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	04/08/2019

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31982 Based on surveyor observation, it was determined that the facility staff failed to protect and value residents' private space by failing to knock and request permission before entering a resident's room. This was evident, but not limited to, 3 (#69, #122, #174) residents observed on both units of the facility. Based on observation, record review and staff interview, it was determined that the facility failed to treat residents with dignity and respect by labeling and identifying resident's as feeders, hovering and standing over a resident, or staff conversing with other staff while assisting residents to eat, and failing to serve all residents at the same table at the same time. This was identified for 3 (#13, #41, #109) residents observed during dining observations. The findings include. 1.) On 3/21/19 at approximately 1:20 PM, the surveyor was conducting an initial interview with Resident #122 in his/her bedroom. The room contained 3 resident beds. At 1:30 PM, Staff #29 entered the room and tended to the resident lying in the first bed, then left the room. At 1:34 PM, Staff #30 entered the room, crossed the room to the 3rd bed, removed a bag of trash from the bedside trash can, then exited the room. Neither staff member knocked nor requested permission from either of the 2 residents who were present in the room, prior to entering their room. 2.) During an interview with Resident #69 on 3/21/19 at 10:47 AM, in his/her room with the door shut, staff opened door to place something on the bed. There was no knock and staff did not acknowledge that they had interrupted the resident. 3.) On 03/21/19 02:26 PM, while conducting an interview with resident #174 in the resident's room with the door closed on 3/21/19 at 2:26 PM, an unidentified staff member came into the room to retrieve a garment for the resident's roommate. The unidentified staff person failed to knock on the door. A few minutes later, the unit manager (staff #50) knocked on the door then immediately opened the door without waiting for a response. 41248 (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) On 3/20/19 at 12:06 PM, the surveyor observed 2 residents sitting at a table in the dining room. Resident # 13 was awake and was noted to be looking at the covered plate sitting on the table. The other resident at the table was fed by a GNA (geriatric nursing assistant) staff #34. In an interview with Staff #34, on 3/20/19 at 12:07 PM, the surveyor asked if resident #13 needed assistance with eating and the Staff #34 stated, Yes but could only feed each resident, one at a time, due to the positioning of the residents reclining chair. Staff #34 started feeding resident #13 at 12:12 PM 5.) On 03/21/19 at 9:08 AM, the surveyor observed Resident #41 in his/her room eating breakfast. Utensils were noted to be within reach. The resident was using his/her fingers to scoop food from the plates/bowls. It was also observed that food was put in their cup on the table and there was food on the clothing, in the chair and on the floor. A record review, conducted on 03/21/19 09:49 AM, revealed a care plan for Resident #41 to be in group for all meals and staff assistance with feeding as needed. Staff was to monitor/document/report for signs and symptoms of swallowing difficulty, which included, pocketing food, choking, coughing and drooling. 15701 6.) During a dining observation on 3/21/19 at 12:45 PM, it was noted that dignity and respect for resident #109 was not maintained as Staff #3 was observed standing and hovering over resident #109 while feeding the resident. While staff were passing lunch time meal trays on 3/27/19, staff #37 and #5 were over heard identifying residents as feeders. Staff #37 opened a meal cart stating these are the feeders closed the cart and walked away. Staff #5 removed a meal tray from the cart and indicated the tray was for a feeder. On 3/27/19 a GNA (staff #5) was sitting on the resident's bed facing away from resident conversing with another GNA in the room. Staff #5 would only turn toward the resident for each spoonful of food.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 37276 Based on resident and staff interview and medical record review, it was determined that the facility failed to include the resident/representative in the development and implementation of the resident's person-centered care plan by failing to have a care plan meeting to review the updated care plan. This was evident for 2 (#42, #199) of 6 residents reviewed for care plans and 1 (#70) of 1 reviewed for hospice care. The findings include: 31982 1) Resident #70's medical record was reviewed on 3/25/19 at 1:29 PM. The record revealed that a 15 page care plan had been developed to address resident #70's needs. On 3/26/19 at 1:51 PM, the surveyor conducted an interview with Staff #31 regarding the coordination of Resident #70's Hospice care. Staff #31 indicated that the facility had not held a care plan meeting since the resident's admission in the middle of February 2019. He/She added we're aware that the care plans haven't been done. When asked why they have not been done, Staff #31 replied it's just something we are trying to get done. He/She was unsure of how far behind the facility's care plans were and added that an audit was done and the issue was referred to the QAPI (Quality Assurance and Performance Improvement) committee in February. 15701 2) Resident #42's medical record was reviewed on 3/26/19. Review of resident #42's paper and electronic medical record did not reveal documentation that a care plan conference was held around the time that the (MDS) minimum data set assessment (with an assessment reference date (ARD) of 2/4/19) was completed. The last documented care plan meeting was dated 8/21/18. During an interview with the resident on 3/26/2019 at 1:15 PM, the resident acknowledged not being invited to a care plan meeting in a long time. 37585 3) Resident #199's medical record was reviewed on 4/3/2019 at 2:54 PM. During the review, although a care planning meeting sign-in sheet was found from November, 2018, no evidence could be found that a care planning meeting had been held within the previous 5 months. Without a care plan meeting, Resident #109 or his/her representative would not be able to participate in a setting where all the members of the resident's interdisciplinary team were available to answer questions and assist the resident or representative in deciding what care would be best for the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41248 Based on observation, resident interview, and record review, the facility failed to assess a resident's preference for activities and promote their participation in those activities by not assisting Resident #86 out of bed to attend their preferred scheduled events. This was evident for 1 (#86) of 2 residents reviewed for activities. The findings include: During an observation made at the time of entrance into the facility on [DATE], resident #86 was lying in bed yelling out. Resident #86 was noted in bed over multiple observations. A resident interview conducted on 3/20/19 at 11:33 AM revealed that resident #86 wanted to get up for activities, but stated that the staff doesn't assist her/him to get out of her/ his bed. Activities that interested the resident included bingo and gardening. In an interview conducted on 3/28/19 at 9:00 AM with staff members #16 and #17, both staff members stated that they can't always get resident #86 up due to working short staffed, but they felt that resident #86 seemed to not holler out as much when out of bed for activities. During an interview conducted on 3/28/19 at 9:20 AM with the Activities Director, she stated that they read to resident #86 2-3 times a week in the room. When surveyor asked what the resident's preferences were for activities, she stated coffee hour. An interview on 3/28/19 at 11:45 AM, with staff members #18 and #15 revealed that they do not get resident #86 out of bed due to low staffing. A record review on 3/28/19 at 9:30 AM revealed a care plan that was not patient-centered towards activities of the residents choosing, such as bingo and/or gardening.

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Deficiency Text Not Available

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 40927 Based on review of the medical record and interview with the resident and staff, it was determined that the facility failed to notify the physician when a resident's prescribed medication was not available to administer, failed to notify physician and family of a resident falling and failed to provide prior notification to a resident of a room change. This was evident for 3 (#178, #69, #112) of 40 residents reviewed during the investigative stage of the survey. The findings include: 1.) During an interview with Resident #69 on 3/21/19 at 10:47 AM, it was reported that the resident was moved from his/her room while at an appointment, and when he/she returned he/she all their belongings were in a different room. An interview with the Social Worker Staff # 31 on 3/22/19 at 2:54 PM, revealed that the facility process was that resident are verbally informed and given written notices of a room change prior to the change. A medical record review on 3/22/19 at 3:01 PM, revealed no documentation that this resident was informed of the room change verbally or in writing. A subsequent interview with Social Worker Staff #31 on 3/22/19 at 4:32 PM, confirmed these findings. On 3/22/19 at 4:58 PM, the Administrator and Director of Nursing were informed of these findings. 41248 2.) A record review conducted between 3/28/19 and 4/1/19 revealed that Resident #112 had an unwitnessed fall on 3/18/19. Documentation between 3/18/19 and 3/21/19 did not reveal that nursing staff had provided post fall assessment on the resident, which would have included neurological checks (obtaining vital signs; every 15 minutes x 4, then every hour x 4, then every 4 hours x 4, then daily x 4, monitoring pupil size, monitoring strength or range of motion in the extremities, and monitoring level of consciousness), skin assessment, or had notified the resident representative or the physician following the fall. On 3/21/19, resident #112's attending physician (staff #112) was informed that the resident's right arm looked bruised and was swollen. An x-ray of the right arm was ordered. The x-ray was obtained at 8:30 PM. The results were phoned to the physician at 11:30 PM. The x-ray revealed a distal humorous fracture with anterior displacement. A record review revealed that Nurse #10 wrote a notification note (an instrument to document a change of condition) on 3/22/19 at 2:30 AM and back dated for 3/18/19. In the note, the nurse stated she notified the physician on 3/18/19 at 5:40 PM and the resident's representative at 6 PM of the fall. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A further record review revealed that a neurological check was completed on 3/24/19 at 2:22 PM a pain assessment, which indicated pain was noted, and a fall risk observation checklist was completed on 3/22/19 and back dated for 3/18/19. An interview was conducted with resident #112's attending physician (staff #6) on 3/28/19 at 3:02 PM. The attending physician indicated that s/he was not notified of the fall until 3/21/19 after s/he started investigating the swelling and bruising of the right arm. S/he stated that is when staff members came forward to tell her about the fall on 3/18/19. On 3/28/19 at 1:30 PM, a phone interview of the resident's representative revealed that he/she was notified of the resident's fracture on 3/21/19 at 11:39 PM and was not notified of the fall that had occurred on 3/18/19. The Director of Nursing was made aware of the findings on 3/29/19, prior to the exit interview. 37276 3.) On 4/2/19, a review of Resident #178's medical record was conducted. Review of Resident #178's December 2018 MAR (medication administration record) revealed a 12/22/19 order for Temazepam (Restoril) (hypnotic) by mouth every day at bedtime that was documented as unavailable & not given on 10 days (12/22/18, 12/23/18, 12/24/18, 12/25/18, 12/26/18, 12/27/18, 12/28/18, 12/29/18, 12/30/18, 12/31/18). Review of Resident #178's January 2019 MAR revealed an order for Temazepam by mouth every day at bed time was documented as unavailable and not given on 1/1/19. The order was discontinued on 1/2/19. On 12/23/18 at 10:48 PM, in a progress note, the nurse documented that the physician was made aware that the resident had not received the Temazepam as the pharmacy had not yet delivered the medication. On 1/2/19 at 2:23 PM, in a progress note, the nurse documented that Temazepam was discontinued related to non-use. Continued review of Resident #178's medical record failed to reveal documentation that the pharmacy had been contacted to determine why the medication had not been delivered and there was no further documentation that the physician had been notified that Resident #178 was not receiving the Temazepam as prescribed. On 4/4/19 at 10:20 AM, the Director of Nurses (DON) was made aware of the above findings. On 4/4/19 at 4:13 PM, the DON confirmed the findings. The DON stated that he/she called the pharmacy and was told that the pharmacy had never received a prescription for Resident #178's Temazepam, therefore, the pharmacy did not deliver the medication.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37276 Based on review of Medicare beneficiaries who were discharged from skilled therapy and nursing services and interview with staff, it was determined that the facility staff failed to provide 2 (#277, #278)) of 3 Medicare beneficiaries reviewed with a written notice of Medicare Provider Non-Coverage. The findings include: The SNFABN (Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage) provides information to residents/beneficiaries that services may no longer be covered by Medicare and addresses the resident's liability for payment should they wish to continue receiving the skilled services. The NOMNC (Notice of Medicare Non-coverage) informs the beneficiary of his or her right to file appeal of the decision and right to an expedited review of Medicare non-coverage of services. On 3/22/19, a review of the SNF Beneficiary Protection Notification Review worksheet completed by the facility indicated that Resident #277 was discharged from skilled services on 10/28/18 with benefit days remaining. The worksheet indicated that a SNFABN form and NOMNC form had not been provided to the resident/representative with no explanation written on the worksheet. Also, on 3/22/19, a review of the SNF Beneficiary Protection Notification Review worksheet completed by the facility indicated that Resident #278 was discharged from skilled services on 9/24/18 with benefit days remaining. The worksheet indicated that a SNFABN form and NOMNC form had not been provided to the resident/representative with no explanation written on the worksheet. On 3/22/19 at 4:00 PM, during an interview, Staff #31 stated he/she was unable to find evidence that Resident #277 and Resident #278 had been issued the required SNFABN and NOMNC letter.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37276 Based on surveyor observation, it was determined the facility staff failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable and homelike environment. This was evident throughout the survey on 2 of 2 nursing units. The findings include: 1.) On 3/20/19 at 10:34 AM, observation of room108's shared bathroom revealed the toilet seat was dirty and there was a brown ring of dried debris around the base of the toilet. 2.) On 3/21/19 at 10:58 AM, observation of room [ROOM NUMBER] revealed that the door knob insert was missing on the outer closet door. In the room, there was a blue vinyl chair with a loose chair back. Observation of room [ROOM NUMBER]'s shared bathroom revealed there was an over the toilet commode seat that had rust on top of the frame, rust under the metal bar in front of seat frame and there was rust on the lower legs of the frame. The floor around the toilet was soiled brown. 31982 3.) The surveyor observed room [ROOM NUMBER] on 3/20/19 at 8:11 AM. A cardboard saltine cracker box was on the floor under the right side of the head of the first bed. Rice cereal and sunflower seed shells were scattered on the overbed table and the floor to the right of the bed. The edges of the overbed table were chipped with the edging pulling away and exposing the underlying particleboard. The surveyor observed the room again on 3/20/19 at 10:12 AM. The rice cereal and sunflower seed shells were gone but the saltine box remained under the head of the bed. Cross reference F 925. In the bathroom, the surveyor observed torn pieces of clear plastic bags tied around the safety grab bars on both sides of the toilet. A raised toilet seat with a tubular metal frame was over the toilet. Paint was peeled at the front and rear of the frame where it met the seat. The exposed metal was rust colored and rust colored powder was on the seat and the toilet bowl beneath. A towel was balled up in the sink. 4.) On 3/21/19 at 9:55 AM, the surveyor observed room [ROOM NUMBER]. The bathroom door and wall board on each side of bathroom doorway had deep scuffs into their surfaces. 5.) On 3/21/19 at 1:41 PM, the surveyor observed the bathroom in room [ROOM NUMBER]. The toilet seat had numerous dark brown spots, a ball of toilet paper with brown spots was on the floor to the left of the toilet. The toilet paper dispenser was empty. 6.) On 3/28/19 at 4:27 PM, an observation was made of Resident #46 sitting in his/her wheel chair in the dining room located on the main level of the facility. The lower frame of Resident #46's wheel chair was dirty with and there was caked on debris around the frame.

