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	215092	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collingswood Rehabilitation and Healthcare Center	299 Hurley Avenue Rockville, MD 20850

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and interviews with staff, it was determined that the facility failed to attend to and answer call bells in a timely manner for dependent residents (Resident #149). This was evident during a tour of the first floor when a call bell was observed to be active and was subsequently validated during the recertification/complaint survey.The findings include: During a tour of the facility on 8/08/25, at 12:50 PM, a call bell screen on the 1 [NAME] unit showed that a call bell from Room [number of the room] had been active for 113 minutes. When the surveyor asked Staff #14 (a nurse) about the screen, she confirmed that the call had been on for 113 minutes. She added, someone is working on fixing something in that room.The surveyor immediately checked the room and found only Resident #149 lying in the bed. No other staff were present, and there was no evidence of a construction procedure. The resident was vulnerable, with a tracheostomy and tube feeding. While the surveyor was in the room, Staff #26 (Geriatric Nursing Aide) entered. After Staff #26 exited the room, the surveyor interviewed him. Staff #26 stated, the resident [Resident #149] pushed the call bell by accident; he/she did not need help. The surveyor asked how Staff #26 communicated with the resident. Staff #26 stated that he was able to communicate through the resident's facial expressions since the resident was non-verbal. He also assumed the bell was pushed accidentally since it was located under the resident's elbow.In an interview with the Director of Nursing (DON) on 8/08/25, at approximately 2:00 PM, the DON confirmed that the facility had a call bell screen only on the 1 [NAME] unit (ventilator unit). She said, since we have residents who use ventilators, we have a call bell screen on the unit. We expect nurses to respond to the call bell immediately. The surveyor shared the concern from the observation, and the DON validated it.

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and facility staff interview it was determined that the facility failed to post a notice of the availability of survey results in a prominent, publicly accessible location. This was evident for all residents and visitors of the facility.The findings include:During this annual survey from 7/31/25 to 8/8/25, surveyors noted that no state inspection results or notices were found in the lobby or other public areas. A tour of the facility confirmed no signs were posted directing residents and visitors to the location of these results.On 8/07/25 around 11 AM, a group interview with seven residents (Resident #3, #13, #23, #31, #34, #66, and #135) revealed that none were aware of their right to review survey results or that the results should be publicly accessible. They also did not know where the results were located.At 11:33 AM on 8/07/25, two surveyors observed no signage for the survey binder at the reception desk. Staff #45 (receptionist) produced the binder from a location behind the desk, out of public view. When asked about other locations, the staff member was unsure.In an interview with the Director of Nursing (DON) on 8/07/25, at 1:12 PM, she confirmed that the survey binder should be in the lobby with proper signage. The DON acknowledged the surveyors' findings that residents were uninformed and that the binder was not publicly accessible. During an exit conference around 3 PM on 8/8/25, the DON stated that the facility staff immediately replaced the signage for the survey results right after the surveyors provided feedback.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with facility staff, it was determined that the facility failed to notify the resident's physician and/or responsible party (RP) following an accident/change in condition. This was evident for 1 of 3 residents (Resident #160) reviewed for urinary catheters during the facility's recertification survey. The findings include:An indwelling urinary catheter, often referred to as a Foley catheter, is a flexible tube inserted into a patient's urethra (the tube that carries urine from the bladder to the outside of the body) and remains in place to collect the urine into a drainage bag. Urinary catheters can be ordered for several reasons such as urinary incontinence (leaking urine or unable to control when you urinate), urinary retention (being unable to empty your bladder), during and/or after a surgery, or related to other medical conditions such as a spinal cord injury. However, urinary catheters are associated with an increased risk of urinary tract infections (UTI) as well as other adverse events and should be used only when clinically indicated and ordered by a physician.In an interview with Resident #160's RP on 7/31/25 at 2:04 PM, they stated when they came yesterday Resident #160 was feeling bad. During the interview they stated, yesterday something happened, right now he/she is not going to the bathroom on his/her own. He/she has a Foley catheter, and we do not know what happened, maybe he/she disconnected the catheter, but it got disconnected. On 7/31/25 at 1:48PM record review revealed Resident #160 was admitted [DATE] with a Foley catheter and diagnoses including, but not limited to, obstructive and reflux uropathy, neuromuscular, dysfunction of bladder, other specified disorders of bladder, cognitive communication deficit, and unspecified dementia. Further review of the medical record revealed the following care plan: Focus: I have an indwelling urinary catheter r/t urinary retention. Date Initiated: 07/26/2025. Goal: I will be free from catheter related trauma and infections through the review date. Date Initiated: 07/26/2025. Interventions/Tasks: Monitor/record/report pain/discomfort due to urinary catheter. Date Initiated: 07/27/2025. Monitor for signs and symptoms of UTI, such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Report abnormal findings to Practitioner, Document findings and interventions. Date Initiated: 07/26/2025On 8/4/25 at 4:01 PM in an interview with Licensed Practical Nurse (LPN #17) when asked about the incident with Resident #160 and his/her Foley catheter, she stated she emptied his/her Foley catheter around 6:00 AM. During the interview she stated she went to change the other bed [resident] in Resident #160's room at almost 7:00 AM and saw Resident #160's Foley catheter on the floor. When asked if she notified anyone, she stated she let the morning nurse, LPN # 4, know that the patient had pulled out the Foley, that he/she had voided, and that she had documented the amount [of urine]. When asked if she notified any providers, she stated no because she told LPN #4 about it so he would reinsert it. When asked if she notified the resident's RP she stated, I did not tell anyone I just handed over to LPN # 4 and gave report for him to follow up. Resident #160's medical record was reviewed on 8/1/25 at 9:52 AM. The review revealed a progress note from 7/29/25 6:02 AM that documented, Resident is post admission remains in bed sleeping foley intact and draining well amount 500ml (milliliters) amber urine obtained no complaint voiced out. However, the review failed to show that a provider was notified by LPN #17 after Resident #160's Foley came out.On 8/5/25 at 7:34 AM the Director of Nursing (DON) was interviewed. During the interview when asked what the expectations were if during their shift a nurse found a foley on the floor and no longer inserted into a resident, she stated notify the provider and family member to let them know it came out and what we are going to do. The facility's policy entitled Indwelling (Foley) Catheter Insertion, Male Resident was reviewed on 8/5/25 at 8:41 AM. The review revealed the following statement: Notify the physician of any abnormalities (i.e. pain, bleeding, obstruction, etc.).

