensure that the consults are completed after the referral was made. She indicated she was not sure and that she did not recall if Resident #35's referral was discussed in morning meeting. The facility staff failed to provide any further information regarding follow up actions when Resident #35's Psychiatric consult was not provided as ordered. The DON added that, toward end of last year (2022), the Psych NP - made us aware that we need to attach to the referral email if the referral is requested in reference to a self-reported incident. She stated prior to that we were just doing a routine follow up. Now they are aware if the referral is made related to an incident involving the resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 16218 Based on review of medical records and policies, and interviews, it was determined the facility 1) failed to ensure that agency staff were assigned unique identifiable signatures to be used in the electronic health record. This failure resulted in an inablity to identify which staff documented assessments and progress notes. This was evident for 1 (Resident #51) out of 26 residents reviewed related to complaints, but was found to potentially affect all the residents in the facility, and 2) the facility failed to keep complete and accurate medical records as evidenced by failing to void a resident's MOLST form when an updated MOLST form was completed. This was evident for 1 (#58) of 26 residents reviewed as part of complaint investigations The findings include: 1. On [DATE], review of Resident #51's medical record revealed the resident was originally admitted to the facility in [DATE]. On [DATE], review of the medical record revealed a Change in Condition Evaluation with an effective date of [DATE] at 5:15 PM. This note was signed Temp 10 Temp/Agency Nurse on [DATE]. The note was in regard to Resident #51having been found on the floor. The note revealed that the primary care clinician was notified at 9:00 PM and that the family was notified on [DATE] at 2:00 AM via a call back voice mail. An interview was conducted with the Director of Nursing (DON) on [DATE] at 3:33 PM. Surveyor reviewed the documentation regarding the fall with the DON. Surveyor reviewed that the Change in Condition note was documented by an agency nurse with temp credentials, and requested clarification. The DON indicated she would have to investigate to determine if the agency nurse that completed the assessment was an RN. On [DATE] at approximately 10:10 AM, Surveyor requested the [DATE] assignement sheets and the name of Temp Nurse #10 who wrote the assessment evaluation related to Resident #51's fall. In response to the request for Temp Nurse #10's name, on [DATE] the facility provided nurse #109's name and phone number. During an interview with Nurse #109 on [DATE] at 2:15 PM, the nurse reported she was a LPN, and the nurse could not recall the resident. On [DATE] at 2:39 PM, Nurse #109 called surveyor back and reported that after looking at her time sheets she remembered the incident. She reported that it was her second day working at the facility, that she had worked from 6:25 AM until 12:30 AM. She reported she did not assess the resident. She reiterated several times that she did not go back to see the resident and that she did not assess the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Further review of the medical record revealed revealed documentation of neuro checks were initiated on [DATE] at 7:30 PM. The neuro checks were documented as completed every 15 minutes x 4, then every hour x 4; then every 4 hours x 1 by Temp 10/ Temp Agency nurse. The last assessment completed by Temp 10 was documented on [DATE] at 4:15 AM. This was almost 4 hours after Nurse #109 had left the facility after having worked a double shift. On [DATE] at 3:15 PM, surveyor reviewed with the Administrator, corporate administrator #1, and Regional Director of Clinical Services #22 that, upon interview, Nurse #109 denied having completed the assessment of Resident #51. Also, that the nurse stated she left for the day at 12:30 AM but the Change in Condition note was locked after 2:00 AM and referenced a call to the family at 2:00 AM. Surveyor again requested identification of the nurse that completed the assessment after the fall. On [DATE] at 12:44 PM, the DON, the corporate administrator #1, and the Regional Director of Clinical Services #22 met with the survey team to discuss Resident #51's fall. The DON reported that, on ,d+[DATE], a Change in Condition was initated at 1715 (5:15 PM) by Nurse #109. She reported the nurse was working a double shift, 16 hours, that day. During the [DATE] at 12:44 PM discussion with the DON and corporate it was revealed there are only a finite number of Temp numbers for agency nurses to use when at the facility. Surveyor then requested clarification if each temp nurse has a unique number or if multiple nurses are able to document on the same number. Regional Director of Clinical Services #22 indicated they would get clarification. On [DATE] at 2:15 PM, staff development Nurse #113 was interviewed in regard to the process of assigning electronic medical record access numbers to the agency nurses. She reported either she or the staffing coordinator #77 would assign the number. She confirmed there was a limited number of temporary log in numbers and that they recycle the log ins. She indicated there was a spreadsheet with the name and date of the log in used, and reported that agency staff that are here more often use the same number over again. She stated only one person can use the number at a time. Surveyor requested the documentation of who was documenting under Temp nurse 10 on [DATE]. On [DATE] at 4:00 PM, the DON reported that she was attempting to reach RN #114 to determine if she was Temp 10 on [DATE]. The DON confirmed that she previously reported it was LPN #109 since that was the nurse assigned to the resident's new room on the evening shift of [DATE]. Surveyor reviewed the concern that interview with the staff developer earlier today revealed there was a grid that would identify which nurse was documenting under which temp number but that the Temp 10 on [DATE] has not been identified. Reviewed concern that there is no process in place to identify who documented on which resident. This spreadsheet was not provided for review until [DATE] at 11:40 AM. The spreadsheet only provided information on 12 out of the 20 temporary nursing numbers. There was only one date documented for each of the numbers that did have names associated with them, but 5 of the dates had at least two nurse names associated with the number. The dates ranged from [DATE] to [DATE]. The date for #10 was [DATE] and identified two different LPNs, neither of which were working on Resident 51's unit on the evening of [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] an interview was conducted at 9:36 AM with the DON, Nursing Home Administrator, Regional Director of Clinical Services #22 and Corporate Executive Director #29. The issue regarding the temporary agency staff documentation was brought up and the corporate executive director #29 reported: this issue came up yesterday and that they had no explanation at this point. On [DATE] at 10:26 AM the Regional Director of Clinical Services #22 reported they have identified the nurse that assessed the resident after the fall as Nurse #112 and that she was identified through the call to the nurse practitioner. A phone interview was completed by the surveyor with the DON, the corporate nurse #22 and Nurse #112. Nurse #112 reported it was an evening shift, one of the GNAs found the resident, pretty sure it was the GNA assigned to the resident but did not recall the GNA's name. Nurse #112 reported that she had assessed the resident, took the vitals, and called the telehealth. She indicated she did some documentation, thought it was a Change in Condition but could not remember. She was unable to recall what the resident told her after the fall. Review of the assignment sheet for Resident #51's unit for the [DATE] evening shift revealed the Unit Nurse Manager #2 was listed as the supervisor, the resident census was 64 and there were three nurses (LPN #109, RN # 114, and LPN #112) and four GNAs working on the unit. Nurse #112 was not assigned to either the resident's original room, or the room s/he was moved to on [DATE]. All three nurses working on the unit were agency staff. Review of the Weekly Time Card Report for [DATE] - [DATE] for Nurse #112 revealed she worked from 6:00 AM until 11:00 PM on [DATE]. No documentation was found to indicate Nurse #112 worked on [DATE]. The Change of Condition and the Neuro Check assessments were both documented on after Nurse #112 had left the facility. On [DATE] during an interveiw at 10:56 AM with the DON and Regional Director of Clinical Services #22 it was determined that more than one staff person could document using the same temp agency number during the course of the day. On [DATE] at 10:00 AM Regional Director of Clinical Services #22 reported : we have a corporate policy on how to manage the log ins. Regional Director of Clinical Services #22 presented with Nurse PCC Temp Account Process document which outlined a process for assigning and tracking temp account numbers. He indicated this process had been emailed to the facility in 2022 and confirmed the facility was not following the process. On [DATE] at 10:35 AM an interview was conducted with the staff developer Nurse #113 and the scheduler #77. During this interview it was determined that previously all of the temporary numbers shared the same password. They indicated that moving forward they would be following the corporate policy regarding the temp account process and indicated they had initiated the monitoring process as outlined. On [DATE] at 11:41 AM the staff developer Nurse #113 confirmed that prior to this survey she was not aware of the Nurse PCC Temp Account Process policy. On [DATE] at 4:22 PM the Administrator reported that she could not remember when she was notified verbally about the policy for the temp account process, but that she has an email dated [DATE] for this policy. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The concern regarding the failure to have an effective system in place to track which staff person was using which temp number in the electronic medical record was reviewed at time of survey exit on [DATE] at 4:00 PM. 37276 2) Maryland MOLST (Maryland Orders for Life Sustaining Treatment) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. The medical orders are based on a patient's wishes about medical treatments. If an updated MOLST form is completed, all older forms shall be voided in accordance with the MOLST's instructions: Voiding the Form: To void this medical order form, the physician, NP, or PA shall draw a diagonal line through the sheet, write VOID in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician, NP, or PA to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record. On [DATE] at 11:00 AM, during an interview, when asked how he/she would know a resident's MOLST status, Staff #40, LPN (licensed practical nurse), stated he/she would look in the resident's paper medical record, and the resident's MOLST should be found in the front of the medical record. On [DATE] at 11:05 AM, a review of Resident #58's paper medical record revealed there were 2 active MOLSTs in Resident #58's medical record. In the front of the resident's paper medical record was one MOLST form that was signed and dated [DATE] that documented Resident #58 elected Attempt CPR (cardiopulmonary resuscitation) indicating if cardiac and/or pulmonary arrest occurs, attempt CPR and, in the back of the medical record there was a MOLST form that was signed and dated [DATE] that documented Resident #58 elected No CPR, Option B, Palliative and supportive Care. The practitioner failed to void the previous MOLST form when a new MOLST had been created. On [DATE] at 3:40 PM, the above concern regarding the failure to ensure the old MOLST was voided when an updated MOLST was completed was discussed with the Director of Nurses. On [DATE] at 4:00 PM, copies of Resident #58's 2 active MOLSTs were provided to the surveyor. At that time, Staff #8, medical records, indicated that the MOLST in the back of the chart must have been from the hospital and that he/she removed the older MOLST from the chart for the physician to void.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 16218 Based on a review of medical records and other pertinent documentation, interviews and observations, it was determined that the facility failed to ensure that the Quality Assurance Performance Improvement (QAPI) Committee developed an effective plan of correction to address identified deficiencies as evidenced by the identification of multiple deficiencies in same areas as the November 2021 survey. This was found to be evident for 6 out of 36 deficiencies cited in 2021 that were repeated in the 2023 survey. The findings include: Review of the 2567 (statement of deficiencies) for a complaint survey with an exit of 11/3/21 revealed the facility was cited for multiple issues that were identified during the current survey. These repeat concerns include: 1) failure to ensure narcotics removed from the resident's supply were documented as administered to the resident; 2) failure to identify potential diversion as evidenced by drug control sheets indicating remaining doses ; 3) failure to ensure that staff assessed a resident's pain level when administering as needed pain medications ; 4) failure to ensure staff only documented care that was actually provided to the resident. Cross reference to F 755; F 757 , F 658; F842 Additionally, deficient practice was identified regarding abuse, abuse reporting and abuse investigations again this survey. Cross reference to F 600, F 609, and F 610. Review of the Plan of Correction revealed plans to monitor/audit these issues for at least 3 months and submit the results to the Quality Assurance Performance Improvement Committee for 3 months and then the committee was to determine the need for further audits and/or action plans. On 1/12/23 at approximately 4:30 PM, the Nursing Home Administrator (NHA) confirmed that she was in charge of the Quality Assurance program at the facility for the past year. On 1/13/23 at 12:30 PM, interview with NHA revealed that she had not received official training in Quality Assurance. She reported that corporate assisted the facility team and had a lot of involvement in developing the plan of correction for the survey which concluded in November 2021. She reported that, in February 2022, QA notes indicated the initial audits were completed and ongoing. The Administrator could not provide information, when asked, if the audits were finding issues. She was unable to provide information as to when the audits were stopped. On 1/13/23 at 4:00 PM, surveyor reviewed the concern regarding the failure to ensure effective QA program to develop effective plan of correction as eveidenced by multiple deficiencies in same areas as the November 2021 survey with the NHA, the DON and the Corporate Executive Director #29.