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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. 41248 Based on review of resident, facility records, and staff interviews, it was determined that the facility staff failed to thoroughly investigate alleged abuse and prevent further potential abuse by failing to address an alleged staff to resident altercation. This was evident for 1 (#179) of 1 residents reviewed for abuse. The findings include: On 4/01/19 at 1:47 PM, a record review of a facility reported incident, MD # 00134760, revealed that facility staff failed to thoroughly investigate allegations of verbal abuse between a staff member and Resident #179. The investigation and witness statements contained very little information on the incident. An interview with the Regional nurse and the Director of Nursing on 4/1/19 at 2:15 PM, failed to reveal insight on the investigation.

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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. 41248 Based on medical record review, it was determined that the facility failed to document the hospital transfer in the medical record for 1 (#76) of 1 residents. The findings include: On 3/27/19 at 10:22 AM, a review of the nursing notes revealed that Resident #76 was sent to the emergency room (ER) at 5p on 3/26/19. The concurrent review was not filled out and the nursing note failed to document that the transfer notice was given or that the family was notified of transfer.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37276 Based on medical record review and staff interview, it was determined that the facility: 1) failed to notify the resident/resident representative in writing of a transfer/discharge of a resident along with the reason for the transfer and, 2) failed to notify the Office of the State Long-Term Care Ombudsman of a transfer/discharge of a resident. This was evident for 4 (#102, #66, #4, and #76) of 7 residents reviewed for hospitalization and 1 (#120) of 5 residents reviewed for accidents. The findings include: 1) On 3/22/19, a review of Resident #102's medical record revealed on 2/22/19, in a progress note, the nurse documented that Resident #102 developed a fever and mild confusion, an order was given to send the resident to the hospital, the resident was sent to the hospital and admitted for Sepsis (potentially life-threatening complication of infection). There was no documentation found in the medical record that the resident or representative was notified in writing of the resident's transfer to the hospital. On 3/22/19 at 4:32 PM, during an interview, the Staff #31, stated that, when a resident was transferred from the facility to an acute care facility, the social worker did not notify the resident/representative in writing and did not notify the Ombudsman in writing of the resident's transfer to the hospital, and indicated that another department might provide written notifications. On 3/22/1 at 4:48 PM, during an interview with the Director of Nurses (DON) and Administrator, the DON stated that the social worker notified the Ombudsman when a resident was transferred to the hospital and could not confirm that a resident/representative was notified in writing of the reason for the transfer. The DON & Administrator were made aware of the surveyor's conversation with Staff #31 at that time. The facility staff was unable to provide evidence that resident #102/representative were notified in writing of the reason for the hospital transfer and failed to provide evidence the Ombudsman was notified when a resident was transferred from the facility. 2) On 4/2/19, a review of Resident #120's medical record revealed that, on 11/20/18 at 22:24, in a progress note, the nurse documented that Resident #120 was sent to the hospital emergency room following a fall resulting in a fracture. There was no documentation in the medical record that the resident/representative was notified in writing of the reason for the hospital transfer. 37585 3) Resident #66's medical record was reviewed on 3/22/19 at 9:57 AM. During the review, it was found that the resident was hospitalized in early January and early February, 2019. Both were identified as a facility-initiated transfer due to the resident's condition worsening beyond what could be managed at the facility. The medical record was reviewed for evidence that the resident or the resident's representative received written notice of transfer for either of these hospitalization s and none could be found. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff #31 was interviewed on 3/22/19 at 4:32 PM. During the interview, Staff #31 stated that s/he does not provide written notification to the resident, the resident's representative party, nor the ombudsman of a resident's transfer to the hospital. 40927 4) On 3/21/19 at 3:17 PM, during an initial review of Resident #4's medical record revealed a progress note that stated, Late Entry: Note Text: Resident was observed to have yellow emesis, on her shirt. Vitals were taken and temp was 101.0. CRNP was made aware. CRNP had nurse call family to see if they want the nurse to send the resident to the hospital. Family was called and they agreed to sending the resident to the hospital. Resident went to the hospital 911 approx. 1300. However, further review of the electronic medical record and paper medical revealed no documentation that written notice of transfer was sent to the resident's representative. An interview with the Social Worker, staff #31 on 3/22/19 at 4:54 PM, revealed that s/he had not been sending a written notification of transfer to the resident's representative or to the Office of the State Long Term Care Ombudsman. During an interview with the Administrator (NHA) and Director of Nursing (DON) on 3/22/19 at 4:58 PM, it was revealed that the facility had not been sending notification to the resident's representative upon transfer and the Social Worker was responsible for notification to the Office of the State Long Term Care Ombudsman. They were made aware of the findings. The Ombudsman confirmed on 3/25/19 at 11:51 PM, that the facility had not been sending notifications of transfers prior to January 2019. On 3/27/19 at 10:22 AM, a review of the nursing notes revealed that Resident #76 was sent to the hospital at 5p on 3/26/19. The documentation did not reveal information related to written notification of the transfer, nor was there information that the family was notified of the transfer to the hospital. 41248

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prepare residents for a safe transfer or discharge from the nursing home. 37585 Based on review of the medical record and interview with facility staff, it was determined that the facility failed to prepare residents for an orderly discharge or transfer from the facility. This was evident for 4 (#66, #126, #325, #4) of 7 residents reviewed for hospitalization and for 1 (#120) of 5 residents reviewed for accidents. The findings include: 1) Resident #66's medical record was reviewed on 3/22/19 at 9:57 AM. During the review, it was determined that the resident had been hospitalized at the beginning of January and the beginning of February, 2019. Review of the medical record failed to reveal evidence that facility staff provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer from the facility. 2) Resident #126's medical record was reviewed on 4/3/19 at 3:22 PM. During the review, it was revealed that Resident #126 was hospitalized prior to the beginning of the survey. Review of the medical record failed to reveal evidence that facility staff provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer from the facility. 3) Resident #325's medical record was reviewed on 3/27/19 at 12:30 PM. During the review, it was revealed that Resident #325 was hospitalized prior to the beginning of the survey. Review of the medical record failed to reveal evidence that facility staff provided sufficient preparation and orientation to the resident to ensure safe and orderly transfer from the facility. 40927 4) On 3/21/19 at 3:17 PM, during an initial review of Resident #4's medical record revealed a progress note that stated, Late Entry: Note Text: Resident was observed to have yellow emesis, on her shirt. Vitals were taken and temp was 101.0. CRNP was made aware. CRNP had nurse call family to see if they want the nurse to send the resident to the hospital. Family was called and they agreed to sending the resident to the hospital. Resident went to the hospital 911 approx. 1300. However, further review revealed there was no documentation that indicated the resident was prepared and oriented for a safe transfer to the hospital. An interview on 3/22/19 at 4:48 PM, with the Administrator and Director of Nursing (DON) revealed that they was unaware of the regulatory requirement of documented sufficient preparation and orientation for a resident prior to a facility-initiated transfer to an acute care facility. 37276 5) On 4/2/19, a review of Resident #120's medical record revealed on 11/20/18 at 22:24, in a progress note, the nurse documented that Resident #120 was sent to the hospital emergency room following a fall resulting in a fracture. the note failed to document any information related to sufficient preparation and orientation to the resident to ensure safe and orderly transfer from the facility.

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F 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 40927 Based on record review and staff interview, it was determined that the facility failed to provide residents/resident representatives with a written notice of the facility's bed hold policy upon transfer or therapeutic leave. This was evident for but not limited to 2 (#4, #76) of 7 residents reviewed for hospitalization . The findings include: 1.) A record review on 3/21/19 at 3:17 PM of Resident #4's progress notes revealed a note, dated 9/14/18, that documented the resident was transferred to an acute care hospital. However, further review of the electronic and paper medical record revealed no evidence that the bed hold policy was provided to the resident's representative at the time of transfer. During an interview with the Administrator (NHA) and Director of Nursing (DON) on 3/22/19 at 4:58 PM, it was revealed that the facility had not been providing written notice of the facility's bed hold policy to the residents and/or the resident's representative. 41248 2.) On 3/27/19 at 10:22 AM, a record review revealed that Resident #76 was transferred to the emergency room (ER). The facility staff failed to document that the bed hold policy was given in writing to the resident and/or resident representative.

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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** 37585 Based on interview with residents and review of the medical record, it was determined that the facility failed to ensure that newly admitted residents had physician orders for the resident's immediate care at the time of admission. This was evident for 1 (Resident #328) of 40 residents reviewed during the investigation phase of the survey. The findings include: Resident #328 was admitted on [DATE] with a hip replacement that had been performed two days prior on 4/2/2019 at a nearby hospital. Resident #328 had come to the facility to receive rehabilitation services related to the hip replacement. Resident #328 was interviewed on 4/5/2019 at 2:33 PM. During the interview, the resident stated that s/he had been newly admitted the prior day, having arrived at the facility at about 2:30 PM on 4/4/2019. The resident stated that, despite being in the bed closer to the door with the door wide open, (indicating that s/he was clearly visible to staff walking by), nobody came in to welcome him/her, provide any services, or perform any form of evaluation. Resident #328 stated that, after a few hours, s/he was upset enough that s/he was crying. S/he stated that, at that time, the Admissions Director came in and comforted him/her but again did not provide any services or perform any noticeable evaluation. Resident #328 stated that s/he remembered waking up at 8:30 PM on the same day still feeling disoriented and not having received any services including pain medication. Resident #328 stated that s/he was in pain and decided to call his/her family member to request him/her to call the facility to tell them that Resident #328 was there and wanted to speak to staff. Resident #328's family member was present for this interview and confirmed that s/he called the facility at about 8:30 PM and spoke to a nurse on the second floor but could not confirm the staff member. The family member stated that the nurse told him/her that the nurse didn't know Resident #328 was in the facility and would let the responsible nurse know. Resident #328 continued the interview by stating that nobody entered the room until 10:00 PM when the nurse whom the family member had called came into the room and apologized. Resident #328 recalled that the nurse said, None of your medications are ordered. I am getting your pain medication. However, Resident #328 asserted that s/he did not receive a dose of pain medication until a different nurse came in at 10:30 PM to give the medication. Resident #328 indicated that no staff member had oriented him/her to the room's call bell and that s/he didn't know s/he had one until the surveyor indicated the device, which was on the floor at the time of the interview. Resident #328 also expressed concern that a dietary aid told him/her on the morning of 4/5/19 that there was no breakfast tray for him/her. Finally, Resident #328 stated that s/he did not receive his/her regular medications on the day of admission, including medications the resident characterized as important psychological meds that are dangerous for me to miss. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #328's medical record was reviewed on 4/5/2019 at 2:24 PM. During the review, it was revealed that the resident received his/her first pain medication on 4/4/19 at 10:32 PM. The first nursing note in the medical record was written on 4/5/2019 at 2:54 AM. The resident was noted to not have received any other medication on 4/4/2019. Cross Reference F 658, F 684

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Deficiency Text Not Available