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on resident and staff interviews, review of Resident Council Minutes/facility documents, and observation, it was determined that the facility failed to: address grievances from the Resident Council meeting, inform staff and residents of the Grievance Process (including how to file concerns or grievances), and have resolutions to grievances/concerns to include notifying residents regarding a resolution. This was evident for 5 of 6 months of Resident Council meetings reviewed the recertification/complaint survey. The findings include: On 08/06/2025 at 1:54 PM, a review of Resident Council Minutes from January 2025 through July 2025 revealed the following unaddressed concerns:-In January 2025, review of Resident Council minutes revealed a resident's concern regarding staff's unwillingness to provide restroom assistance. There was no evidence that this concern was addressed or that the resident was informed of a resolution.-In February 2025, persistent concerns regarding staff members not responding to a resident's call light and exhibiting impatience during toileting or transferring. There was no indication that the facility addressed these concerns or informed the resident of any resolution.-In April 2025, multiple concerns were unaddressed regarding several issues, including extended call light wait times during weekends and night shifts, the need for improved staff bedside manners, functionality of call lights, and difficulties obtaining necessary supplies or receipts from the facility.-In June 2025, the concerns included: - - Staff Conduct: Loudness during shift changes was a recurring complaint. - - Housekeeping & Environment: Concerns were raised regarding unchanged bedding, filthy shower areas, and housekeeping failing to sweep under residents' beds. Additionally, rooms were reported to have inconsistent air conditioning (either too hot or too cold), and a resident reported a clogged toilet. - - Resident Care & Activities: There were staffing shortages in Activities, leading to cancellations. Furthermore, residents and their family members felt compelled to assist with personal care, such as putting residents to bed or making beds due to concerns about staff timeliness and reliability.-In July 2025, the concerns included slow maintenance response times, extended call light wait times during night shifts, weekend understaffing, poor bedside manner, and non-functional air conditioning units in some rooms leading to high temperatures. Additionally, residents' clothing continued to go missing.A review of Resident Concern forms, provided to the Surveyor by the Facility Administrator on 08/07/2025 at 2:30 PM, revealed five forms from a second Resident Council meeting held in July. Four of the five forms lacked a resident identifier, one form stated it would be addressed at the next scheduled meeting, and for all five forms, there was no evidence that the resolution had been communicated to the resident.On 08/07/2025, at 11:00 AM, during a scheduled resident council meeting that the surveyor held with seven residents present, several concerns were raised regarding concerns not being addressed and a lack of awareness on how to obtain a concern/grievance form. Four of the residents reported that the following concerns had been expressed in previous resident council meetings but had never been addressed by the facility:-Resident #66: Reported call lights not being responded to for over an hour, concerns that have been voiced in previous Resident Council meetings have not been addressed. -Resident #31: Stated a black pant and shirt have been missing for two months with no resolution, and that broken glasses reported three weeks prior remain unfixed.-Resident #23: Reported that facility concerns are not addressed, night shift staff are loud, nothing is done to rectify this, and he has to take his own laundry down to laundry, with clothes often going missing. -Resident #13: Corroborated the issue of slow call light response by stating, Oh yeah we have that problem. During a facility tour and interview with Staff #46 on 08/07/2025, at 12:19 PM, it was observed that there were no visible postings of detailed information on how to file a Grievance or that provided the contact information for the Grievance officer. Staff #46 indicated that residents are instructed to request a Concern form from the nurse. Staff #46 stated that these forms are stored in a clear, upright document holder on a desk in the back office, behind the nurses' station. On 08/07/25, at 12:24 PM, during an interview, Staff #11 stated that if a resident had a concern, he/she would either write a concern form or give it to the resident to write. However, during the interview, Staff #11 had to ask Staff #44 where these forms were kept. During an interview with the Director of Nursing on 08/07/25 at 1:09 PM, the DON stated the facility's Administrator is the Grievance Officer and the Social Worker also serves as the Grievance Officer. During an Interview with the Facility's Social worker on 08/07/2025, at 1:29 PM, he/she stated that information regarding grievance forms are included in the admission packet.During an interview with the Facility's Administrator on 08/08/2025, at 10:26 AM, the Administrator stated the facility had completed a performance improvement plan in July of 2025 because they noticed no concern forms were being generated from the Resident Council

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of medical records and a staff interview, it was determined that the facility failed to provide written notification of its bed-hold policy to the resident or their representative when the resident was transferred to an acute care facility. This was evident for three (Resident #8, #66, and #154) of five residents reviewed who were transferred to an acute care facility.In Maryland, the bed hold policy for long-term care facilities is governed by state regulations and Medicaid guidelines. Nursing homes must provide a written bed hold policy to residents at the time of admission and upon transfer to a hospital or for therapeutic leave. The policy details the duration of the bed hold, the rights of residents to return to the facility, and the the cost of holding the bed. 1) On [DATE], at 1:33 PM, the surveyor reviewed Resident #154's medical records. The records showed that on [DATE], around 4:40 AM, Resident #154 was found unresponsive. Staff initiated CPR and called 911. EMTs arrived around 4:55 AM and took over the resident's care. However, there was no documented bed-hold policy for this transfer. In an interview with Licensed Practical Nurse (LPN) #8 on [DATE], at 8:01 AM, the staff member stated that the facility provides all necessary documentation to the hospital, including the change in condition form, transfer documentation, face sheet, recent orders, and a medication list. When asked whether a bed-hold policy was included, LPN #8 said, I'm not sure about it. We gave all the papers to the EMTs, not the family or residents, unless they requested it. On [DATE], at 10:48 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the bed-hold policy should be part of the electronic transfer documentation and that the business office tracks these policies, with a copy filed in the residents' chart. The surveyor requested evidence that Resident #154 or their responsible party received the bed-hold policy on the date of transfer. At 12:45 PM on [DATE], the DON confirmed that Resident #154's medical record did not contain the bed-hold policy for the transfer. The surveyor shared their concerns, which the DON validated. 2) On [DATE] at 8:30 AM a review of Resident #66's medical record was conducted and revealed that the resident was transferred from the facility to a hospital on [DATE]. There was no notice of bed hold policy found in the paper or electronic record. On [DATE] at 8:35 AM in an interview with the Unit Manager, Staff #11, he/she stated that when a resident is transferred to the hospital, a copy of the bed hold policy will be given to the resident or the resident representative. Staff #11 also stated that a copy would be in the chart, but he/she could not provide a copy of Resident #66's. On [DATE] at 8:47 AM an interview was conducted with Resident #66 who stated that he/she was not given a copy of the behold policy but recalled getting a call during her hospital stay for a payment for bed hold. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on [DATE] at 7:33 AM concerning bed hold policy. The DON stated that when a resident is transferred to the hospital there is a discussion about the bed hold policy, and a copy is given to resident. Surveyor requested a copy of documentation that resident received a copy of the bed hold policy. On [DATE] 8:51AM, the DON stated that she was unable to find any evidence that a bed hold policy was given to the resident during transfer to the hospital. The DON and Administrator were made aware that this was a concern. 3) A review of Resident #8's clinical record revealed the resident was sent to the hospital on [DATE]. Evidence of the resident and/or family being given a copy of the bed hold policy and a notice of the reason for the transfer to the hospital could not be found. This surveyor interviewed the Director of Nursing (DON) on [DATE] and I requested any evidence that the two documents were provided. DON provided a post-it note saying they could not find the bed hold notice. A copy of the notice stating the reason for the transfer was not provided. This surveyor reviewed the above findings with the DON on [DATE] at 5:12 PM. She acknowledged that neither two documents were provided to the resident or family.