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 16218 Based on observation and interview, it was determined that the facility failed to ensure that nursing staff followed basic infection control practices during medication administration (one out of three nurses observed during medication administration); failed to ensure that care was provided to prevent the development of wound and urinary tract infections; failed to ensure that the infection preventionist was monitoring infections that were acquired within the facility; and failed to implement transmission-based contact precautions for a resident according to current infection control standard. This was found to be evident for three (Resident #90, #51, and #86) out of 26 residents reviewed in relation to complaints. The findings include: 1) On 1/13/23 at approximately 8:10 AM, surveyor began a medication administration observation with Nurse #58, who was preparing medications for Resident #90. The nurse was observed putting the following medications into a medicine cup: Tylenol 325 two tabs Aspirin 81 mg 1 tab The nurse was noted to be was pouring these medications from a bottle directly into her bare hand prior to placing into the medicine cup. Surveyor then asked the nurse if this was her normal practice, the nurse indicated the medicine was supposed to go directly into the cup. For the remainder of the medication pass observation, the nurse poured/popped the pills directly into the medicine cup. This observation was reviewed with the Director of Nursing on 1/13/23 at 9:18 AM. 2) On 12/28/22, review of Resident #51's medical record revealed that the resident was originally admitted in July 2022. Further review of the medical record revealed the resident developed urinary retention in September and a foley catheter was ordered. A foley catheter is a flexible tube placed through the urethra into the bladder to drain urine. The tube remains in the bladder (indwelling) to provide continuous drainage of urine which collects in a bag. A resident with an indwelling foley catheter is not considered continent (able to control urinary voiding) or incontinent (not able to control urinary voiding) since the catheter allows for continuous removal of urine. Review of the resident's care plan failed to reveal a plan to address the use of the foley catheter. Review of the GNA documentation for bladder incontinence revealed that staff could document: 0 for continent; 1 for incontinent; 2 for did not void; 3 Continence Not Rated due to Indwelling Catheter; or 4 Continence Not Rated due to Condom Catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the GNA documentation from September 15 until October 7 2022, revealed that GNA staff documented the presence of the indwelling catheter on 15 out of the 69 shifts. The majority of the other shifts the GNA staff documented that the resident was incontinent of urine. Additionally, on 7 shifts there was no documentation and on 3 shifts, staff documented NA (not applicable). No documentation was found to indicate the GNAs were completing foley catheter care. Review of the Treatment Administration Record (TAR) revealed the nurses began documenting, on 9/15/22, foley cath care every shift with soap and water. On 1/12/23 at 4:12 PM, interview with the DON revealed that both nurses and GNAs were responsible for completing foley catheter care. Surveyor then reviewed the concern that GNA staff were documenting the resident was incontinent rather than the presence of a catheter on multiple occassions, thus not acknowleging the presence of the catheter. Further review of the medical record revealed that a sacral pressure ulcer was identified on 9/27/22, with orders for daily dressing changes. The sacrum is located at the base of the spine. The resident was also seen by the wound specialist on 10/3/22 with an update to the dressing change orders which was implemented. Further review of the TAR revealed staff continued to document daily dressing changes to the sacral wound. On 10/8/22, the resident was sent to the emergency room due to being found unresponsive with a rapid respirator rate. Review of the hospital medical record's initial physical exam revealed the resident had a large stage 4 sacral decubitus ulcer. Further review of the medical record failed to reveal documentation to indicate the resident had left the facility from the time the foley catheter was initiated until the discharge to the hospital in October 2022. Further review of the hospital medical record revealed the resident was admitted for septic shock, required intubation, fluids and antibiotics. Wound, blood and urine cultures were found to be growing Proteus. Proteus is found abundantly in soil and water, and although it is part of the normal human intestinal flora, it has been known to cause serious infections in humans. The most common clinical manifestations of Proteus infection are urinary tract infections (UTIs). Urinary catheter use and improper catheter cleaning or care are risk factors related to UTIs. Further review of the medical record failed to reveal documentation to indicate the resident left the facility between the initiation of the foley catheter, the development of the pressure ulcer and the eventual admission to the hospital for sepsis. On 1/5/23 during an interview at 9:36 AM, the Administrator reported that the Assistant Director of Nursing (Nurse #107) had submitted his resignation. On 1/9/23 at 3:00 PM, the DON reported the Assistant Director of Nursing (ADON) had been the infection preventionist (IP). The corporate nurse #22 then stated that the DON was now responsible for that role, but that corporate would be consultative. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215336	A. Building B. Wing	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hagerstown Healthcare Center	750 Dual Highway Hagerstown, MD 21740