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 40927 Based on medical record review and staff interview, it was determined the facility staff failed to ensure that Minimum Data Set (MDS) assessments were accurately coded . This was evident for 1 (#69) of 5 residents reviewed for activities of daily living (ADLs), 2 (#59, #120) of 2 residents reviewed for activities, for 1 (#112) of 9 residents reviewed for nutrition, and 1 (#7) of 4 residents reviewed for urinary catheter care The findings include: The MDS is part of the Resident Assessment Instrument that was federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1.) During an interview with Resident #69 on 3/21/19 at 10:38 AM, it was reported that the resident needed assistance to take a shower because he/she becomes shaky and unsteady at times. The residents stated that staff were not providing that assistance. When asked why staff were not helping, he/she reported that staff #50 would tell him/her they were capable of taking a shower without assistance. It was observed at this time that the resident used a wheelchair for locomotion. On 3/27/19 at 2:14 PM, a review of the resident's medical record revealed a quarterly MDS for Resident #69 with an Assessment Reference Date (ARD) of 2/2/19 that documented under section G that the resident was independent for showers (which included getting in and out of the tub). This MDS assessment also documented in the same section that he/she required the assistance of 1 staff member for personal hygiene. Further review of the medical record revealed a care plan that documented Resident #69 had impaired mobility. There was documentation of falls with interventions to remind the resident to use a call light for assistance. Resident also has a care plan initiated on 1/11/19, Resident is resistive to care AEB (as evidenced by) periodic refusals to participate in planned skilled rehab therapy sessions in order to improve balance and fall recovery skills in order to decrease risk for falls. Also, the review revealed a care plan initiated on 11/15/18 for ADL self-care performance deficit related to pain, physical limitations, and COPD (a respiratory condition that causes decreased energy). This care plan had an intervention to provide encouragement to use the call bell when assistance was needed and requires limited assist of 1 for ADLs. ADLs refer to basic skills performed each day of a person's life and include personal hygiene, eating, bathing, mobility, and similar skills. An interview with a nurse Staff #33 revealed that Resident #69 required at least supervision with a shower. This was noted to be different from the above MDS assessment which indicated that no supervision was necessary for bathing for this resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Registered Nurse Assessment Coordinator (RNAC, Staff #14) on 3/28/19 at 11:26 AM, it was revealed that he/she reviewed the medical record and hospital reports to complete the MDS. However, he/she stated he/she knew this resident and, because the resident would go on leaves of absence with his/her family for days without a wheelchair, the RNAC determined that this resident was independent for ADLs. The RNAC reported he/she was aware that this resident has had issues with shortness of breath and high blood sugars which affected his/her functional abilities. The RNAC stated the assessment was accurate and that a resident may ask for help when needed despite what the assessment indicated. On a second interview 3/28/19 at 3:21 PM, the RNAC stated he/she is required to code the MDS with the most dependent level assessed and documented by staff members who work with the resident on a daily basis. This contradicted the RNAC's earlier statement that he/she utilized personal knowledge of the resident's capability when coding some ADLs as evidenced by recalling that the resident has gone on leaves of absence without his/her wheelchair. The RNAC was unable to clarify why he/she felt the coding for personal hygiene relied solely on staff documentation while the coding for bathing could incorporate the RNAC's personal experience with the resident. On 3/28/19 at 9:52 AM, Administrator and Director of Nursing made aware of the findings. 37276 2.) On 3/28/19, a review of Resident #59's quarterly assessment with an ARD (assessment reference date) of 2/13/19, Section C100. Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be conducted? was not coded yes and not coded no. The MDS failed to indicate whether the BIMS interview with the resident should be conducted and there was no documentation that a BIMS had been completed. Review of Section D, Mood, D0100. Should Resident mood interview be conducted? was not coded yes and not coded no. The MDS failed to indicate whether a resident mood interview should be completed and there was no documentation that a mood interview had been completed. Continued review of Resident #59's quarterly assessment with an ARD of 2/13/19, Section M, Skin Conditions, M0300. Current number of unhealed pressure ulcers/injuries at each stage, B. Stage 2 was coded 1, indicating the resident had 1 stage 2 pressure ulcer. Review of Resident #59's medical record revealed on 1/24/19, 1/30/19, 2/7/19 an 2/13/19, in a Skin Grid Non-Pressure note, the nurse documented Resident #59 had a non-pressure wound on the medial base of the left big toe. There was no documentation in the medical record that indicated Resident #59 had a pressure ulcer. On 3/29/18, during an interview, Staff #35, stated Resident #59's wound was an old wound that had reopened in the same area and had been identified by the wound doctor as a non-pressure wound. On 4/1/19, review of Resident #120's quarterly assessment with an ARD of 3/6/19, Section K0300. Weight loss, loss of 5% or more in the last month or loss of 10% or more in the last 6 months, was coded 0, No. Review of the resident's medical record indicated Resident #120 had weight loss of greater than 10% in 6 months. Review of the EMR (electronic medical record) revealed on 3/6/19 Resident #120's weight was documented as 166.2 lb. and on 9/1/18, the resident's weight was documented as 184.6. This was a weight loss 11.07%, indicating a weight loss greater than 10% in 6 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued review of Resident #120's quarterly assessment with an ARD of 3/6/19, did not capture the resident's active diagnosis of heart failure and did not capture the resident's diagnosis of edema (swelling). Review of the medical record revealed documentation that the resident had heart failure and had edema. Review of Resident #120's March 2019 MAR (medication administration record) revealed an order for Lasix (furosemide) (diuretic) by mouth in the morning for CHF (congestive heart failure) that was documented as given every day. Review of Resident #120's progress notes revealed that, on 3/5/19 at 12:51 PM, in a progress note, the Nurse Practitioner wrote that the resident was seen for left lower extremity edema. Review of Resident #120's progress notes revealed on 2/24/19, in a 60 day visit note, the physician wrote the resident had recurrent congestive heart failure and edema. On 12/29/18, in a progress note, the physician documented Resident #102 had worsening edema and recurrent congestive heart failure. Staff #14 was made aware of the findings on 4/1/19 at 1:00 PM. The Director of Nurses was made aware of the above findings on 4/4/19 at 7:13 PM. 41248 3.) A record review conducted on 04/01/19 09:14 AM, revealed that resident #112 had a weight loss of 22. 6% between 10/3/18 - 3/2/19. the quarterly MDS assessment with an ARD of 10/3/18 indicated resident's weight was 177 pounds and the recorded weight on the quarterly assessment for 3/2/19 was documented as 137 pounds. This represents a 40-pound weight loss. A significant weight loss is defined as greater that 10% negative weight difference within a 6-month time frame. The quarterly assessment with an ARD date of 3/2/19 failed to capture the significant weight loss in section K swallowing/nutrition status at K0300. An interview with the Registered Nurse Assessment Coordinator (staff #14) on 4/1/19 at 3:31PM, failed to reveal insight into the discrepancy on the MDS assessment. 4) Based on medical record review and staff interview, it was determined that the facility staff failed to conduct an accurate, comprehensive assessment by failing to assess a resident's cognition and mood on comprehensive Minimum Data Set (MDS) assessments. This was identified for 1(#7) of 4 resident's reviewed for urinary catheter care. The findings include. The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on these individualized needs, and that the care is provided as planned to meet the needs of each resident. Interview of resident #7 on 3/20/2019 revealed that resident #7 was alert and oriented to person, place, and time. Review of the medical record for resident #7 on 3/28/19, revealed an incomplete MDS assessment. Review of the admission MDS, with an assessment reference date (ARD) of 12/17/18, failed to assess the resident in Cognition and Mood, Section C & D. Interview of the director of nursing and nursing home administrator on 3/28/19 at 2:30 PM revealed that the MDS nurse assessor was to complete that section. Further review of resident #7's medical record revealed that the quarterly MDS assessment with an ARD of 3/18/19 failed to assess the resident's cognition and mood, sections C and D.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on review of the medical records and interviews with staff, it was determined that the facility staff failed to develop and implement baseline care plans that included instructions needed to provide effective and person-centered care of the resident with physicians' orders and initial goals. Additionally, the facility failed to provide the resident and/or their representative a summary of the baseline care plan including medications. This was evident for 5 (#122, #70, #23, #174 and #60) of 40 residents reviewed during the investigation phase of 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) Resident #122's record was reviewed on 3/25/19 at 8:53 AM. The resident was admitted [DATE]. A Plan of care note, dated 3/24/19 17:08, indicated: Admission care plan completed. Further review of the record failed to reveal an admission baseline care plan. At 10:18 AM on 3/25/19, Staff #33 confirmed that Resident #122's baseline care plan was not in the record. At 12:02 PM, the baseline care plan was provided to the surveyor; the DON indicated that it was found in a folder on the unit. Review of the baseline care plan failed to identify the resident's goals, safety needs or care and services that were to be provided. The Physicians Orders section was blank and failed to reflect that the resident's current medication list was reconciled with the resident/representative or that they were provided a copy of the medication list. The plan was not signed by the resident/representative and did not reflect that the resident/representative were invited to participate and their acceptance or declination. 2) A review of Resident #70's medical record was conducted on 3/25/19 at 1:29 PM. The record revealed a baseline care plan, dated 2/20/19. The Physicians Orders section was blank and failed to reflect that the resident's current medication list was reconciled with the resident/representative or that they were provided a copy of the medication list. The plan was signed by a Registered Nurse, Social Services, Activity personnel and Therapy. The lines labeled: Nursing assistant, Dietary, Physician or Practitioner, Resident and Representative were blank. Spaces provided at the bottom of the page to indicate if the Resident/Representative participated or declined to attend and accepted or declined a copy of the care plan were all blank. During an interview on 3/26/19 Staff #31 confirmed that the plan had not been reviewed with the resident and/or his/her representative and that a care plan meeting had not been held since the residents admission on 2/19/19. Staff #31 confirmed when asked that the facility was behind with the resident's care plans. Cross reference F 656. 3) Resident #23's medical record was reviewed on 4/5/19 at 11:03 AM. The surveyor was unable to find a baseline care plan in the record. On 4/05/19 at 2:40 PM during an interview, the Director of Nursing (DON) indicated that a baseline plan of care had not been done because Resident #23 was admitted in October 2018 and the regulation did not go into effect until November. The DON and Administrator. were made aware that the regulation went into effect in November 2017 prior to the residents admission on 10/10/18. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15701 4) Resident #174 was admitted to the facility on [DATE]. The resident was interviewed on 3/21/2019 at 1:59 PM with acknowledgement that s/he had a discussion with staff, and s/he had been presented with a baseline care plan. Review of resident #174's medical record on 3/21/19 revealed that a copy of a baseline care plan was in the resident's paper medical record. The baseline care plan was signed by various members of the interdisciplinary team, dated for 3/18/19. Review of the Baseline Care Plan revealed that the facility did not provide the minimum healthcare information necessary to properly care for this resident immediately upon admission to the facility. Review of the hospital discharge summary (dated 3/6/19 for the day of h/his admission to the facility) revealed that the resident had extensive spinal surgery and was to wear a back brace when out of bed. The baseline care plan did not include any documentation related to rehabilitation from the resident's recent surgery nor was there any indication of use of a back brace. Further medical record review on 3/27/19 revealed one plan of care focus in the electronic record related to the resident's advanced directive choices. 5) Review of resident #60's paper medical record on 3/28/19 revealed a blank baseline care plan. There was not any documentation on the four pages of the Baseline care plan. Resident #60 was originally admitted in September of 2018. There was not any documentation in the electronic medical record related to the completion and presentation of a baseline care plan to resident #60.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on observations, medical record review and interviews with a resident and staff, it was determined that the facility failed to develop accurate, resident centered care plans with measurable goals and objectives and failed to follow a resident's care plan. This was evident for 13 (#108, #8, #23, #70, #122, #105, #69, #84, #14, #41, #76, #86 and #120) of 40 residents reviewed during the investigative phase of the survey. The findings include: 1) During an interview on 3/20/19 at 8:22 AM, Resident #8 indicated that he/she was scheduled to have cataract surgery that day, but it had to be cancelled. Review of the resident's record on 3/26/19 at 11:12 AM revealed a Cataract evaluation dated 2/25/19, which indicated Cataract, mixed; Both eyes. The Director of Nursing (DON) confirmed that the resident was scheduled to have Cataract surgery. Further review of the record revealed a plan of care for: Eye infection and allergies affecting eyes initiated 12/6/18. The resident's goal was: (Resident #8's) eye infection will be resolved without complications, however, no plan of care was developed to address the resident's needs related to his/her cataracts including planned surgical intervention. 2) During an interview on 3/20/19 at 10:19 AM Resident #122 was observed with a urinary catheter bag hanging under his/her wheelchair. The resident indicated that he/she was not sure why he/she had the catheter and thought that the doctor had told him/her about 3 weeks ago that it would be coming out but had not heard anything further. Review of the resident's record on 3/25/19 at 8:53 AM revealed a plan of care for an indwelling suprapubic catheter (a catheter that is surgically placed into the urinary bladder through the abdominal wall). The plan failed to identify if routine catheter care was to be provided. The DON was made aware of these findings and confirmed that the plan of care inaccurately identified the residents urinary catheter as suprapubic. 3) Resident #70's record was reviewed on 3/25/19 at 1:29 PM. The resident was admitted to Hospice services 2/19/19. A plan of care was developed on 3/11/19 for: (Resident #70) has a terminal prognosis an is on hospice service. The goal: (Resident #70's) comfort will be maintained through the review date. The goal did not include measurable objectives. The interventions included: Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met however the plan did not reflect that he facility had collaborated with hospice and the resident to identify the residents needs and to identify interventions to assist the resident in reaching his/her goal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Resident #23's medical record was reviewed on 4/4/19 at 12:48 PM. A Medication Admin Audit Report for November 2018 - January 2019 revealed that Resident #23's medications had been administered outside of the 1 hour administration window numerous times during the 3 month period. Further review of the record revealed a plan of care for: Medications are to be administered by family members per Residents request. The goal was that family members will administer the resident's medications at the correct time, dose and frequency. The interventions were to educate the family members on proper storage, purpose and side effects, evaluate ability to administer, monitor family members administering medications. The plan failed to address the care and services that staff were to provide to ensure the timely administration of the residents medications. During an interview on 4/5/19 at 11:36 AM, the DON was made aware that the plan of care did not provide details as to how family members were to administer the residents medications timely. The DON indicated that the family did not administer the medications , but wanted to be present and observe the staff administering the medications and that sometimes it took over an hour to administer the resident's medications. The facility failed to develop a plan of care to address the resident's individual medication administration needs. Cross reference F 760. Further review of Resident #23's plan of care for nutrition/fluid imbalance revealed a goal: weight maintenance within +/- 3%. The goal did not identify the resident's baseline weight for staff to accurately evaluate if he/she was reaching this nutrition goal. 15701 5) Interview of resident #108 on 3/25/19 at 2:10 PM revealed that the resident was dependent on staff for activities of daily living. The resident had expressed concern that, at times, s/he was only getting one bath per week and there werere times when s/he was left in stool (bowel incontinence) for long periods of time. Review of a comprehensive assessment dated [DATE], indicated resident #108 was totally dependent on staff for bathing. The care plans for resident #108 were reviewed on 3/26/19. The facility had developed a plan of care related to the resident's activities of daily living self-care deficits. A goal for this care area was written as all needs will be anticipated and met This written goal was not measurable or quantitative. 