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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** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to ensure 1) a baseline care plan was completed and 2) a BLCP summary, including a current list of medications, was provided to the resident and/or resident representative (RP). This was evident for 3 (Resident #54, #160, #2) out of 36 residents reviewed during the investigation phase of the facility's recertification survey.The findings include:A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to each resident and/or his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission. On 7/31/25 at 12:15 PM Resident #2's medical record revealed that he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP.On 7/31/25 at 1:16 PM review of Resident #54's medical record revealed that he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP. On 7/31/25 at 1:48PM review of Resident #160's medical record revealed that he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP.On 8/1/25 at 12:25 PM the Director of Social Services (DSS #1) and Regional Director of Social Work #2 were interviewed about BLCP's. DSS #1 stated when we have a new admission, we do our 48 hour meeting where everyone goes in and introduces themselves to the resident/family. During the interview she stated the BLCP is initiated by nursing, but when we have the Care Navigation Meeting and the corresponding Initial Guide, we print out their care plan and give it to them as their BLCP. When asked who gets a copy of the BLCP, DSS #1 stated the resident and family. DSS #1 was interviewed on 8/5/25 at 8:14 AM. During the interview when asked if the BLCP provided to the resident/RP includes a list of current medications and dietary instructions, she stated yes, we do give them a list of the orders including medications and goals. The surveyor requested a copy of the BLCP for Resident #160 and Resident #54 and evidence from the medical record that it was provided to the resident or RP. On 8/5/25 at 10:05 AM the surveyor requested to the DSS #1 a copy of the BLCP for Resident #2 and evidence from the medical record it was provided to the resident or RP. On 8/5/25 at 10:36 AM the DSS #1 stated that she did not have any of the above documentation the surveyor had requested.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of resident medical records and interview with facility staff, it was determined that the facility failed to hold care plan meetings of the interdisciplinary team for residents at the time of the quarterly revision of their care plan. This was evident for 1 (Resident #54) of 6 residents reviewed during the investigation phase of the facility's recertification survey.The findings include:A care plan is developed for residents to guide the care that they receive in the facility. It should be individualized and outlines the interventions used to address the residents' needs. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team (IDT) including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable).A review of Resident #54's medical record was conducted on 8/4/25 at 11:46 AM. The review revealed that Resident #54 had a quarterly MDS assessment completed on 7/23/25. There was no evidence in the medical record that a care plan meeting had been held with the resident and/or responsible party (RP) and the interdisciplinary team around the time of the quarterly MDS assessment or at the time of care plan revision. On 8/4/25 at 11:53 AM a review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revealed the following: The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS assessment.On 8/5/25 at 8:15 AM in an interview with the Director of Social Services (DSS #1) the surveyor requested any evidence that a care plan meeting had been held for Resident #54 after his/her most recent MDS assessment. On 8/5/25 at 9:54 AM in an interview with the DSS #1, she was unable to provide any evidence of the most recent (July 2025) care plan meeting. During the interview when asked when the most recent care plan meeting should have been held, she stated July 2025. When asked if a care plan held was held in July 2025 for Resident #54 she stated no, she did not see a July care plan meeting was held, but that she could research in her other office to see if they did. Additionally, DSS #1 was asked if she documented after care plan meetings and she stated yes, after care plan meetings we are supposed to write a social services note. We have an assessment, called a care plan review, where we write everything that happened at the meeting. The surveyor again requested any evidence that a care plan meeting was held in July. On 8/5/25 at 10:36 AM in an interview with DSS #1 she verified and confirmed there was no invitation, care plan meeting or other evidence/documentation from July 2025.

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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. Based on medical record review and interviews the facility failed to provide services to maintain hearing. This was evident for 1 of 2 (Resident #3) reviewed for communication difficulty and/or sensory problems (vision and/or hearing) during the recertification/complaint survey.The findings include: On 07/31/2025, at 11:12 AM, Resident #3 was interviewed and stated that he/she had lost their hearing. Resident #3 reported requesting to see an ENT (Ear, Nose, and Throat) a month prior, but the nurse informed him/her that their insurance would not cover the visit.08/06/2025 at 8:15 AM, a review of Resident #3's medical record revealed no indication of an appointment for an ENT examination, nor any care plan addressing hearing difficulties. Further review of Resident #3's medical record progress notes revealed the following:-According to the Nurse Practitioner progress note dated on 06/30/2025, at 10:05 PM, the Nurse Practitioner assessed the resident, who reported left ear complaints and admitted to a hearing change, describing the ear as stuffy. Dark brown, dry, impacted earwax was noted in the left ear.-According to a nurse's progress note dated on 07/2/2025 at 15:37, Debrox Solution 6.5 % Instill 5 drops in left ear two times a day for earwax buildup of Left ear for 4 Days, be delivered by pharmacy. -According to a nurse's progress note dated on 7/2/2025 at 16:15, Physician was notified that Debrox was not available and said to administer when available and to reschedule for the total of 4 days therapy. Patient self RP was made aware. -According to a Physician Progress note on 07/16/2025 at 3:06 PM eardrops have not relieved blockage yet-plan to continue current medications.-On 07/17/2025 a Physician order for Debrox Solution 6.5 % (Carbamide Peroxide) Instill 5 drops in both ears two times a day for earwax buildup for 4 Days.During an interview on 08/06/2025 at 1:21 PM with the DON regarding a resident's request for an ENT consultation, it was confirmed that such an appointment would be external, requiring a physician's order and scheduling by the Unit Clerk. The DON expected follow up for the resident regarding ear wax buildup and hearing loss. It was also verified that the resident had no follow-up or scheduled ENT appointment, despite their request. On 08/07/2025 at 8:57 AM, the DON stated that the resident now had an ENT appointment scheduled for 08/12/2025 at 10:00 AM. The DON confirmed that it was made only after the surveyor raised the concern.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review and staff interviews it was determined the facility failed to implement wound consults timely which resulted in residents not receiving wound care treatments. This was evident for 2 (Resident #63 and #127) of 7 residents reviewed for pressure ulcer/injury during the recertification/complaint survey. The findings include:1) On 08/01/2025, at 8:44 AM, a review of Resident #63's medical record revealed a wound progress note from 02/11/2025, at 5:43 PM. This note, signed by a wound Nurse Practitioner, documented a Stage 4 sacral wound. Recommended treatments included daily (and as needed) cleansing of the wound with wound cleanser, application of Dakins moistened fluffed gauze, and Zinc Oxide Paste to the periwound to the base of the wound, secured with bordered foam and an ABD pad.Continued review of Resident #63's Treatment Administration Record (TAR) revealed a physician's order for sacral wound care. The order, effective from 7:00 AM on 02/07/2025 to 7:08 AM on 02/13/2025, prescribed daily cleansing with normal saline, application of Medihoney, and covering with gauze secured by a border gauze dressing during the day shift. The record was blank, with no treatment administered, on 02/13/2025.Upon further review, Resident #63's TAR showed a physician order start date of 02/14/2025, at 7:00 AM. This was three days after the wound Nurse Practitioner's recommendation to cleanse the wound with wound cleanser, apply Dakins moistened fluffed gauze, Zinc Oxide Paste to the periwound and base of the wound, and secure with bordered foam and an ABD pad, with daily and as-needed changes. An X on the date of 02/13/2025 indicated that this treatment was also not administered on that day. Therefore, the TAR reflected that the resident did not receive any wound care on 02/13/2025. 