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/10/23 at 1:21 PM, the DON reported that she had the IP certification, but confirmed that she had not previously held that position. When asked if the facility tracks infections found in residents who are discharged to the hospital, the DON responded: We talk about it, we discuss it, if it is something we see is going on. Surveyor asked if they had identified why Resident #51 was admitted to the hospital in October. Surveyor also requested the non-COVID line listing for October. Review of the documentation provided on 1/11/23 at 9:10 AM revealed Resident #51's name, but in relation to an antiviral medication the resident was receiving related to chemotherapy. This line listing failed to identify the fact that the resident had been diagnosised with positive Proteus cultures in the blood, wound and urine when sent to the hospital in October. On 1/12/23 at 4:12 PM, the DON reported that she had seen the hospital records and acknowledged the resident had sepsis. 45139 2. On 1/4/23 at 11:29 AM, review of Resident # 86's medical records revealed that the resident had been admitted to the facility for rehabilitation following above knee amputations (AKA) on both legs. Further review of the medical records revealed the following order, dated 11/9/22, Contact isolation related to MRSA of bilateral AKA wounds. Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Methicillin-resistant staphylococcus aureus (MRSA) is a type of staph that is resistant to the antibiotics that are often used to cure staph infections. Contact Precautions means, whenever possible, patients with MRSA will have a single room or will share a room only with some else who also has MRSA. Healthcare providers and visitors will put on gloves and wear a gown over their clothing while taking care of patients with MRSA. When leaving the room, healthcare providers and visitors remove their gown and gloves and clean their hands. On 1/12/23, review of a progress notes titled skin/wound, dated 1/10/23, revealed that the resident had positive cultures which grew MRSA and Proteus. Further review of orders revealed the order for contact isolation related to MRSA of bilateral AKA wounds remained active. On 1/12/23 at 3:47 PM, the surveyor interviewed the Director of Nursing (DON). During the interview, the DON reported that, if a resident had an order for contact precautions, a sign would be placed on the door providing instructions on what should be worn prior to going into the room and how to discard the items prior to leaving the room. In addition, she reported that, to her knowledge, no one in the facility was on contact precautions, but she would investigate it. Multiple observations were made during the survey that failed to reveal any sign or notice, on the door of Resident # 86's room that alerted the staff or visitors that additional protections were required before entering the room. These observations were made on the following dates: 1/4/23 at 12:50 PM, 1/6/23 at 2:10, 1/9/23 at 7:47 AM and 1/12/23 at 9:45AM. In addition, these observations failed to reveal that any gowns were available outside the door or immediately upon entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple interviews revealed that facility staff relied on the door signs to alert them that additional protective clothing was required before entering the room. During an interview on 1/12/23 at 12:50 PM, Housekeeping Staff # 41 reported that, if she had seen any sign on a resident's door, she would have gone and asked the nurse for information about what she was supposed to wear, and in the absence of any sign she would enter room in normal work attire. On 1/13/23 at 10:57 AM, surveyor interviewed Speech Therapist # 47. The therapist reported that she had treated Resident # 86 shortly after admission and had discharged her/him a couple of weeks ago. She reported that she had not been aware of any special transition-based precautions for the resident. She reported that, if she had seen a sign on the resident's door, she would have talked to the nurse before entering the resident room. On 1/12/23 at 9:45, during a brief interview with Nurse# 39, she reported that no one on the first floor was on contact precautions. She continued that, when someone is on contact precautions, a sign is placed on the resident's door. On 1/9/23 at 7:47 AM, during a brief interview with Nurse #34,the nurse reported that her duties that day included administering medications on the floor where Resident # 86 resided. Nurse #34 reported that, to her knowledge, no one on the floor that she had worked on that day had transmission-based precautions. On 1/13/23 at 11:00 AM, the surveyor conducted an interview with the DON. The DON reported that Resident #86 was still considered to be infected with MRSA. She reported that a sign that alerted staff and visitors of contact precautions was just placed on the door, and the required protective clothing, including gloves and gowns, was placed in front of the room. The DON also reported that the facility would investigate placing the resident in a private room