37585 6) Resident #105 was interviewed on 3/25/19 at 10:17 AM. During the interview, the resident stated that s/he had sustained a hand injury on his/her right hand. Surveyor observation confirmed that the injury prevented the resident from gripping with the right hand, and impacted his/her ability to perform activities of daily living such as repositioning, bathing, dressing, and eating. Resident #105's medical record was reviewed on 3/25/19 at 11:40 AM. During the review, Resident #105's care plan was examined for whether or not Resident #105's right hand injury was addressed. Although a care plan topic that included activities of daily living was identified, no care plan addressed the needs of the resident in regards to his/her hand injury, including activities of daily living, therapy, and restorative treatment. 40927 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) During an interview with Resident #69 on 3/21/19 at 10:38 AM, it was reported that the resident needed assistance to take a shower because he/she becomes shaky and unsteady at times. The residents stated that staff were not providing that assistance. When asked why staff were not helping, he/she reported that staff #50 would tell him/her they were capable of taking a shower without assistance. It was observed by the surveyor that the resident used a wheelchair for locomotion. On 3/27/19 at 2:14 PM, review of the medical record revealed a care plan which documented that Resident #69 had a self-care performance deficit related to pain, physical limitations, and COPD (a respiratory condition that causes decreased energy) that was initiated on 11/15/18 activities of daily living (ADLs).(ADLs refer to basic skills performed each day of a person's life and include personal hygiene, eating, bathing, mobility, and similar skills). An interview with staff# 4 on 3/28/19 at 8:55 AM, regarding shower schedules revealed that residents were not getting their showers due to staffing levels. The residents do not get most of the care they need, especially being turned and changed every two hours they are lucky to get changed 1-2 times a shift, because there is not enough time. On 3/28/19 at 9:41 AM, an interview with the Administrator (NHA) and Director of Nursing (DON) revealed they did not use agency staff because they mandate their staff to stay over when needed. They were trying to hire more staff. DON reported that she utilized the census to determine the number of staff scheduled. NHA and DON made aware of the above findings. 8) An interview with Resident #84's family member on 3/21/19 at 10:01 AM, revealed the facility had reported that the resident had an open area on his/her bottom. A record review on 3/22/19 at 9:53 PM, revealed an order written on 3/11/19, for wound care. However, there was no care plan for skin issues included. Further review of the care plan revealed a documented risk for a urinary tract infection (UTI) (an infection in the urinary system in the body) and the goal stated I (resident) will be free of UTI. This goal was not measurable or quantitative. On 4/8/19 at 2:00 PM, NHA and DON were made aware of the findings. 41248 9) On 03/21/19 at 9:08 AM, the surveyor observed Resident #41 eating breakfast in his/her room, unassisted. A record review of a care plan on 3/22/19 at 1:47 PM, revealed that resident #41 was to be in a feeding group for all meals with the staff assisting as needed. 10) On 3/22/19 at 2:55 PM, a review of the care plan revealed care area related to a right above knee amputation for resident #19, who had a diagnosis of left above the knee amputation. An interview on 3/22/19 at 3:31 PM, conducted with the registered nurse assessment coordinator (staff #14), revealed that the unit managers were to update the Care Plans daily. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11) On 3/25/19 at 02:03 PM, a record review for Resident #76 revealed a care plan for strict fluid restrictions, which was not reflected in the physician orders. This resident had at least 16 ounces of water on bedside table. An interview with staff #40 on 3/27/19 at 11:14 AM, revealed that resident #76 was not on fluid restrictions. 12) On 3/27/19 at 1:55 PM, a record review of Care plans initiated on 2/14/19 revealed that Resident #86 was receiving seizure medication for a seizure disorder. This resident did not have a physician order for seizure medication. 13) On 3/28/19, a review of Resident #120's medical record revealed a 3/18/19 physician order for weekly weights x 4 weeks every day shift, every Wed for 30 days with 3/20/19 start date and 4/19/10 end date. Review of Resident #120's weights in the EMR (electronic medical record) revealed Resident #120's last recorded weight was on 3/16/19. Review of Resident #120's MAR (medication administration record) revealed an order weekly weights x 4 weeks every day shift every Wed for 30 days was documented as 9 (other, see nurses notes) on 3/20/19 and 3/27/19. Review of Resident #120's nurses notes revealed on 3/20/19 at 2:04 pm, in a progress note, the nurse wrote Weekly weights x 4 every day shift every Wed for 30 days, na indicating the weight was not obtained. On 3/27/19 at 2:48 PM, in a progress note, the nurse wrote Weekly weights x 4 every day shift every Wed for 30 days, pass to on coming shift. On 4/1/19 at 1:25 PM, the unit manager, Staff #50, was made aware of these findings. At that time, during an interview, Staff #40, a nurse, confirmed Resident #120's weight was not obtained on 3/20/19, and stated it was because the resident was not in the building and the 3-11 shift should have followed up, and, confirmed the resident's weight was not obtained on 3/2719 and stated it may have been because they were short staff and it was passed on. Review of Resident #120's care plans revealed a nutrition care plan, Resident #120 has the potential for nutritional and hydration imbalances that included the interventions weights as ordered: monitor weights. The facility staff failed to follow the care plan by failing to monitor Resident #120's weights. The Director of Nurses was made aware of the above findings on 4/1/19 at 7:13 PM.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37585 Based on review of medical records and interview with residents and facility staff, it was determined that the facility failed to review and revise care plans as resident needs change and at least quarterly. This was evident for 11 (#42, #108, #8, #23, #53, #105, #109, #325, #120, #59, #82) of 40 residents reviewed during the investigation phase of the survey. The findings include: 1) Resident #53's medical record was reviewed on [DATE] at 1:45 PM. During the review, the resident's Maryland Orders for Life Sustaining Treatment (MOLST) form was located. The MOLST form reflected that the resident did not wish to have cardiopulmonary resuscitation (CPR) performed if the resident developed cardiac arrest. This was different from what was listed in the resident's care plan which stated that the resident did want to have CPR performed in the event of cardiac arrest. The MOLST form, which contains physician orders and can be considered more authoritative than care plan interventions, had been updated more recently than the care plan and the care plan had not changed to reflect it. 2) Resident #105's medical record was reviewed on [DATE] at 10:17 AM. During the review, it was noted that the most recent review date for all of the goals of the care plan topics was in March, 2018. No revisions to the goals of any care plan topic were found in the medical record or provided by the facility. 3) Resident #109's medical record was reviewed on [DATE] at 2:54 PM. During the review, no evidence could be found that a care plan meeting had been held within the previous 5 months. Without a care plan meeting, the interdisciplinary team could never meet with the resident or his/her responsible party to evaluate and modify the care plan. It was also noted that the care plan goals had not been changed within the previous 5 months. 4) Resident #325's responsible party (RP) was interviewed on [DATE] at 11:45 AM. During the interview, the RP stated that s/he had not been invited to a care plan meeting during the resident's stay at the facility. Resident #325's medical record was reviewed on [DATE] at 1:40 PM. During the review, no evidence could be found that indicated the resident's RP had been invited to a care plan meeting or had attended a care plan meeting. 31982 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Resident #8's medical record was reviewed on [DATE] at 8:47 AM. A plan of care was developed on [DATE] to address the care and services that the facility staff were to provide related to the resident receiving hemodialysis (filtering of blood through a machine). The resident's goal was Resident #8 will have no signs or symptoms of complications from dialysis through the review date. 15 interventions were identified to assist the resident in meeting his/her goal. Resident #8 also had a plan of care for potential for imbalanced nutrition. His/Her goal was: Resident #8 will not develop complications related to obesity, including skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date. The plan included 10 interventions staff were to implement to assist the resident in reaching his/her goal. Further review of the record revealed Care Plan Notes (dated [DATE], [DATE] and [DATE]) which failed to measure the residents progress or lack of progress toward reaching his/her Dialysis and Nutrition goals including the effectiveness of the interventions. The record also failed to reflect that Resident #8's plans of care were reviewed and revised by the interdisciplinary team after each comprehensive or quarterly review assessments. 6) Resident #23's medical record was reviewed on [DATE] at 10:55 AM. The record revealed plans of care which included Activities, fall risk, medication administration by family, Skin impairment, risk for nutrition/fluid imbalances, anti-anxiety medications, altered respiratory status, potential for infection, Restorative nursing program, Antibiotic therapy r/t C-diff, end of life choices, and ADL self-care performance deficit. Progress notes entered into the record [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] were labeled Care Plan progress notes. Some indicated that the plan of care was reviewed with the resident and/or family, the family's concerns, and plans to transfer the resident to another facility, however the notes failed to measure the residents progress or lack of progress toward reaching his/her care plan goals. 37276 7) On [DATE], Resident #59's medical record was reviewed. On [DATE] at 7:01 PM, in an annual Activity Preference Interview, the activities assistant documented that Resident #59's current interest in activity pursuit patterns were: 1) crafts/arts/hobbies (coloring), 2) music, watching TV, watching movies, radio, 3) computer/keeping up with the news, 4) trips/shopping/community outings, 5) Spending time outdoors/walking or wheeling outdoors, 6) talking/conversing/helping others/volunteer work. Review of Resident #59's care plans revealed an activity care plan, the resident attends activities of interest/choice and engages in self-initiated leisure activities with the goal, the resident will initiate leisure activities ,d+[DATE] x/day such as visiting with family/friends had the interventions 1) Inform of newspaper and daily chronicle availability in activity room, 2) Invite, encourage and assist as needed to activities of choice, interest as tolerated by the resident, 3) Provide activity calendar in room and 4) Respect wish to decline invitations when rest/leisure-type activities are preferred. The plan of care was not resident centered with measurable goals; the interventions were not resident specific to indicate the resident's preferences. Continued review of the medical record revealed an annual assessment with an ARD (assessment reference date) of [DATE], a quarterly assessment with an ARD of [DATE] and quarterly assessment with an ARD of [DATE] had been completed for Resident #59. There was no documentation in the medical record that Resident #59's plan of care had been reviewed after each of these resident assessments. On [DATE], at 12:55 PM, Staff #13 was made aware of above findings (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8) On [DATE], review of the medical record revealed Resident #120 had a quarterly assessment with a reference date of [DATE]. Review of Resident #120's care plans revealed a nutritional care plan, Resident #120 has the potential for nutritional and hydration imbalances had the goals: maintain adequate nutritional status by consuming >75% of 2 or more meals a day within the review period and Maintain wt between , d+[DATE] lbs had interventions: 1) Diet as ordered, CCD (carbohydrate controlled diet), 2) Monitor po (oral) intake, 3) Weights as ordered: monitor weights, 4) HS (hour of sleep) snack as ordered: PBJ (peanut butter/jelly) at HS, 5) speech/OT (occupational therapy) consult as needed and 6) RD (registered dietician) to make recommendations as needed. The facility staff failed to follow the care plan by failing to monitor Resident #120's weights as ordered. There was no documentation in Resident #120's medical record that the resident's nutrition care plan had been reviewed after the assessment, including the resident's progress or lack of progress toward reaching his goals or revised to address the resident's weight loss. 15701 9) Resident #42's medical record was reviewed on [DATE]. Review of resident #42's paper and electronic medical record revealed no documentation that a plan of care meeting was held around the time that the annual minimum data set assessment (MDS) (with an assessment reference date (ARD) of [DATE]) was completed. Review of resident #42's care plans revealed indications of revisions to care plans, however, only the target dates of the plans were changed to reflect the next quarterly assessment. The last documented care plan meeting was dated [DATE]. During an interview with the resident on [DATE] at 1:15 PM, the resident acknowledged not being invited to a care plan meeting in a long time. There was not any other documentation to reflect the residents progress or lack of progress toward reaching his/her care plan goals for the annual assessment period. 10) Interview of resident #108 on [DATE] at 11:20 AM, revealed that s/he has not been invited and/or had a care plan meeting in a long while. Review of resident #108's medical record on [DATE] revealed the resident had a quarterly assessment, with a reference date of [DATE], and previous to that assessment, one was dated [DATE] without indication of a care plan meeting/conference. On [DATE] at 3:20 PM. an interview with the director of nursing (staff #2) and the social worker (staff #31) revealed that the social worker was responsible for writing a care plan meeting note. A copy of the care plan letter that invites resident to care plan meetings was requested as resident should have had a recent meeting. The social worker never provided a copy. Further review of the medical record did not reveal any social worker notes and/or any type of care plan meeting note related to the quarterly assessment of [DATE]. Without a care plan meeting, the interdisciplinary team could never meet with resident # 108 to evaluate and modify the care plan. Review of the entire plan of care did not reflect any recent revisions except that the target dates were changed to reflect the next quarterly evaluation period. Two notes labeled quarterly care plan note were reviewed. One note, dated [DATE], listed all the resident's diagnoses, and indicated that the care plan was reviewed and documentation was revealed that all interventions are current as per care plan. The second note was dated [DATE], and was written by the dietary manager in training. This note listed all of the resident's diagnoses and stated careplan reviewed goals/interventions remain appropriate. Will adjust as needed. It was noted that all care plan goals were not quantitative or measurable; cross reference to F656. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11) On [DATE] at 12:19 PM, during an interview, Resident #82 was asked if he/she attended his/her care plan meeting, Resident #82 stated that he/she was unable to say if he/she had had attended a care plan meeting or was invited to his/her care plan meeting. On [DATE], a review of Resident #82's medical record revealed that the resident had a quarterly assessment, with a reference date of [DATE], and a quarterly assessment with a reference date of [DATE]. There was no documentation in the medical record to indicate that a care plan meeting was held to review and update the care plan following the completion of Resident #82's quarterly assessments on February 18, 2019. On [DATE] at 3:00 PM, the Director of Nurses and the Administrator were made aware of the above findings.