2) On 08/01/2025 at 9:45 AM, Resident #127's medical record was reviewed. A wound progress note, dated 06/24/2025 and signed by the wound Nurse Practitioner, indicated that the resident had a reopened wound on their left heel. The recommended treatment included daily cleansing with wound cleanser, application of Calcium alginate to the wound base, and securing it with bordered foam, with changes as needed.Continued review of Resident #127's Treatment Administration Record (TAR) showed a physician's order for left heel apply skin prep, abdominal pad, Kerlex every day and evening shift with a start date of 06/21/2025, at 3:00 PM, and a discontinuation date of 06/25/2025, at 1:05 PM. This order was left blank on the day shift of 06/25/2025 and marked with an X on the evening shift.Further review of Resident #127's Treatment Administration Record (TAR) showed that a physician's order for wound care on the left heel, including cleansing with wound cleanser, pat dry, application of calcium alginate, and securing with bordered foam daily and as needed, had a start date of 06/26/2025 at 7:00 AM. This was two days after the wound recommendations were made. Additionally, an X on 06/25/2025 indicated that the resident did not receive wound treatment on that day. Therefore, the TAR reflected that the resident did not receive any wound care on 06/25/2025.During an interview with the Director of Nursing (DON) on 08/05/2025, at 10:39 AM, the DON explained the wound care recommendation process. The Wound Nurse Practitioner discusses recommended wound treatments with the Unit Manager and/or charge nurse, and these recommendations are then sent to the Primary Care Physician for approval. The DON stated that this process is expected to be completed on the same day a treatment recommendation is received. Concerns were validated with the DON regarding delays in residents' wound care recommendations, which resulted in missed wound treatments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, staff interview, and clinical record review it was determined that the facility staff failed to ensure residents were free from accidents by failing to properly educate staff on how to operate a Hoyer lift, and by failing to maintain supervision of residents from the locked dementia unit. This was evident for 3 (Resident #4, #95, #20) of 7 residents reviewed for accidents during the facility's recertification survey.The findings include:The Health Care Decisions Act, which became effective [DATE], applies in all healthcare settings. In Maryland a patient is presumed to have capacity until two physicians certify that the individual lacks the capacity to make healthcare decisions or a court has appointed a guardian of person to make health care decisions. The form in the medical record titled, Physician's Certification of Incapacity to Make an Informed Decision, documents that a physician has examined a resident on a specific date and time and based on that examination finds the resident is unable to make a rational evaluation of the burdens, risks, and benefits of the treatment related to his/her medical condition and is incapable of making an informed decision about the provision, withholding, or withdrawing of the following treatment because of a condition which is then listed on the form. 1) During the initial tour of the facility on [DATE] Resident #4 was determined to be non-interviewable and a review of the clinical record revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 which showed low level of cognitive functioning. As a result, Resident #4's family was interviewed on [DATE] at 12:53 PM. Resident #4's Mother stated that on [DATE] the resident wanted to go outside. The staff (one Geriatric Nursing Assistant (GNA) Staff #51 and a Respiratory Therapist (RT) (Staff #52) got the resident into a Hoyer lift sling that was too big for the resident. When the sling was lifted it caused the resident's chin to tuck into the chest. This blocked the airway. Mother said the resident was turning purple and she yelled for staff to lower the resident down. The GNA, Staff #51, could not or would not lower her. The RT who was at the air unit started to shout to lower the resident. The GNA, Staff #51, still did not lower her. The door was open and the nurse practitioner who was across the hall saw what was happening. She stood up and shouted to lower the resident. The nurse practitioner and another RT came into the room. They started to assist the GNA in getting the resident down. The Hoyer lift appeared to be stuck. They eventually got it to lower the resident, and when they did the resident no longer had a pulse. CPR was started and after 2-4 minutes the resident started to breathe again. The facility told the mother that they had ordered an appropriately sized sling. The facility had not been able to explain to the family what exactly happened, but they speculated it was the battery. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The mother of Resident #4 was interviewed again on [DATE] at 1:30 pm. The surveyor asked if the large size sling has been used since [DATE]. She replied No, they ordered a new but smaller one. This surveyor asked to review the incident for clarification. The mother said that Staff #51 operated the lift by herself. GNA placed sling under the resident. Asked the mother of Resident #4 to go on other side of bed and help apply the four hooks. The mother did and was on that side of the bed when the GNA had the sling lift the resident up and out of the bed. Resident was now in the air and between the foot of the bed and the wall. RT was behind the wheelchair which was located at the resident's feet. Resident started to turn purple secondary to the sling bringing the resident's chin to chest. RT yelled for the GNA to lower the resident. The GNA could not so the RT told her to get the other RT. The GNA turned and left the room. Second RT and Nurse Practitioner entered room. They were able to get resident out of the sling and into the bed. CPR was started and about 20 seconds later, the resident started to breathe again. Mother repeated that Staff #51 operated the lift by herself, and mom has not seen her since [DATE]. The nurse practitioner (Staff #3) was interviewed on [DATE] at 8:43 AM. She was asked about the incident on [DATE]. She said she was sitting at her desk and saw that the resident was in the lift and agitated. The resident shimmied down the sling and had some issues. Staff had some problem with getting the lift down, but she was not sure what exactly was wrong. We got her disconnected. We had to bag her because she was in respiratory distress. There were two Respiratory Therapists and a Geriatric Nursing Assistant (GNA) in the room. Mom was at the bedside and the GNA was operating the lift. The GNA did not leave the room and stayed with the resident. One RT managed the [NAME] bag (Artificial Manual Breathing Unit). She said she could not feel a pulse, so she began chest compressions and the resident quickly recovered. They tried to reconnect the resident to the vent but could not. This surveyor asked if the sling was the appropriate size. Staff #3 said she was not sure if the sling was the appropriate size. She stated that the resident was at a pretty good angle, 45 degrees. She added that the resident's arms and legs were underdeveloped, so she was not sure if that had anything to do with it. Staff #3 said she could see the resident from the hall waving their arms and legs. The Respiratory Therapist Director (Staff #15) was interviewed on [DATE] at 12:19 PM. When asked about the incident, she said the family wanted to put the resident in a geri-chair to go to the living room for activities. Staff needed a Hoyer lift and while the resident was in the air, the resident's trach (tracheotomy opening) became blocked. The resident comes off of the ventilator during the day. The resident was being transferred from the bed to the wheelchair and was off of the vent. Resident became cyanotic (bluish or purplish discoloration