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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. Deficiency Text Not Available

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37585 Based on review of resident medical records, interview with facility staff, interview with the staff of contracted Hospice services, and review of facility policy, it was determined that, when the facility was unable to immediately identify a resident's end-of-life wishes upon his her/cardiac arrest, the facility failed to perform Cardiopulmonary Resuscitation (CPR) while they attempted to clarify the resident's wishes.As a result of these findings, a state of immediate jeopardy was declared on [DATE] at 12:30 PM and the facility was provided with the Immediate Jeopardy Template at that time. The facility submitted a removal plan on [DATE] at 4:00 PM and the State Agency was unable to accept this plan. The facility submitted a second plan on [DATE] at 6:30 PM and the removal plan was accepted at 7:00 PM. The immediate jeopardy was removed on [DATE] at 9:30 AM Following the removal of the immediate jeopardy finding on [DATE], the scope/severity of the tag was lowered to a D level deficiency. This was evident for 1 (Resident #327) of 3 residents reviewed for death. The findings include: Resident #327's medical record was reviewed on [DATE] at 11:25 AM. During the review, the following note was found by Licensed Practical Nurse (LPN) #28 written on [DATE] at 7:48 PM: While going to administer medications, [Resident #327] was unresponsive at 6:48 PM, with no pulse. RN made aware and hospice notified. Another note was found written by RN #21 on [DATE] at 8:53 PM that stated, Was called to 1st floor for [Resident #327] being unresponsive . Checked [Resident #327's] Maryland Orders for Life-Sustaining Treatment (MOLST) form and it was not clear. [Physician #23] was called immediately and s/he stated the resident was Do Not Resuscitate (DNR). Hospice was notified. Time of death 6:48 PM. RN #21 was interviewed by telephone on [DATE] at 1:00 PM. During the interview, RN #21 stated that s/he was on the second floor when s/he was called to come down to the first floor because Resident #327 wasn't breathing. Upon arrival to the unit, RN #21 stated that s/he went to the room, confirmed the resident was deceased , and then asked staff who were present in the room (doesn't recall who) if anyone knew the resident's code status. RN #21 stated that the staff all indicated they did not know. RN #21 stated that s/he then went to the paper medical record to refer to the resident's MOLST, however this form was ambiguous because both Perform CPR and Do Not Perform CPR were checked off. RN #21 stated the form had been filled out by the hospice physician (Staff #26). RN #21 stated that s/he then called the attending physician (Staff #23) who said not to do CPR because Resident #327 was on hospice and the code status had already been discussed. When asked what s/he would have done if s/he could not reach Physician #23, RN #21 refused to answer. When asked why s/he was called for this code event, RN #21 stated that, although s/he was not the supervisor, s/he was the RN on duty in the facility and is frequently called to code events to run the code. RN #21 confirmed that no CPR was performed on Resident #327. LPN #28 was called on [DATE] at 1:10 PM and stated that s/he could not recall events from a date as long ago as [DATE]. When asked about the resident, LPN #28 stated that s/he did not remember that resident. When the surveyor read him/her the above note that s/he had written on [DATE], LPN #28 stated that s/he did not remember writing that note nor the events of that night. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no evidence in the medical record or provided by the facility to indicate that CPR was ever provided by the facility staff to Resident #327 when s/he was found unresponsive and his orders for end of life care were unclear on [DATE]. The facility provided a policy entitled, Initiate CPR, with an effective date of [DATE] to the survey team on [DATE]. The policy stated that, The facility will maintain and train staff on a communication method that will quickly alert staff as to the code status of a resident in the event heart or respirations cease. Residents found unresponsive, not breathing or without a pulse, will have staff immediately locate the Code Status and communicate this to the team. Code status will be reviewed and updated for any changes, new orders, new advance directives and with each transfer to remain current with the resident requests. The Director of Nursing (DON) was interviewed on [DATE] at 12:30 PM. During the interview, the DON stated that s/he was aware of the confusion that the MOLST dated [DATE] caused nursing staff on the night of [DATE] and had performed an investigation afterwards. The survey team requested evidence of the DON's investigation and a single page document entitled, Follow Up Investigation From [Resident], was provided on [DATE]. The investigation specified the following: Notified Medical Director - Had Med Director review chart on visit. Attending physician reviewed chart and made note regarding code status on [DATE]. Hospice Leadership accepted education and stated that they will educate their team. MOLST audit conducted on all hospice residents by Medical Director and no other residents were identified. The Follow Up Investigation did not specify any education that the DON provided to nursing staff or any education that the Medical Director provided to facility providers. As a result of these findings, a state of immediate jeopardy was declared on [DATE] at 12:30 PM and the facility was provided with the Immediate Jeopardy Template at that time. The facility submitted a removal plan on [DATE] at 4:00 PM and the State Agency was unable to accept this plan. The facility submitted a second plan on [DATE] at 6:30 PM and the removal plan was accepted at 7:00 PM. The immediate jeopardy was removed on [DATE] at 9:30 AM. After determination of immediate jeopardy concerns, an extended survey was conducted from [DATE] until [DATE]. The facility's accepted plan of removal contained the following provisions: -House wide audit on [DATE] by nursing leadership to identify other residents with MOLST forms containing conflicting code status orders. -Education of all nursing and social service staff by Staff Development on [DATE] and ongoing regarding requirement of clear and accurate MOLST forms. -Education of all nursing staff by Staff Development on [DATE] and ongoing to initiate CPR if the MOLST is unclear. -Facility physicians and extenders educated by Medical Director on [DATE] with in-person education on [DATE] regarding clear and accurate MOLST. -Auditing by social worker and medical records of 10% of MOLST forms for accuracy weekly x3, monthly x3. Report to QAPI committee meeting.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 37276 Based on observations, medical record review and staff interview, it was determined the facility failed to implement an ongoing resident centered activities program designed to meet the interests and support the physical, mental and psychosocial well-being of each resident for 2 (#59, #86) of 2 residents reviewed for activities. The findings include: 1.) Intermittent observations were made of Resident #59 by the surveyor during the morning and afternoon of 3/20/19, 3/21/19, 3/22/19 and 3/28/19. On each of these surveyor observations, Resident #59 was observed sitting up or lying down in his/her bed, in a quiet room without TV or a radio on. Resident #59 was not observed to be out of his/her room in a group activity and was not observed in a 1 to 1 with activity staff during the surveyor observations. On 3/28/19, Resident #59's medical record was reviewed. On 12/6/18 at 7:01 PM, in an annual Activity Preference Interview, the activities assistant documented Resident #59's current interest in activity pursuit patterns were: 1) crafts/arts/hobbies (coloring), 2) music, watching TV, watching movies, radio, 3) computer/keeping up with the news, 4) trips/shopping/community outings, 5) Spending time outdoors/walking or wheeling outdoors, 6) talking/conversing/helping others/volunteer work. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Review of Resident #59's care plans revealed an activity care plan, the resident attends activities of interest/choice and engages in self-initiated leisure activities with the goal, the resident will initiate leisure activities 1-2 x/day such as visiting with family/friends had the interventions 1) Inform of newspaper and daily chronicle availability in activity room, 2) Invite, encourage and assist as needed to activities of choice, interest as tolerated by the resident, 3) Provide activity calendar in room and 4) Respect wish to decline invitations when rest/leisure-type activities are preferred. The plan of care was not resident centered with measurable goals; the interventions were not resident specific to indicate the resident's preferences. Continued review of the medical record revealed an annual assessment with an ARD (assessment reference date) of 11/19/18, a quarterly assessment with an ARD of 1/14/19 and quarterly assessment with an ARD of 2/13/19 had been completed for Resident #59. There was no documentation in the medical record that Resident #59's plan of care had been reviewed after each of these resident assessments. On 3/28/19, at 12:55 PM, Staff #13 was made aware of above findings and asked to provide the surveyor with documentation of Resident #59's participation in activities. On 3/28/19 at 2:00 PM, during an interview, Staff #13 stated that Resident #59 had minimal attendance of activities and provided the surveyor with an Activities Attendance Record, dated 2/23/19. On the form, the activity mail was written, and Resident #59's name was hand written in attendance. No documentation was provided to indicate the resident received 1 to 1 activity visits and no documentation was provided to indicate the resident refused to attend activity programs. 41248 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) An interview with resident #86 conducted on 3/20/19 at 11:33 AM revealed that he/she liked to play bingo and enjoyed gardening, however, had not been assisted by staff to attend activities. Observation of Resident #86 made during the 9 days of the annual survey recertification revealed that the resident did not get out of bed. On 03/28/19 at 9:20 AM, an interview was conducted with the Activities director and she stated that Resident #86 was out of bed on Monday for coffee hour, which the resident really enjoys. She also had stated that the resident is seen 2 - 3 times a week, in the room, for reading. A record review of the POC (Point of Care where the GNA's document) conducted on 3/28/19 revealed that the resident was not out of bed on that Monday for coffee hour.

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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** 37276 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that each resident received treatment and care in accordance with professional standards of practice by failing to ensurethat physician orders were accurately transcribed, medications were administered as prescribed, and failing to inform a resident when there was a change in his her treatment. This was evident for 2 (#82, #328) of 6 resident's reviewed for care plans. The findings include: On 3/22/19, a review of Resident #82's medical record was conducted and revealed that, on 3/18/19, in a progress note, the physician documented that Resident #82's history of present illness included still has swelling of legs, under the heading review of systems, the physician circled peripheral edema (swelling due to accumulation of fluid) and under assessment/plan, the physician documentation included Increase Lasix (Furosemide) (diuretic) to 40 mg in AM. Continue Lasix 20 mg in PM. Review of Resident #82's physician orders in the resident's paper chart revealed, on 3/18/19, the physician hand wrote orders that included BMP (basic metabolic panel) once a month starting on April 1st. Increase Lasix to 40 mg in AM. Review of Resident #82's March MAR (medication administration record) revealed an order for Lasix 20 mg by mouth, which was discontinued on 3/19/19 was documented as given twice a day, March 1st through March 18, 2019. There was an order initiated on 3/19/19 to give Lasix 20 mg by mouth two times a day for edema until 3/31/19 that was documented as given twice a day, since 3/19/18. The MAR also documented an order for Lasix 40 mg by mouth one time a day for edema, to start on 4/1/19 and an order for Lasix 20 mg by mouth once a day in the evening for edema, to start on 4/1/19. The facility staff failed to correctly transcribe Resident #82's 3/18/19 physician's order to increase the resident's Lasix to 40 mg in the AM correctly, therefore the facility staff failed to administer the resident Lasix as the physician prescribed. Continued review of the medical record failed to reveal documentation that Resident #82 had been made of the physician ordered change in his/her treatment when the physician prescribed a change in the dose of resident's diuretic, Lasix. On 3/22/19 at 3:15 PM, during an interview, Staff #50, confirmed the above findings. 2) The facility failed to timely evaluate and provide pain relief for the first nine hours of admission to the facility for Resident #328. Resident #328 was admitted on [DATE] with a hip replacement that had been performed two days prior on 4/2/2019 at a nearby hospital. Resident #328 had come to the facility to receive rehabilitation services related to the hip replacement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #328 was interviewed on 4/5/2019 at 2:33 PM. During the interview, the resident stated that s/he had been newly admitted the prior day, having arrived at the facility at about 2:30 PM on 4/4/2019. The resident stated that, despite being in the bed closer to the door with the door wide open, indicating that s/he was clearly visible to staff walking by, nobody came in to welcome him/her, provide any services, or perform any form of evaluation. Resident #328 stated that, after a few hours, s/he was upset enough that s/he was crying. S/he stated that, at that time, the Admissions Director came in and comforted him/her but again did not provide any services or perform any noticeable evaluation. Resident #328 stated that s/he remembered waking up at 8:30 PM on the same day still feeling disoriented and not having received any services including pain medication. Resident #328 stated that s/he was in pain and decided to call his/her family member to request him/her to call the facility to tell them that Resident #328 was there and wanted to speak to staff. Resident #328's family member was present for this interview and confirmed that s/he called the facility at about 8:30 PM and spoke to a nurse on the second floor but could not confirm the staff member. The family member stated that the nurse told him/her that the nurse didn't know Resident #328 was in the facility and would let the responsible nurse know. Resident #328 continued the interview by stating that nobody entered the room until 10:00 PM when the nurse whom the family member had called came into the room and apologized. Resident #328 recalled that the nurse said, None of your medications are ordered. I am getting your pain medication. However, Resident #328 asserted that s/he did not receive a dose of pain medication until a different nurse came in at 10:30 PM to give the medication. Resident #328 indicated that no staff member had oriented him/her to the room's call bell and that s/he didn't know s/he had one until the surveyor indicated the device, which was on the floor at the time of the interview. Resident #328 also expressed concern that a dietary aid told him/her on the morning of 4/5/19 that there was no breakfast tray for him/her. Finally, Resident #328 stated that s/he did not receive his/her regular medications on the day of admission, including medications the resident characterized as important psychological meds that are dangerous for me to miss. An interview was performed with Certified Registered Nurse Practitioner (CRNP) #27 on 4/5/2019 at 2:25 PM. During the interview, CRNP #27 stated that she had seen the resident earlier that morning after learning that the resident had not gotten any care yesterday. CRNP #27 stated that her expectation as one of the admitting providers is that nursing staff notify her of the arrival of a new admission within 2 hours of the admission's arrival. CRNP #27 stated that no staff notified her of Resident #328's arrival yesterday. Resident #328's medical record was reviewed on 4/5/2019 at 2:30 PM. During the review, it was revealed that the resident received his/her first pain medication on 4/4/19 at 10:32 PM. The first nursing note in the medical record was written on 4/5/2019 at 2:54 AM. The resident was noted to not have received any other medication on 4/4/2019. Cross Reference F 635