to skin) while in the lift. Resident got CPR and was put back on the vent. 911 was called but did not take the resident to the hospital. RT did not directly help with the lift but that was not their job. Their main job was to make sure the airway was patent. This surveyor interviewed Staff #27 on [DATE] at 11:30 AM. She said a private company oversees the Hoyer lifts. She does not remember the Hoyer lift on the first floor having an issue, but it was most likely a rundown battery. This surveyor interviewed the Director of Nursing (DON) on [DATE] at 5:12 PM. This surveyor reviewed the incident with her. She acknowledged the review and the findings. She said she understood that the Hoyer lift did not lower. DON stated she would like this surveyor to review their investigation into the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON provided the investigation binder on [DATE] at 10:00 AM. This surveyor reviewed the investigation binder at 10:15AM. Review of the investigation binder revealed: Resident #4's mother told the facility staff that she wanted the resident to attend activities in the common area. She assisted the GNA in getting the resident up. Mom assisted with hooking the resident up. The RT (Staff #52) was holding the wheelchair. The GNA then lifted the resident up. Mom noticed the resident was agitated, curled in the sling and their face started to change in color. She shouted to put the resident down. The GNA (Staff #51) pressed the button, but it would not go down. RT told the GNA to get help. Staff #3 then entered the room. Staff #51 stated on [DATE] that the mom kept asking for the resident to be taken out of the room. Staff #51 was hesitant because she had never used the Hoyer lift before. Once she saw the resident change color, she tried to lower resident but was not sure she was pressing the right button. She said she tried to lower the sling bag down to the bed, but it would not lower. She said she does not recall if she was pressing the right button because she was so upset. She says at that point another RT and the Nurse Practitioner came into the room and raised the bed to meet the resident. They started to work on [the resident] so she stepped out of the way while this was happening. Staff #52 said in her statement that when she entered the room the resident was already in the Hoyer lift. She placed the venturi mask (type of mask used to deliver precise amount of oxygen to the resident) on the patient at 40% FIO2 (fraction of inspired oxygen/concentration of oxygen) from oxygen support. During the transfer she noticed the resident had become cyanotic. Staff #52 said she immediately instructed the GNA to return the resident to the bed and get a second RT into the room. Once in bed the resident was noted to be unresponsive and without a pulse. Staff #3 was called into the room, and she initiated chest compressions. At the same time, Staff #52 said she began to bag the resident. EMS was called. Before they arrived, the resident regained consciousness. Staff #3 determined that the resident did not need hospitalization. The facility administration responded to the incident by ensuring staff members were educated on several topics including: family cannot help with a Hoyer lift, staff need to know what button does what and to check the battery before use. The resident was assessed and there were no negative outcomes from the incident. 2) On [DATE] at 7:48AM Resident #95 was observed by the surveyor and Assistant Director of Nursing (ADON) off the unit, unattended with no staff member nearby, sitting in his/her wheelchair by the elevator. The surveyor recognized him/her as a resident from the locked dementia unit. The surveyor observed the Assistant Director of Nursing's (ADON) face, and it appeared she did not seem to recognize this. The ADON asked Resident #95 where he/she was going, and the resident stated up. The ADON stated there was not an up [as the 2nd floor was the highest floor in the building]. Shortly after, the ADON again asked Resident #95 where he/she was going and again the resident stated up. The elevator doors opened, and the resident started to say he/she was going to dialysis. The surveyor then asked the ADON if residents from 2 [NAME] should be unattended and going to dialysis independently. The ADON stated that no, residents from 2 [NAME] do not go to dialysis unattended. She told Resident #95 that she was going to take him/her back to the unit and speak to the nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 7:52 AM the ADON (and surveyor) approached Licensed Practical Nurse (LPN #49) and she inquired about Resident #95. LPN #49 stated the lady came from dialysis to take him/her. The surveyor asked who she was, and LPN #49 stated she would go get her. While waiting for the nurse and transporter to arrive, the surveyor asked the ADON if it was the expectation that dialysis staff or any staff should leave a resident from 2 West, the locked dementia unit, unattended and the ADON stated no and that she did get him/her [Resident #95] back. The surveyor shared the concern that occurred after surveyor intervention. On [DATE] at 7:55 AM Dialysis Transporter #48 came through the double doors onto the unit [2 West] and down the hallway to the nursing station where the ADON and surveyor were standing. When asked if she left Resident #95 unattended in the hallway off the unit by the elevator Dialysis Transporter #48 stated, Yes, I came past you two, went straight down [and off the unit] and went to pick up Resident #36. These are my last two to transport down [to dialysis] and if I can kill two birds with one stone then that's what I'll do. That's what I normally do. After Resident #95 and Dialysis Transporter #48 left for dialysis, the ADON stated, I did not recognize her. The surveyor asked who her was and the ADON stated Resident #95. The surveyor shared they did, which is why they asked the ADON about Resident #95 being off the unit and by the elevator alone. The ADON verbalized understanding. The surveyor asked the ADON to pull Resident #95's paper chart and during a dual observation with the ADON, the surveyor flipped to two certificates of incapacity with the following dates and times: [DATE] at 12:30 PM and [DATE] at 3:00 PM. When asked if it was safe for a resident diagnosed with dementia and two certificates of incapacity to be off the locked unit and unattended the ADON stated no. On [DATE] at 8:46 AM review of Resident #95's medical record revealed a care plan, I have impaired cognitive function and/or impaired thought processes r/t dementia, disease process. Date Initiated: [DATE] 3) On [DATE] at 8:04 AM while the surveyor and ADON are standing at the nurse's station on 2 West, Resident #20 walked over, reached over the nurse's desk, and opened a drawer. He/she then started moving objects around while looking inside the drawer. The ADON did not seem phased, nor did she intervene in any manner. The resident stated he/she was looking for the remote. At this point, the ADON walked from around the front of the nurse's station to behind the nurse's station and handed him/her a remote. He/she explained that one was not to the right TV. The ADON found and handed him/her another remote. As the resident was walking away, the surveyor asked the ADON who that resident was, and she identified him as Resident #20. When asked if residents should be reaching over the nurse's station desk, opening drawers, and rummaging through them, the AODN stated, No, it is not the expectation, but he/she did ask afterward. She then stated we usually have. and dragged the paper shredder box over to the opening at the desk, blocking entrance to the nurse's station. In a dual observation with the ADON, she opened the drawer that the resident had opened, and it had several packs of batteries, a lanyard, and plastic cutlery. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor stated yesterday when we spoke, you had stated that hand sanitizer is not on the unit because it could be a safety risk if ingested. Could batteries, if ingested, a lanyard or plastic cutlery be a safety risk to a resident? The ADON stated, they could be while simultaneously opening the drawer and moving the contents into the adjoining room off the nurse's station. On [DATE] at 8:07 AM in a dual observation with the ADON it was observed that Resident #20 had two certificates of incapacity r/t psychosis and cognitive impairment. The surveyor asked if someone who had cognitive impairment and psychosis on a locked unit should have access to a drawer with batteries, a lanyard, and plastic cutlery and she stated no as she removed all items from the drawer.