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 31982 Based on interview with the resident and facility staff and surgical center staff, and review of the medical record, it was determined that the facility staff failed to ensure that a resident received proper treatment to maintain vision abilities by failing to obtain required preoperative evaluations resulting in the cancellation of the resident's cataract surgery. This was evident for 1 (#8) of 2 residents reviewed for Communication-Sensory concerns. The findings include: During an interview on 3/20/19 at 8:22 AM, Resident #8 indicated that he/she was supposed to have cataract surgery that day, but it was cancelled because pre-operative blood work and EKG were not done. A technician came to obtain an EKG as the surveyor was leaving the resident's room. The resident's record was reviewed on 3/26/19 at 11:12 AM. A physicians order was written 1/25/19 for Ophthalmologist consult for possible cataract. A telephone physicians order was written 3/15/19 10:45 AM for NPO (nothing by mouth) after midnight for eye surgery. During an interview on 3/26/19 at 3:09 PM, Staff #11 confirmed that Resident #8 was scheduled to have cataract surgery. He/She did not think that it was done. A preoperative clearance form signed by the physician and dated 2/27/19 and an unsigned consent form for Cataract Extraction of Right eye were found in the paper record by Staff #21, he/she indicated that Resident #8 was NPO after midnight 3/18/19 and that a note indicted the surgery was cancelled but did not say why. A telephone interview was conducted with the director of nurses (Staff #52) at the surgical center on 3/26/19 at 3:56 PM. He/She indicated that Resident #8 had a cataract evaluation on 2/25/19 and that, on 2/27/19, the resident's surgery was scheduled. He/She indicated that it looked like the facility scheduled the surgery because an afternoon appointment was requested by the Resident. He/She went on to say that every time the Surgical Center called, the facility never knew that the resident was scheduled for surgery and that transportation was not set up for him/her. He/She indicated that the surgery has not been rescheduled because the surgical center was still waiting for clearance. On 3/26/19, the Director of Nursing (DON) was made aware of the above findings. He/She indicated that the resident did not have the surgery because the resident had to go by stretcher lying down and that the surgical center would not take the resident if he/she was sitting up. The DON was asked if everything else was in place for the resident to receive the cataract surgery and confirmed that the residents EKG had not been done and the preoperative clearance had not been sent.

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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. 37585 Based on observation and interview with facility staff, it was determined that the facility failed to 1) maintain an environment free of environmental hazards for confused residents as evidenced by having treatment carts unlocked and unattended in the hallway of the second floor unit. This was evident for 2 of 2 carts observed on the 2nd floor on the day of survey entry. The findings include: During an observation of the 2nd floor nursing unit, made on 3/20/19 at 7:48 AM, there were two treatment carts on the 2nd floor both unlocked and unattended by facility staff. Two surveyors made this observation at 7:48 AM. The carts were reviewed for contents and the following supplies were identified: a bottle labeled iodoform gauze, a bottle labeled hydrogen peroxide, and several loose razor blades. At 7:55 AM, 8:10 AM, and 8:32 AM, both carts were noted to still be unlocked and unattended. Multiple staff were observed walking past both carts without locking them during this time. At 8:50 AM, a brief interview was conducted with licensed practical nurse (LPN) #11. During the interview, LPN #11 stated that it was not the facility's practice to leave the treatment carts unlocked. LPN #11 confirmed that there are some residents on the 2nd floor who are both confused and wander the hallway. After being notified of surveyor observation, LPN #11 locked both treatment carts.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 31982 Based on interviews with the resident and staff and review of the medical record, it was determined that the facility failed to ensure a resident admitted with an indwelling urinary catheter was assessed for removal of the catheter, or ensure that the record demonstrated that catheterization was necessary. This was evident for 1 (#122) of 3 residents reviewed for Urinary Catheter or UTI (Urinary Tract Infection). The findings include: During an interview, on 3/21/19 at 1:30 PM, Resident #122 indicated that he/she was not sure why he/she had a urinary catheter and thought the physician had told him/her about 3 weeks prior that it would be removed, but he/she had not heard anything since that time. Review of the resident's record on 3/25/19 at 8:53 AM revealed that the resident was admitted with the urinary catheter from the hospital. A urology evaluation from the hospital, dated 2/21/19, indicated: the Foley catheter should be removed for a voiding trial when His/her renal function has stabilized. The resident's discharge summary, dated 3/1/19, indicated: has Foley catheter now urinary retention, started on Flomax (a medication that relaxes the muscles in the bladder neck and prostate making it easier to urinate). Follow-up included: urology as outpatient. The resident was then transferred to the skilled nursing facility. A nursing urinary incontinence assessment, dated 3/1/19, indicated that the catheter would not be removed at that time due to retention. Physicians progress notes, dated 3/8/19 and 3/18/19, indicated that the resident had a Foley catheter for urinary retention, but did not reflect that the physician had addressed the urology follow up, removing the catheter, voiding trials or document a rationale if the physician felt the catheter should not be removed. A review of the physician's orders and nursing progress notes failed to reveal that a urology follow up was ordered or scheduled for Resident #122. At 10:05 AM on 3/25/19 during an interview, Staff #6 (the Medical Director) was asked if he/she knew the plan for Resident #122's Foley catheter. Staff #6 reviewed the residents record. He/She indicated the resident should have a urology follow up, but confirmed there was no physician's order. He/She indicated that voiding trials and bladder scans could be done at the facility and that he/she thought the resident's Foley catheter had been overlooked. The Director of Nursing and Administrator were made aware of the above concerns. During an interview on 3/25/19 at approximately 11:10 AM, Staff #32 confirmed that Resident #122's urology consult had not been scheduled.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Deficiency Text Not Available

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 37276 Based on observation, medical record review and staff interview, it was determined that the facility staff: 1) failed to ensure that oxygen was administered at the rate ordered by the physician, 2) failed to accurately document the resident's oxygen rate in the treatment record and 3) failed to follow the resident's care plan related to oxygen administration.This was evident for 1 (#102) of 6 residents reviewed for respiratory care. The findings include: Resident #102 was observed by the surveyor in his/her room on 3/20/19 at 9:14 AM and on 3/22/19 at 2:29 PM receiving oxygen (O2) set at 3 l/min (liters per minute) via a nasal cannula (n/c) connected to an oxygen concentrator. On 3/22/19 at 3:30 PM, the unit manager (Staff #50) accompanied the surveyor to the resident's room and confirmed the oxygen rate setting. On 3/22/19, review of Resident #102's medical record revealed a 2/27/19 physician's order for Oxygen 2 l/m via nasal cannula every shift. Review of Resident #102's March 2019 TAR (treatment administration record) revealed an order for Oxygen 2 l/m via nasal cannula was signed off as administered on day shift on 3/20/19 and 3/22/19. The facility staff failed to administer oxygen per physician orders and then documented that it was administered per orders. Review of Resident #102's care plans revealed a care plan Alteration in Respiratory Status due to Chronic Obstructive Pulmonary Disease (COPD), frequent pneumonia with the goals, Patient with remain free of exacerbation of COPD and Patient will have adequate gas exchange as evidenced by no adventitious breath sounds, absence of respiratory distress and absence of shortness of breath had interventions that included Administer oxygen as needed per physician order and O2 (oxygen) per MD order. The facility staff failed to follow Resident #102's care plan by failing to administer the resident's oxygen as ordered.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Deficiency Text Not Available

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 15701 Based on complaint allegations, resident and family interviews, observations and review of facility documents, it was determined that the facility failed to maintain sufficient staff to provide care to residents to maintain the highest practical physical, mental, and psychosocial well-being of each resident as evidenced by residents failing to receive sufficient help with activities of daily living (ADL) This was evident on 2 of 2 nursing units. The findings include. 1.) Review of the Resident Census and Conditions CMS 672 form that was completed by the Director of Nursing at the beginning of the survey indicated that 112 of the 118 residents in the building were either totally dependent on staff for bathing or required assist of 1 or 2 staff members. 115 of the residents were either totally dependent on staff or required the assist from one or two staff for dressing. There were 91 residents documented with occasional or frequently incontinent of the bladder, and 73 residents with occasional or frequent incontinent of bowel. 91 residents were on a urinary toilet program. Review of the monthly resident council minutes revealed multiple concerns by the council related to resident care issues: Concerns/issues from the 12/4/18 minutes, indicated concerns with residents not getting showers, bed linen not getting changed, call lights not getting answered (staff going to the same residents over and over and not answering all call lights), and ice not getting passed. Concerns/issues from the 1/1/19 meeting minutes include, lack of staffing, call lights not being answered, bed linens not getting changed, ice not being passed, staff on personal cell phones, and concerns about 1 to 1 residents being admitted to the facility and the aides being pulled from the floor to sit with the 1 to 1 residents. From the 2/5/19 resident council minutes revealed continued concerns related to residents not getting showers. The facility did not provide resident council minutes for March of 2019. 2.) Based on complaint #MD00137651 allegation dated 2/2/19 from the Hagerstown Police department documented; .Room (#118) was in deplorable conditions and it appeared the facility was under staffed. I observed several call lights on while I was on the scene and only two individuals appeared to be taking care of things. There were multiple instances of residents and family concerns of staff not responding to call lights/bells and not timely meeting residents request. 3.) Resident #8 stated on 3/20/19 at 8:15 AM sometimes takes about 1.5 hours to get call bell answered. Resident #8 implied that s/he is dependent on staff to get up and s/he is an early bird but sometimes is not assisted out of bed until just before lunch. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4.) Resident #102 stated on 3/20/19 at 8:56 AM they are short staffed often; especially on weekends .you better just forget anything you want done .morning shifts on the weekends are the worse. 5.) Resident #60 stated on 3/20/19 at 9:29 AM; We wait for what seems like hours .I don't like to urinate on myself but that is what happens when they don't come in time. The aides give excuses, short staff 6.) Resident #108 stated on 3/20/19 at 11:16 AM; they don't answer call lights like they should .it has gotten bad the last 5 months . I'm to get a bath twice a week but sometimes I only get one. Resident #108's spouse indicated that resident #108 is left in stool for long periods of time. 7.) Resident #119 stated on 3/20/19 at 11:21 AM They're short staffed a lot .I'm glad I don't need a lot from staff .the weekends are the worse. 8.) Resident #6 stated on 3/20/19 at 12:16 PM sometimes not enough help at night. 9.) Resident #86 indicated on 3/20/19 at 12:59 PM, that staff takes a long time to respond. 10.) Resident #17 indicated on 3/21/19 at 10:34, that night shift staff are slow to respond to call lights and further indicatied that is seems like it takes hours. 11.) An interview with resident #76 on 3/21/19 at 10:34 AM, revealed that the resident has to wait 35 minutes or longer for staff to answer the call light when he/she has to go to the bathroom. The resident stated that sometimes he/she has accidents wets themselves. The resident stated that he/she feels awful when that happens. The resident also stated that staff sometimes comes in, turns the call light off and walks out without finding out what the resident needed. 12.) Resident #70 indicated on 3/21/19 at 10:46 AM, the call light responses often takes about a half hour for response. Long waits occur all the time on no particular shifts or days. 13.) Resident #90 stated on 3/21/19 at 11:10 AM, There is not enough staff .sometimes there's 3 GNA's (Geriatric nurse aide) working that's not enough. Sometimes have to wait a really long time to get call bell answered. 14.) Resident #122 indicated on 3/21/19 at 1:25 PM, It takes a long time for staff to answer call bells, quickest was probably 15 minutes. Resident further indicated that s/he has waited up to about 45 minutes at times. The waits occur on no particular days or times. 15.) Resident #174 stated on 3/21/19 at 1:49 PM, staff are respectful, but movement is too slow for response. You can't put somebody on a bedside commode and tell them to push call bell and then not come back. They don't want you to get up, but you have to wait for them. 16.) An interview with Resident #2, on 3/26/19 at 11:33 AM, revealed the resident was tearful because staff had not given her a bath on Friday and stated he/she was told they would not have time to give one that day. 17.) Random Interviews with staff during the survey revealed the following; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/22/19 at 08:59 AM, during a brief discussion staff #40 acknowledge having over 30 residents to administer medications. Staff #40 indicated the s/he never had that many residents for a case load at previous facility worked. 18.) An interview conducted with staff # 17 on 3/26/19 at 9:43 AM, revealed that the residents are not getting their restorative nursing done because the restorative nurses are working on the hall with a full load of patients, due to being short staffed. The restorative nurses work with residents on both floors. 19.) On 3/26/19 at 12:31 PM, the unit manager (staff #50) was asked; How often are you pulled into count? and s/he responded, every day. 20.) On 3/27/19 at 12:12 PM staff #40 was asked. Are the first round of medication administration ever finished before beginning the next round? with staff #40 responding No, I'm on the cart all the time, I feel like a medication aide and not a nurse. 19.) An interview conducted with staff #20 on 3/28/19 at 8:27 AM, revealed that the second floor had only 2 nurses and an aide for the overnight shift and the other aide was utilized for a 1 to 1. Staff #20 indicated that s/he does not fell the residents get the care they deserve. 20.) On 3/28/19 at 8:55 AM, during an interview with staff #53, it was revealed that residents on Unit 1 were not receiving the care that they needed which included: being turned and repositioned every 2 hours, their attends changed every 2 hours, or getting a shower on their scheduled day. Staff #5 stated he/she has not had to work under these conditions in his/her career. He/she reported he/she will lose their job for having spoken out, but it has been terrible here. Stated the odd side of the hallway has several dependent residents with at least 13 residents that required a mechanical lift. 21.) In an interview conducted on 3/28/19 at 9:00 AM with staff members #16 and #17, the staff members stated that they can't always get resident #86 up due to working short staff, but they felt that resident #86 seemed to not holler out as much when out of bed for some of the activities. 22.) On 3/28/19 at 09:08 AM, an interview with staff #16, 17, and 19 revealed that they were told they would lose their jobs if they talked with State surveyors. They all stated they are short of staff; the residents aren't getting the care they need and that showers were not getting done. 23.) An interview on 3/28/19 at 11:45 AM, with staff members #18 and #15 revealed that they do not get resident #86 out of bed due to low staffing. Staffing sheets for the nursing staff in the facility were reviewed for the weekend of 3/23 and 3/24/19. The review revealed that that, on 3/23 the facility maintained a level of 1.89 nursing hours per patient day (PPD) based on the number of beds the facility was licensed for, which is lower than the Maryland state requirement of 2.0. The PPD for 3/24/19 was calculated to be 1.94.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 15701 Base on random review of staff postings, and comparison to other daily staffing sheets, it was determined that the facility failed to accurately document staff posting, including the correct census at the beginning of each shift. This was exemplified by a review of 5 Federal staffing sheets with 3 days found to be inaccurate for the actual hours worked by licensed and unlicensed staff. The findings include. The Federal staffing sheets were found to be displayed on a bulletin board on the ground level of the facility across from the administrator's office. The staffing sheets were prepared once per day for all three shifts. The staffing for 2/2/19 was requested. Comparison of the daily staffing sheets with employee's name to the Federal staff sheets found discrepancies. The census for the day was posted once for the whole day and did not reflect changes related to discharges or new admissions (there was at least one discharge for evening shift on 2/2/19) The day shift listed 40 hours to mean a total of 5 Licensed Practical Nurses (LPN) on Day shift, but only 4 LPNS were identified on the daily staffing sheet with the employee names. The staffing sheets for 2/2/19 indicated thst one of the nurses had called out for day shift. Actual hours worked by Geriatric nursing aides/Certified nurse aides (GNA/CNA) displayed 64 hours for 8.5 GNA's. The daily staffing sheet had two GNA's crossed off the sheet, and only indicated that there were 6.5 GNA's listed for duty that day. For evening shift, the daily staff sheet indicated that an LPN worked half the shift, leaving at 6:30 PM, but the Federal staffing sheet indicated 16 hours of LPN's for the entire shift. The Federal staffing sheet posted 1.5 hours of RN's, but only one RN was listed on the staffing sheet. The facility created a fourth category and listed 1 Certified medication aide for evening shift, however, it is not a Federal requirement to make a separate category for a certified medication aide (CMA). The daily staffing sheets with employee names did not differentiate the nurses as an RN or an LPN. The two-week master RN and LPN schedules did not differentiate the nursing staff either. A list of all nursing staff 's names and titles was requested and received on 3/28/19 to aid in determining the actual hours worked for RNs and LPNs Review of the day shifts daily staffing sheets revealed 4 LPN names for day shift 2/24/19. The Federal staffing sheet indicated 3 LPNs and 1 RN. The names on the daily staffing sheets for 2/24/19 did not indicate which nurse was an RN on duty for the day. Review of the daily staffing sheets for 3/26/19 revealed that 2 nurses and 4 GNA's had called in. (names were crossed off the sheets). The daily sheets indicated that the nurse health coordinator nurse was pulled into count that day. The Federal staffing sheet indicated tht an RN was on day shift and that nurse was not identified on the daily staffing sheets. Evening shift for 3/26/19 indicated 32 actual hours worked for LPNs or 4 LPNs and no hours for RNs. The staffing sheets indicated 3 LPNs and 1 RN. The evening shift number for GNA's was 12 for 90 actual hours worked. The tally per daily staffing sheet review was only 10 GNA's (including a CMA) as there was two GNA's crossed off. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing staff scheduler (Staff # 32) was interviewed on 3/28/19 at 2:10 PM. The scheduler indicated that s/he provided the count for the staffing posting downstairs. S/he fills out the form in the morning for the Federal staff sheets that are posted on the ground floor. During the discussion, s/he identified nurses as RN's that were LPN's. S/he acknowledge having to change the Federal staffing sheet for 3/28/19 as s/he has previously identified LPNs as RNs.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Deficiency Text Not Available

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 31145 Based on medical record review and staff interview, it was determined that the pharmacist failed to identify excessive medication doses being administered to a resident who was to have medications tapered. This was evident for 1 (#20) of 3 residents reviewed for medical record accuracy. The findings include: Review of Resident #20's medical record on 7/24/19 revealed a handwritten physician's order for the medication Aricept to be given every other day for 2 weeks and then discontinued. A 6/27/19 physician's progress note documented the plan to taper Aricept. Review of Resident #20's June 2019 Medication Administration Record (MAR) documented that the resident received Aricept on 6/27/19, 6/28, 6/29 and 6/30/19 at 8:00 AM and on 6/27/19 at 3:39 PM and 6/29/19 at 3:50 PM. Review of the July 2019 MAR documented that the resident received Aricept on 7/1, 7/2 and 7/3 at 8:00 AM and then twice per day,at from 7/4/19 to 7/17/19 at 8:00 AM and 5:00 PM and then received a dose on 7/18, 7/20, 7/22 and 7/24 at 8:00 AM. The order was transcribed incorrectly, therefore the Aricept was not tapered. The resident received extra doses of Aricept. Resident #20's physician's orders and MAR were reviewed with the Nurse Practitioner (NP) on 7/24/19 at 12:20 PM. The NP confirmed that it was an error and the resident should have only received the Aricept every other day beginning on 6/27/19 and then after the 2 weeks, Aricept should have been discontinued. Further review of the medical record revealed a physician's order, written by the NP on 7/10/19, for Zantac 150 mg to be given every other day for 14 days and then discontinued. Review of Resident #20's July 2019 MAR revealed that the resident continued to receive Zantac 150 mg every evening at 8 PM and received additional doses of Zantac beginning on 7/10/19 every other day until 7/23/19. The NP confirmed on 7/24/19 at 12:20 PM that the Zantac was to be tapered and the resident was not to receive additional doses. The pharmacist did a medication review on 7/24/19 at 12:09 PM and failed to identify the excessive doses that the resident received. The Director of Nursing was advised of the medication issues on 7/24/19 at 1:40 PM.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37585 Based on observation, it was determined that the facility failed to ensure that the medication error rate was not greater than 5%. This was evident from observations made during the medication administration observation facility task. The findings include: Over the course of the survey, 28 medications were observed during the medication administration observation task. Of these 28 medications, errors were made during the administration of 2 of the medications, resulting in a medication error rate of 7.14%. During an observation of medication administration that took place on 3/26/19 at 8:45 AM, Licensed Practical Nurse (LPN) #11 was observed preparing and administering two medications intramuscularly to Resident #76. One medication was 4 mililiters (mL) of a steroidal anti inflammatory and the other was 4 mL of a diuretic. LPN #11 prepared 2 syringes containing 2 mL of medication for each of the medications and took these 4 syringes into the resident's room. LPN #11 asked the resident whether s/he would like the medications administered into the deltoid or into the buttocks and the resident chose the deltoid. LPN #11 then injected two syringes of medication into each deltoid, resulting in a total of 4 mL of fluid being injected into each. During the survey, the Staff Educator identified [NAME] & [NAME] as the resource used for nursing staff education. Review of intramuscular injection recommendations into the deltoid muscle from [[NAME], P. A., [NAME], A. G., Hall, A., & Stockert, P. A. (2017) Fundamentals of Nursing. Ninth edition. St. Louis, Mo.: Mosby Elsevier.] is for no greater than 2 mL of fluid be injected into the deltoid site. It is also a standard of nursing practice to minimize the number of needlesticks that a resident receives. The 4 mL that Resident #76 received in each of his/her deltoids could have been administered in one injection instead of two.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Deficiency Text Not Available