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with facility staff, it was determined that the facility failed to provide appropriate and sufficient services, treatment, and care for a resident with an indwelling urinary catheter. This was evident for 1 of 2 residents (Resident #160) reviewed for urinary catheters during the facility's recertification survey. The findings include:An indwelling urinary catheter, often referred to as a Foley catheter, is a flexible tube inserted into a patient's urethra (the tube carries urine away from the bladder to outside the body) and remains in place to collect the urine into a drainage bag. Urinary catheters are associated with an increased risk of urinary tract infections as well as other adverse events and should be used only when clinically indicated and ordered by a physician. Urine output is an important clinical indicator and can provide insight into a patient's status and guide their care. Normal urine output is approximately 0.5 to 1.0 mL/kg/h (milliliters/kilogram/hour). Therefore, an average, healthy male with a body weight of 70 kg (154 pounds) should produce around 35-70 mL of urine per hour or 840-1,1680 mL per 24 hours. Anuria is the absence of urine production, or less than 50 mL of urine output in a 24 hour period. It is a serious condition that requires prompt medical attention. A lack of urinary output even when a resident has a catheter could be caused by several different problems. However, troubleshooting by replacing the catheter should only be performed under the guidance of a physician.A voiding trial with a Foley catheter involves assessing a patient's ability to urinate after the catheter has been removed. The trial can be either active, where the bladder is filled with fluid before removal of the Foley, or passive, where the bladder is allowed to fill naturally after removal. The purpose is to determine if the bladder is functioning normally and if the catheter can be safely discontinued. On 7/31/25 at 1:48 PM review of the medical record revealed Resident #160 was admitted on [DATE] with a Foley catheter and diagnoses including, but not limited to, obstructive and reflux uropathy (a blockage that prevents urine from flowing freely through the urinary tract and the backward flow of urine), neuromuscular, dysfunction of the bladder, cognitive communication deficit, and unspecified dementia. Further review of the medical record revealed he/she weighed 154 pounds on admission and had the following care plan: I have an indwelling urinary catheter r/t [related to] urinary retention (the inability to completely empty your bladder). I will be free from catheter related trauma and infections through the review date. Monitor/record/report pain/discomfort due to urinary catheter. Monitor for signs and symptoms of UTI, such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Report abnormal findings to Practitioner, document findings and interventions. In an interview with Resident #160's responsible party (RP) on 7/31/25 at 2:04 PM, they stated when they came [to visit Resident #160] yesterday, Resident #160 was feeling bad. During the interview they stated, Yesterday something happened, right now Resident #160 is not going to the bathroom on his/her own. He/she has a Foley catheter, and we do not know what happened, maybe he/she disconnected the catheter, we do not know, but somehow it got disconnected. They [nursing] reconnected it and then waited about 6 hours to see if he/she would void. They also stated in the interview that they [facility staff] had inserted the catheter, and it was wrong because the urine was not coming out. It was almost an emergency and Resident #160 almost had to go to the hospital. The RP shared that they were saying to the staff that Resident #160 needed to go [to the hospital], but they [facility staff] said wait, let's see. So, an emergency nurse [Nurse Practitioner (NP#3)] came from another floor. She noticed the catheter was not in properly, inserted the catheter further, and then the urine came out, and it was like 2 gallons. The RP stated Resident #160 does not complain, and the only time he/she has been in pain since being here [facility] was when he/she was having the issue with his/her catheter. On 8/1/25 at 9:17 AM review of the medical record revealed a SBAR (situation, background, assessment and recommendation) Communication Form written by LPN #4, the day shift [7-AM-3PM] nurse, dated 7/29/25 at 10:35 AM that documented, The resident's [#160] Foley catheter was found detached in bed and the resident is not able to explain how it came off. This writer and the night nurse could not find a Foley catheter size 14 fr [French, the size (diameter) of the tubing] which was there on admission and instead inserted size 16fr which did not work. Further review of the SBAR Communication Form revealed NP #41 ordered a voiding trial for one day and further stated that if the resident did not void in the next 8 hours, to reinsert a 14 fr catheter. According to the SBAR, NP [#41] stated that he would come tomorrow to check on the patient. Continued review of the medical record revealed LPN

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review, resident interview, and staff interviews, it was determined that the facility failed to provide appropriate pain management for a resident. This was evident for 1 (Resident #13) out of 1 resident reviewed for pain during the recertification/complaint survey.The findings include: A pain scale is a numerical scale, usually 0-10, used to determine the severity of a person's pain. Parameters (Instructions in an order on when a medication can be given) for a pain scale are used to determine which pain medication would be given according to a person's severity of pain.On 08/06/2025 at 9:03 AM, while reviewing Resident #13's medical record, a Physician order was found that was dated 07/05/2025 for Tylenol to be given every 6 hours as needed for Mild Pain- Scale 1-3.Further review of Resident #13's medical records revealed a care plan dated 11/09/2023 with a focus of: I have pain and/or potential for pain related to Gout, sacral wound, BPH (benign prostatic hyperplasia), CKD3 (chronic kidney disease stage 3) with interventions of : 1) Anticipate my need for pain relief and respond to reports of pain. 2) monitor/record the presence of pain qshift (every shift) and PRN (as needed). 3) Notify physician if interventions are unsuccessful or significant change from resident's past experience of pain.Additional review of Resident #13's MAR (medication administration record) for June, July, and August of 2025, showed no evidence of pain being monitored or recorded every shift, and Tylenol was not documented as having been administered for pain. There were no orders for additional pain medications for pain levels exceeding 3. On 07/31/2025 at 8:57 AM, in an interview with Resident #13, the resident reported daily knee pain that staff gives him/her Tylenol and it doesn't help much. During an interview on 08/06/2025 with the Director of Nursing (DON) outlined the facility's pain monitoring procedure. This procedure involves using a 0-10 pain scale to guide nurses in administering pain medication. The pain level, which should be documented alongside medication administration, also requires an order on the Medication Administration Record (MAR) for daily monitoring. Documentation of pain levels each shift should align with the resident's care plan. The DON confirmed concerns that the resident's pain level was not being assessed daily per the care plan, and there was no indication or record of the resident receiving pain medication for knee pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on medical record review and interview, it was determined that the facility staff failed to have an emergency dialysis access ports/shunts clamps in rooms as ordered for residents on dialysis. This was evident of 5 (Resident #66, #42, #103, #109, and #124) of 5 residents on dialysis rooms checked during the recertification/complaint survey. The findings include: A dialysis Arteriovenous (AV) fistula is a connection between an artery and a vein to make it possible to receive dialysis. Dialysis is a treatment that filters and purifies the blood using a machine. This helps keep your fluids and electrolytes in balance when the kidneys can't do their job. In the event there is continuous bleeding from the AV fistula, clamps can be applied to the puncture site to effectively control the bleeding. Review of Resident #66's medical record on 07/31/2025 at 10:43 AM revealed that resident received dialysis on Mondays, Wednesdays, and Fridays.Further record review on 08/04/2025 at 9:18 AM noted that resident had orders to monitor left arm AV fistula dialysis access site for signs/ symptoms of infection, drainage, bruising, and bleeding every shift, and as clinically indicated, and keep clamp at bedside at all times.On 8/4/2025 at 10:17 AM, the surveyor did not observe a clamp in the resident's room. The surveyor asked resident if he/she was aware of a clamp in his/her room for any bleeding emergency from her AV fistula. Resident stated that he/she did not see a clamp in the room. During an interview with Staff #13 on 8/4/2025 at 10:32 AM, she/he stated that an emergency clamp should be in the rooms of the resident's receiving dialysis. Staff #13 went to the medication room to locate a clamp and returned and stated that she/he could not find one.An interview was conducted with DON on 08/04/2025 at 12:13 PM. The DON stated that residents on dialysis is assessed before and after dialysis which includes obtaining vital signs, checking the AV site to ensure its functioning, and checking off the dialysis check sheet. Surveyor asked if an AV fistula emergency clamp should be in the room, the DON stated, yes, a clamp should be in the room. On 08/04/2025 at 11:31 AM, the surveyor checked the rooms of residents who were also receiving dialysis and had orders to keep clamp at bedside at all times.Resident # 42 -no clamp in roomResident# 103- no clamp in roomResident # 109- no clamp in roomResident # 124- no clamp in roomA follow up interview on 08/05/2025 at 7:34 was conducted with the DON who stated that the clamps were now placed in the rooms. Surveyor informed DON that this was a concern because the clamps were missing and were placed in the rooms after the surveyor's intervention. DON agreed with the concern.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation of medication carts and staff interview it was determined that the facility staff failed to ensure controlled substance medications are monitored to ensure accuracy. This was evident for 1 out of the 9 facility medication carts. The findings include: The medication cart for the 1 [NAME] unit revealed that the controlled substance logbook had gaps of where two nursing staff signed to verify each resident's controlled substance medication was counted and matched the number of pills, capsules, etc that were left. The controlled substance logbook had gaps under the signature page which showed no signatures for nurses starting their shift or signature for nurse ending their shift for the following: day shift on 6/2/25, day shift on 6/12/25, evening shift on 6/16/25, day shift on 6/18/25, day shift 6/21/25, day shift on 6/22/25, day shift on 6/27, and on night shift on 7/4/25. Staff #59 was shown that there were gaps in the sign on/sign off section of the controlled substance logbook and she replied Oh, I see.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical record and interview with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 1(Residents #125) of 1 resident reviewed for unnecessary medication during the recertification survey.The findings include:An interview concerning the Medication Regimen Review (MRR) report was conducted with the Assistant Director of Nursing (ADON) on 8/6/25 at 12:43 PM. The ADON stated that the pharmacist would send her and the unit managers the MRR via email. The ADON printed out the recommendations and provided the unit managers with copies to ensure the recommendations are addressed by the physician. the physician will sign and put the copy in the binder. The binder is stored in the Director of Nursing (DON)'s office; however, a copy of the completed recommendation is not placed in the paper chart. The ADON also stated that the facility is going to change this process to make sure a copy is placed in the paper chart because a binder in the DON's office is not a part of the medical record. During Resident #125's medical record review on 8/6/2025 at 1:05 PM, it was noted that Resident had a diagnosis of Bipolar Disorder and medication order for risperidone (Risperdal) 1 milligram tablet by mouth at bedtime for mood. On 8/7/2025 at 08:50 AM, the ADON provided surveyor with copies of the consultant pharmacist report for resident #125 from [DATE] to July 2025. There was recommendation to please evaluate Risperdal use for mood/psychosis on 3/9/2025. The report was signed by the physician with a written recommendation for a psych consult. Further record review on 8/7/2025 at 09:10 AM, surveyor could not locate an order, or a psychiatrist consultation note in the resident's medical record. In an interview on 8/7/2025 at 9:22 AM, the DON stated that he/she will try to locate documentation that a psychiatrist evaluation was done.On 8/08/25 at 10:12 AM, during a follow up interview with DON, he/she stated that the resident was not consulted by a psychiatrist within the time frame of the recommendation and agreed that this was a concern.

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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. Based on the medication administration task it was determined that the facility nursing staff failed to ensure residents receive medication according to physician's orders. This was evident for 2 medications out of the 26 medications observed as part of the medication administration task during the recertification/complaint survey. The findings include: Resident #121 was observed at 11:11 AM on 8/6/25 to have been administered insulin at 11:11 AM instead of the 9:00 AM scheduled administration time. This represented a delay of one hour and eleven minutes beyond the medication administration window of one hour before or one hour after the scheduled time. Resident #91 was observed to have received insulin at 11:12 AM on 8/6/25 instead of the 9:00 AM scheduled administration time. This represented a delay of one hour and twelve minutes beyond the medication administration window of one hour before or one hour after the scheduled time. The facility administration team was informed of the findings at the exit conference on 8/8/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations of medication rooms and staff interviews, it was determined that the facility staff failed to ensure a medication refrigerator maintained proper temperature. This was evident for 1 out of the 2 medication rooms that were observed as part of the medication administration task during the recertification/complaint survey. The findings include: This surveyor observed the medication refrigerator of one west on 8/8/25 at 11:20 AM. The freezer compartment was filled approximately 3/4 of the way with a solid piece of ice. This finding was shown to the Unit Manager who replied Oh, I have to defrost. The thermometer read 28 degrees Fahrenheit. The thermometer was shown to the Unit Manager who said Probably because it was so close to the freezer. I'll move it or get another thermometer.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a tour of the kitchen, staff interview and observation, it was determined that the facility staff failed to label stored food items to ensure safety and prevent contamination which could lead to unsafe food and potential illness. This has the potential to affect all residents.The findings include:During the initial tour of the kitchen on 07/31/2025 at 0740 AM these items were found in the walk-in cooler: Box of blue berries box of 4 pks not labeled with received by date or used by date. Box of oranges with no received by dates. Biscolli cheese received by date of 5/29/2025 with no used by date. Found in the deep freezer: Box of chicken thighs - not labeled. 2 Logs of Sysco Fire River farm ground beef sitting on 2nd shelf and 1 log by itself on cart all without labels.The Dietary Aide (Staff #62) was interviewed on 7/31/2025 at 7:58 AM. The surveyor showed him/her the unlabeled items and the items without a used by date. He/ She stated that the unlabeled items should have had a received by date label, and the items that were opened should have had a used by date label. During a follow up tour of the kitchen on 07/31/2025 08:31 AM, the regional director of dining services, Staff # 63 accompanied surveyor and was made aware of the following items of concern:- a box of [NAME] tortilla not opened without a received by date label- single bag of hoagies not opened without a received by date label- Broccoli in a bag in refrigerator without any labels- bag of cube like sausages in the refrigerator not labeled- 3 lamb patties in a bag - no labels of receipt or use by date- 7 sticks of gold and sweet butter out of an original container - not labeled 08/05/2025 at 7:35 AM surveyor revisited kitchen and informed the food service director, staff #28 about the areas of concerns. Staff #28 stated that he would re-educate his staff on proper labeling of food items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation of the soiled utility and laundry rooms, interviews staff, and documentation review, it was determined that the facility staff failed to follow infection control practices and guidelines to prevent the development and transmission of infection and disease. This was evidenced by 1) soiled linens and residents' outfits were not bagged in plastic bags in the laundry room, and 2) Precaution signage for residents who required care were not appropriately placed. This was evident in four of four laundry bins and two (Resident #36 and #71) of the 63 residents reviewed for precaution signage during the recertification/complaint survey.The findings included:Transmission-Based Precautions (TBP) is a set of infection control measures used in addition to standard precautions when patients are known or suspected of being infected with pathogens that can be transmitted through specific routes. These precautions are designed to prevent the spread of infection and are implemented based on the mode of transmission of the infectious agent.Enhanced Barrier Precautions (EBP) is an infection control strategy focused on preventing the spread of multidrug-resistant organisms (MDROs) in healthcare settings, particularly nursing homes.EBP and TBP require the use of Personal Protective Equipment (PPE) such as gloves, gowns, masks, and/or eye shields, depending on the type of infection and risk of exposure, to prevent the spread of infections.1)During a tour of the facility laundry room on 8/05/25, at 12:21 PM with Staff #29 (Housekeeping Director), it was observed that four full bins contained used linens (3 bins) and residents' clothing (1 bin). However, they were not bagged. Staff #29 stated that they were currently overloaded, which is why all the bins were full. She also confirmed that all contaminated (used) linens or residents' clothing should be placed in plastic bags and tied before being transferred from each unit to the laundry room. Staff #29 confirmed that these items were not properly bagged and added, We have trained the nursing aides several times, but it still happens.During an interview with the Infection Preventionist (IP) on 8/05/25 at 2:41 PM, she confirmed that all contaminated linens and clothing should be bagged before transferring to the laundry room. The surveyor shared the observation; IP validated the concern.2) On 8/05/25, at 12:45 PM, the surveyor toured each unit to compare the precaution signage on residents' rooms with the list of EBP orders. During the tour, it was found that Resident #36 and Resident #71, who were on the EBP order list, did not have signage posted on their room doors.At 1:00 PM on 8/05/25, a medical record review of Resident #36 and Resident #71 revealed that Resident #36 had an EBP order for hemodialysis access, and Resident #71 had an EBP order for tracheostomy and gastrostomy.During an interview with the Director of Nursing (DON) on 8/05/25, at 2:38 PM, the DON stated that residents' precaution status should be posted by the Infection Preventionist (IP).In an interview with the IP on 8/05/25, at 2:41 PM, she stated that the contact precaution signage was posted by the unit manager.On 8/06/25, at 9:54 AM, the IP and Staff #33 (Regional Infection Preventionist) offered a different explanation for the missing signage: Resident #36's precaution signage had fallen off the door, and the unit staff was about to put it back. Since Resident #71 had just completed contact precautions due to loose stool, the facility staff was about to replace the EBP signage. The surveyor informed the IP and Staff #33 that the surveyor had been on the unit for more than 15 minutes, but no staff members were observed managing the residents' precaution signs. The IP and Staff #33 validated the concerns that the facility failed to appropriately manage residents' precaution signage.