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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. 37585 Based on observation and interview with facility staff, it was determined that the facility failed to store medications in a manner that protected the medications during storage. This was evident for 1 (2nd floor) of 2 medication storage rooms. The findings include: Medications requiring specific refrigeration temperatures are at risk for breaking down or for changing in their effectiveness when exposed to temperatures that are either too high or too low. Insulin is known to be particularly sensitive to colder temperatures and can become ineffective at lowering blood sugar levels if the insulin is frozen (drops below 32 Fahrenheit). After review of the recommendations of the three manufacturers of insulin in the United States (Lilly, Sanofi-Aventis, and Novo Nordisk), all unopened insulin should be stored between 36 and 46 Fahrenheit (F) and no insulin should be used if it has been exposed to freezing temperatures. During an observation of the 2nd floor medication storage room that took place on 3/20/19 at 7:21 AM, it was noted that the medication refrigerator was measuring 22 degrees F. This was determined by observation of the internal refrigerator and in the presence of Staff #11. The refrigeration temperature logs were also reviewed. Only the month of March, 2019, was provided for the survey team. This log showed that staff had documented that the 2nd floor refrigerator had maintained a temperature of less than 24 degrees F. The top of the temperature log indicated that the refrigerator temperature should be between 36 - 46 degrees F. Review of the contents of the refrigerator in the presence of Staff #11 revealed various ophthalmic products, acetaminophen suppositories, and three varieties of insulin in vial and pen formulation. The Director of Nursing (DON) was interviewed on 4/1/19 regarding the frozen insulin and other medication products. The DON stated that all products in that refrigerator had been disposed of following surveyor identification of freezing temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 15701 Based on observations of the facility's kitchen and food services, it was determined that the facility failed to maintain food service equipment in a manner that ensured sanitary food service operations and failed to utilize appropriate hair restraints for employees preparing meals for residents. This was identified during multiple observations of the facility's kitchen and food services operation. The findings include. Observation of the food service operation in the kitchen on 3/25/2019 at 12:15 PM, revealed that a dietary employee (staff #43) with a goatee was working the tray line without a hair restraint covering beard/goatee. The certified dietary manager (CDM) staff #4 was in the kitchen during the meal service operation. The CDM also had exposed facial hair and was asked if the facility had hair/beard restraints/shields? Staff #43 was observed preparing meal plates to all the residents in the dining room without a beard restraint/protector at 12:30 PM. The person-in-charge failed to ensure that effective hair restraints were utilized to keep hair from contacting food and food contact surfaces. On 03/27/19 at 09:50 AM, observation of the dish machine revealed that the wash temp was stationary at 146 degrees Fahrenheit. The dietary manger was alerted, and he observed the same. The wash water temperature gauge remained steady at 146 degrees Fahrenheit while dietary employees continued to put dishware into the dish washing machine. The manufacture's plaque on the machine indicated that the minimal wash temperature is to be 160 degrees Fahrenheit. Review of the Dish Machine Log for March 2019 revealed that the wash temperature for the dinner time operation was less than 160 degrees Fahrenheit for the entire month. Additionally, the Dish Machine log indicated that the staff was recording a chemical sanitizing level of 200 parts per million or greater. The dish washing machine was a hot water sanitizing machine that did not have any chemical sanitation attached and running into the machine. Staff were observed washing dishware for the lunch dishes at 1:55 PM with the wash temperature gauge at 138 degrees Fahrenheit without a recording of the wash temperature on the dish machine log. The person-in-charge failed to ensure that the manufacturers specifications for wash water temperature of at least 160 degrees Fahrenheit was maintained.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 31982 Based on review of facility records and interview with staff, it was determined that the facility failed to document a facility-wide assessment that included staff competencies that were necessary to provide the level and types of care needed for the resident population. This was evident during sufficient staffing review. The findings include: During an interview on 4/5/19 at 2:40 PM, the facility's Acting Administrator (staff #1) indicated that he/she did not have access to Relias (a program used to provide staff training). The Facility Assessment was reviewed on 4/5/19 at 4:10 PM and revealed that the section related to staff competencies for meeting the needs of each resident was blank. The Acting Administrator confirmed this finding and stated, all we have to do is pull it up in Relias. He/She was asked to provide the surveyor with the staff competency information, however it was not provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37585 Based on review of medical record and interview with facility staff, it was determined that the facility failed to ensure that resident's medical records were maintained in an accurate and complete manner. This was evident for 5(Residents #53, #109, #178, #82, #122) of 40 residents reviewed during the investigation phase of the survey. The findings include: 1) Resident #53's medical record was reviewed on [DATE] at 1:45 PM. During the review of the paper medical record, a form called the MOLST form (Maryland Orders for Life Sustaining Treatment) was found that had been completed for the resident. The MOLST form contains physician orders for treatment that the resident wishes performed in the case of cardiac arrest. Resident #53's MOLST form reflected that the resident did not wish to have cardiopulmonary resuscitation (CPR) performed in the event of cardiac arrest. The MOLST form was dated February, 2019. During contemporaneous review of the resident's electronic medical record, an electronic order was found for CPR to be performed in the event of cardiac arrest. The date of the order preceded the date of the above MOLST form. The Director of Nursing (DON) was interviewed on [DATE] at 2:15 PM. During the interview, the DON stated that the MOLST was correct for the resident and was based on the resident's current wishes. The DON stated that the electronic order had failed to be updated when the resident's MOLST changed. 2) Resident #109's medical record was reviewed on [DATE] at 1:02 PM. During the review of the paper medical record, a pharmacy medication management record sheet was found that indicated the consultant pharmacist had made a recommendation in the most recent record review. However, the actual recommendation could not be found in the medical record. When this was brought to the attention of the Director of Nursing (DON), the DON was able to produce the recommendation from his/her own records. The recommendation had been documented and responded to correctly, however was not being maintained in the resident's medical record. 37276 3) On [DATE], a review of Resident #82's medical record was conducted and revealed that, on [DATE], in a progress note, the physician documented that Resident #82's history of present illness included still has swelling of legs and the physician's assessment/plan documentation included Increase Lasix (Furosemide) (diuretic) to 40 mg in AM. Continue Lasix 20 mg in PM. Review of Resident #82's physician orders in the resident's paper chart revealed, on [DATE], the physician hand wrote orders that included Increase Lasix to 40 mg in AM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #82's March MAR (medication administration record) revealed an order for Lasix 20 mg by mouth, that was documented as given twice a day, [DATE]st through [DATE]; the order was discontinued on [DATE]. There was an order initiated on [DATE] to give Lasix 20 mg by mouth two times a day for edema until [DATE], an order for Lasix 40 mg by mouth one time a day for edema, to start on [DATE] and an order for Lasix 20 mg by mouth once a day in the evening for edema, to start on [DATE]. The facility staff failed to correctly transcribe Resident #82's [DATE] physician's order to increase the resident's Lasix to 40 mg in the AM which would have started on [DATE]. On [DATE] at 3:15 PM, during an interview, the unit manager (saff #50) confirmed the above findings. 4) On [DATE], a review of Resident #178's medical record was conducted and documented the resident was admitted to the facility in late [DATE] following discharge from an acute care facility where he/she had been treated for a wound infection. Review of Resident #178's hospital discharge summary indicated that Resident #178 was to receive Ampicillin/Sulbactam (antibiotic) 3 grams intravenously (IV) every 6 hours for 20 days. Review of Resident #178's [DATE] MAR (medication administration record) revealed an order for Ampicillin/Sulbactam Sodium Solution Reconstituted 3 grams, inject 3 gram intramuscularly (IM) every 6 hours for cellulitis and documented that Resident #178 received the medication IM for 1 dose on [DATE] and for 3 doses on [DATE]. The order was discontinued on [DATE] at 5:03 PM. Continued review of the MAR revealed an order for Ampicillin/Sulbactam Sodium Solution Reconstituted 3 grams intravenously every 6 hours for Cellulitis for 18 days that that documented Resident #178 received the medication IV 4 times a day from [DATE] through [DATE]. Continued review of the medical record failed to reveal documentation that the physician ordered the Ampicillin/Sulbactam Sodium Solution to be given intramuscularly. On [DATE] in a progress note, the physician documented that Resident #178 was in the facility for IV antibiotic. The facility staff failed to transcribe a physician's order as prescribed. On [DATE] at 4:13 PM, the Director of Nurses was made aware of these findings and confirmed the above findings. 31982 5) During a review of Resident #122's record on [DATE] at 8:53 AM, a plan of care for an indwelling suprapubic catheter (a catheter that is surgically placed into the urinary bladder through the abdominal wall) was noted . Further review of the record failed to reveal any other documentation to support that the resident's urinary catheter was suprapubic. The DON was made aware of these findings and confirmed that the plan of care inaccurately identified the residents urinary catheter as suprapubic.

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	215336	A. Building B. Wing	04/08/2019

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31982 Based on review of the facility's last recertification and complaint surveys, deficient practices identified during the current survey and interview with facility staff, it was determined that the facility was noted to have an ineffective Quality Assurance and Performance Improvement (QAPI) program by failing to monitor measures that were developed to correct deficient practices. This was evident during Quality Assurance review. The findings include: A MOLST(Maryland Orders for Life Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. It includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. The medical record of Resident #327, a hospice patient, was reviewed on 4/3/2019 at 11:25 AM. The record revealed that the facility failed to ensure that a clear and accurate MOLST form was present in the medical record that reflected the Resident's wishes for life sustaining treatment. Review of a complaint survey conducted 7/27/18 - 8/8/18 revealed that the same deficient practice was identified and plan of correction was developed and accepted by the state agency. The measures the facility developed to monitor their corrective action was Social Services to complete audit on new hospice residents MOLST, voided MOLSTS, incapacity certifications and surrogacy decision making as it relates to the MOLST for 3 months to ensure appropriateness and accuracy. The results of these audits will be forwarded to the QAPI committee for review and recommendations x 3 months. The On 4/4/19 at 10:25 AM, the surveyor requested copies of the audits and QAPI program follow up information. The documentation revealed 1 Advance Directive Audit of 90 residents conducted over 9/5/18, 9/7/18 and an unknown date. The audit did not contain voided MOLST information for 86 out of 90 residents and did not reflect which residents were new Hospice residents. No further audits and no QAPI follow up or recommendations were provided. During an interview at that time, Staff #2 was unable to identify who completed the audit and indicated that an action plan was done by the Social Worker,however ,no action plan was provided to the surveyor. During an interview on 4/8/19 at 10:14 AM, Staff #31 indicated that he/she did not work at the facility in August and did not know where any additional audits would be. The facility failed to monitor the corrective measures they developed to address the deficient practice identified during the complaint survey. This resulted in the recurrence of the same deficient practice.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 31982 Based on review of facility records it was determined the facility failed to ensure that the required committee members attended the quality assessment and assurance meetings quarterly. This was evident during review of the quality assessment and assurance review. The findings include: The QAPI committee sign in sheets from April 2018 to present were reviewed on 4/5/19 at 3:47 PM. The facility had sign in sheets for monthly meetings as required by the Code of Maryland Regulations, however the sign in sheets for 8/2018 and 3/2019 meetings were missing. The sign in sheets for 1/2019 and 2/2019 revealed the Medical Director was not present at those meetings. During an interview at that time the Administrator was made aware of the above findings and indicated that the 3/2019 meeting was not held because the survey was in progress. She indicated that the DON could not find the sign in sheet for 8/2018 but it was OK since (a meeting) only had to be held quarterly. The Medical Director was not present 1/2019, 2/2019 and no meeting was held 3/2019 therefore the Medical Director failed to attend a quarterly QAPI meeting during the first quarter of 2019.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on surveyor observation, it was determined that the facility staff failed to maintain an effective infection control program by failing to ensure that resident care equipment and supplies were maintained in a in a manner to minimize the resident's exposure to infectious organisms. This was evident for 5 (#122, #29, 84, #96, #4) of 34 residents on both floors of the facility observed during the initial pool selection. These practices have the potential to affect all residents, staff, visitors, and volunteers in the facility. The findings include: 1.) Resident #122 was observed on 3/20/19 at 10:19 AM sitting in a wheelchair at his/her bedside. A urinary catheter drainage bag was lying directly on the floor beneath the resident's wheelchair. 2.) The surveyor observed Resident #29's bathroom on 3/20/19 at 10:52 AM. A pink fracture bed pan (a wedge shaped bed pan) and an open package of depends undergarments were lying directly on the floor to the right of the toilet. Neither were stored in a manner to minimize contact with potentially harmful organisms. The bed pan was not labeled to ensure it was not used for more than one resident. 3.) On 3/21/19 at 1:41 PM, the surveyor observed the bathroom for room [ROOM NUMBER]. The toilet seat had numerous dark brown spots, a ball of toilet paper with brown spots was on the floor to the left of the toilet. 2 graduated measuring containers were on the toilet tank and weren't labeled as to whom they belonged. 40927 4.) On 3/21/19 at 9:41 AM, an observation of Resident #84 room was made during an initial tour of the facility. The resident's room had a dark brown, raised substance adhered to the wall next to the sink and under the sink. There was no trash bag in the trashcan under the sink. Trash can had a dried dark brown, raised substance on the inside around the top half of trashcan. There was a sheet rolled up on the floor behind the trashcan and a pair gloves lying on the floor. There was other debris noted on the floor, such as food and straw wrappers and napkins. 5.) During an interview on 3/21/19 at 9:41 AM with Staff #5, a dirty attends rolled on a white sheet was noted. He/she stated so this is what they are doing now. Staff #5 had come into the room and he/she stated he/she does not know what the other aides were doing, but he/she would not have discarded it in that manner. 6.) An observation was made on Unit 1 on 3/28/19 at 1:35 PM; staff #38 was passing ice water to residents. He/she was observed in a resident's room to retrieve ice water cups and the ice chest was wide open exposing the ice. During an interview with staff #38 on 3/28/19 at 1:35 PM, it was revealed that he/she knew the ice chest should be closed unless in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7.) An interview with Resident # 90 on 3/30/19 at 7:33 AM revealed that there was an issue with mice in the room. Observation revealed mouse droppings near a chair leading back to the wall. Also, a drawer in the bedside stand belonging to Resident #4 had a large amount of mouse droppings almost covering the bottom. On 3/28/19 at 2:58 PM, Director of Nursing was made aware of the findings.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on surveyor observation and interview with facility staff, it was determined that the facility staff failed to ensure that residents had a means of directly contacting caregivers by failing to ensure the call bell system was operational for each resident. This was evident for 1 of 32 resident rooms observed on the second floor of the facility. The findings include: During an observation of room [ROOM NUMBER] on 3/20/19 at 8:35 AM, the surveyor attempted to test the call bell for the first bed by pressing the activation button. The light in the hallway above the room door failed to light when the button was pressed. A test of the call light for the second and third beds in the room also failed to activate the light in the hallway. The staff developer (Staff #44) was made aware and confirmed these findings.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on observation, record review, staff and resident interview, it was determined that the facility failed to maintain an effective pest control program. This was evident for 2 of 2 nursing units. The findings include: 1.) An interview with Resident #96 on 3/20/19 at 7:33 AM, revealed that there was an issue with mice in the room. An observation made during this time, revealed mouse droppings near a chair and leading back to the wall. Also, He/she revealed a drawer in the bedside stand that belonged to Resident #4 that had a large amount of mouse droppings almost covering the bottom. 2.) The surveyor observed room [ROOM NUMBER] on 3/20/19 at 8:11 AM. Rice cereal and sunflower seed shells were scattered on the overbed table and the floor to the right of the first bed and a cardboard saltine cracker box was under the head of the bed. One of the 3 residents who reside in the room indicated at that time that a couple of mice had been caught in the room and that, on one occasion, 2 mice ran out from under a box when an aide picked it up from his/her nightstand. Another resident in the room confirmed that he/she had observed mice in the room on several occasions as well. 3.) On 3/20/19 at 8:59 AM, during an interview, when asked if the resident felt his/her room and building were clean and comfortable, Resident #102 stated we have mice; we have one that likes to come out & play at night. Resident #102 stated he/she saw one last night and indicated it came out from under the heater. 4.) A record review of the Pest Sighting Log conducted on 3/22/19 at 3:11 PM, revealed mice were reported on 4/12/18 in room [ROOM NUMBER]; 12/10/18, in rooms 105,110, 106, 104, and 101; and on 1/23/19 in rooms [ROOM NUMBERS]. 5.) An interview on 3/22/19 at 3:18 PM, with the Administrator (NHA) and Maintenance Supervisor staff #51, revealed they were unaware that there was a current issue with mice. Reported that they had purchase a bin to place outside for bird seed storage instead of allowing residents to keep it in their rooms. 6.) On 3/22/19 at 3:41 PM, an interview with staff #50 regarding the mice, revealed it was a known issue on the unit. Stated he/she communicated the issues to staff #51 either verbally or through a computer system Tels. 7.) On 3/22/19 at 3:59 PM, an interview with Resident #2 revealed that Staff #51 had been supplying him/her with sticky traps to place under a chair and heater in his/her room. He/she reported they have caught 6 mice in the last month and staff had been discarding them. At the time of the interview, mice droppings were observed by the heater and in the corner next to the doorway. 3/22/19 at 4:00 PM, the NHA observed the findings in this room and in resident #96's room.