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record reviews and staff interviews, the facility failed to adequately monitor and track residents receiving antibiotics. This deficiency was evident in 1 (Resident #11) of the 3 residents reviewed for antibiotic use and the facility's antibiotic stewardship program during the recertification/complaint survey.The findings included:Background on Antibiotic Stewardship: Effective antibiotic stewardship requires a facility to develop and implement robust policies, procedures, or protocols to ensure residents needing antibiotics are treated appropriately. This is crucial for minimizing the risk of adverse drug reactions, preventing unnecessary antibiotic administration, and mitigating the development of antibiotic-resistant organisms. A facility-wide process for monitoring antibiotic use is essential, with results and feedback consistently reported to nursing staff and prescribing clinicians.On 8/05/25, at 9:40 AM, the surveyor reviewed Resident #11's medical records regarding his/her antibiotic use. The review revealed that Resident #11 had wounds on the left lower legs with a Methicillin-resistant Staphylococcus aureus (MRSA) infection. He/she had been on broad-spectrum antibiotics since being hospitalized prior to the readmission date of 6/30/25. The discharge record for Resident #11, dated 6/30/25, documented, ID (Infectious Disease) recommended continuing IV (intravenous) antibiotic Ceftaroline 200mg IV until 8/04/25.Further review of Resident #11's Medical Administration Record (MAR) for June, July, and August 2025 revealed the following:Ceftaroline 200mg every 8 hours, scheduled as 0600 (6 a.m.), 1400 (2 p.m.), and 2200 (10 p.m.). The order started on 7/01/25, and was discontinued on 7/13/25 (the resident transferred to the hospital on 7/12/25).Ceftaroline 200mg every 8 hours, scheduled as 0000 (midnight), 0800 (8 a.m.), and 1600 (4 p.m.). The order started on 7/19/25 (readmission date), and was discontinued on 7/23/25 (transferred to the hospital).Ceftaroline 200mg every 8 hours, scheduled as 0600 (6 a.m.), 1400 (2 p.m.), and 2200 (10 p.m.). The order started on 7/23/25 (readmission date), and was discontinued on 8/02/25 (transferred to the hospital).However, the MAR documented that Resident #11 did not receive Ceftaroline from 7/01/25 to 7/02/25, at 2 PM, which meant he/she missed four doses of the antibiotic. The night dose was also missed on 7/04/25 and 7/07/25. Additionally, all three doses were not given on 7/19/25. The July 2025 MAR also documented that Resident #11 received a total of four doses of Ceftaroline on 7/23/25, at 0000, 0600, 1400, and 2200.During an interview with the Infection Preventionist (IP) on 8/05/25, at 10:54 AM, she explained that facility staff reviewed residents' antibiotic use during monthly antibiotic stewardship and daily clinical meetings. During these meetings, they discussed infection symptoms, lab results, duration of usage, and sensitivities. When asked about any concerns regarding Resident #11's antibiotic use, the IP confirmed that no issues were noted for the resident.In a subsequent interview with the IP on 8/06/25, at 9:30 AM, she stated that the facility's contracted pharmacy, located in New Jersey, takes a day to deliver new prescriptions. The surveyor asked about Resident #11's missed doses of Ceftaroline. The IP said, It was not stocked in the facility. In this case, nurses should contact the physician and get an alternative order that can replace Ceftaroline. The surveyor shared concerns that Resident #11 had missed antibiotics and that this was not monitored through the antibiotic stewardship program. The IP responded, It should not be missed. Also, the surveyor and IP reviewed Resident #11's Ceftaroline administration record for 7/23/25: it was documented that midnight scheduled dose was given at 5:24 AM, 6 AM scheduled dose was given at 6:41 AM, 2PM scheduled dose was documented as to be administered at dialysis, and 10 PM scheduled dose was given at 10 PM. The IP verified that since the order was three times per day (every 8 hours), the Ceftaroline should not be given four times that day.

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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. Based on resident interview, staff interview, and observation, it was determined that the facility staff failed to ensure a call system operated correctly for each room. This was evident for 1 resident (#85) out of 60 residents in the survey sample. The findings include: While interviewing Resident #85 on 7/31/25 at 11:22 AM it was observed that the call bell system was alerting staff to the fact that the resident needed assistance. This surveyor asked the resident about the call bell going off. The resident replied that it will not turn off. The unit manager came into the room at 11:25 AM and asked if the resident needed assistance. The resident replied No, it comes on by itself and will not turn off. It has been like this for two days. Staff respond, ask what do I need, and when I reply nothing, they turn it off and leave but it comes back on. Resident then added that it had been like this for two days. The Unit Manager said she would take care of it and left. This surveyor asked the resident for clarification as to how long this has been going on. The resident replied, Two days. Resident said that nursing staff keep coming into the room and they ask what he/she needs, and he/she tells them that he/she did not press the call bell, but no one can turn it off. This surveyor interviewed one of the maintenance staff (#35) on 8/6/25 at 11:27 AM. He was asked about the call bell in the resident's room. He said they tried to reset it and were unaware it was going off constantly for two days. He added that whoever tried to fix it stuck a one-man device on a two-man system so that the call bell was constantly being triggered. The Director of Nursing was interviewed on 8/6/25 at 5:12 PM. The findings were shared with her. She stated that staff were answering the call bell and she was unaware of any malfunction. The Surveyor informed her that the survey team has not observed it sounding without being triggered by the resident since 7/31/25, after surveyor intervention.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of Employee files and interviews, it was determined the facility failed to have a process in place to ensure Geriatric Nursing Assistance (GNA) received at least 12-hours of In-Service training annually. This was evident for 3 (GNA #53, #54, and #55) out 5 reviewed for training. The findings include:On 08/08/2025 at 8:00 AM in review of GNA's training files revealed the following:1) In review of Employee # 53 Employee Training hours file, revealed Employee # 53 only received a total of 1.73 hours of training for the year of 2024.2) In review of Employee #54 Employee Training hours file, revealed Employee # 54 only received a total of 11.53 hours of training in a 2 year period for the years of 2023 and 2024.3) In review of Employee #55 Employee training hours file, revealed Employee #55 only received a total of 6.43 hours of training in a 2 year period for the years of 2022 and 2023. During an Interview with the Facility's Human Resource Director on 08/08/2025 at 8:46 AM, the Director stated that Employee's Annual 12 hour training for GNA's is completed through Relias upon hire and then annually.During an interview with the Facility's Staff Developer/Educator on 08/08/2025, at 10:00 AM, the Staff Developer stated that he/she runs weekly reports. If tasks are not completed, he/she will call staff to ensure completion. The expectation is that annual training will be completed before the end of the year, with a final check in November.On 08/08/25, at 12:22 PM, the Facility's Staff Developer/Educator confirmed that Staff Members #53, #54, and #55 had not completed the required 12-hour training. This issue was subsequently communicated to the Facility's Director of Nursing around 1:00 PM on the same day.