STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215105	A. Building B. Wing	06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citizens Care and Rehabilitation Center of Frederi	1920 Rosemont Avenue Frederick, MD 21702

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37979 Based on medical record review and staff interview, it was determined that facility staff failed to honor a resident' s right to formulate a Do Not Resuscitate (DNR) advance directive and performed CPR (cardiopulmonary resuscitation) against the resident's stated written request. This was evident for 1 of 5 residents (Resident # 43) reviewed for Advance Directives during the survey, and the deficiency was cited to the level of actual harm. The findings include: Facility Reported Incident MD00140887 was reviewed on [DATE]. The Incident Report stated that, on [DATE], CPR (Cardio Pulmonary Resuscitation) was initiated on Resident # 43 and discontinued when it was determined that the resident had formulated a DNR (Do Not Resuscitate) advanced directive. The patient subsequently expired. Cardiopulmonary Resuscitation (CPR) refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased. A DNR directive instructs health care providers not to perform (CPR) if a patient stops breathing or if their heart stops beating. The facility CPR policy was reviewed on [DATE]. The Facility's CPR policy states that CPR should be administered in accordance with a resident's MOLST. Resident # 43's medical record was reviewed on [DATE]. Review of the record revealed that a Maryland Medical Order for Life Sustaining Treatment (MOLST) was completed on [DATE]. The MOLST is a portable and enduring medical order form covering options for CPR and other life-sustaining treatments. Resident # 43's MOLST was coded to reflect that the resident's health care agent, as named in the resident's advanced directive, requested that CPR not be attempted if cardiac and/or pulmonary arrest were to occur. A healthcare agent is a person designated and authorized by an advance directive to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions. (continued on next page)

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

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F 0578 Level of Harm - Actual harm Residents Affected - Few	On [DATE], A Facility Investigation Summary Form, completed on [DATE], was reviewed. The Investigation Summary Form stated that, on [DATE] at 6:50 PM, Registered Nurse (RN) Supervisor # 7 phoned the Director of Nursing (DON) and informed him/her that Resident # 43 had expired. The form noted that, on [DATE] at approximately 3:15 PM, the Memory Care Unit Manager reported to the DON that Registered Nurse (RN) # 2 had informed him that RN # 1 had performed CPR on Resident # 43. In a statement RN # 1 wrote that she/he may have performed CPR on the resident. RN# 1's employee file was reviewed on [DATE]. This review revealed that RN # 1's employment was terminated on [DATE] due to her/his job performance. The Memory Care Unit Manger was interviewed on [DATE] at 12:30 PM. The Memory Care Unit Manager stated that RN # 2 came into her/his office on [DATE] and informed her/him that RN # 1 had performed CPR on Resident # 43. RN # 1 was contacted on [DATE] at 12:58 PM. RN # 1 declined interview. RN # 2 was interviewed on [DATE] at 1:08 PM and stated: RN # 3 and I were sitting at the nurse's station. Geriatric Nursing Assistant (GNA) # 3 came running to our unit from Memory Care to get the backboard and he/she told us to call a Code Blue. (A backboard aids in the administration of cardiopulmonary resuscitation by creating a flat, rigid surface to use under the person in need of care. A Code Blue indicates an emergency and is announced in a facility when an individual's breathing or heart stops). We were already on the phone with RN Supervisor # 7. We told her/him about the code blue and then we went running over there. We got there at the same time as RN Supervisor # 7. He/she went to the nurse's station to get Resident # 43's chart and we went to the resident's room. When we went to the room, RN # 3 and I saw Resident # 43 on the floor and RN # 1 doing chest compressions on top of him/her. RN Supervisor # 7 told RN # 1 to stop CPR because Resident # 43 was a DNR. RN # 3 was interviewed on [DATE] at 2:00 PM. RN # 3 stated that, on [DATE], GNA # 3 ran to their unit and requested that they call a Code Blue. RN # 3 stated that he/she and RN # 2 ran to The Memory Care Unit to respond to the Code Blue. When RN# 3 arrived at the resident's room he/she saw that Resident # 43 was on the floor and that RN # 1 was doing chest compressions. RN # 3 stated that RN Supervisor # 7 had arrived on the unit at the same time as he/she had and checked Resident # 43's medical record. RN Supervisor # 7 told RN # 1 to stop compressions because the resident was a DNR. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	GNA # 3 was interviewed on [DATE] at 1:07 PM. GNA # 3 stated that, on [DATE], s/he had gone into Resident # 43's room to give him/her a bath. GNA # 3 stated: I got my basin, undressed Resident # 43 and began to give him/her a bath. His/her eyes began to roll back and forth in his/her head, he/she became less responsive and his/her breathings slowed down. I stopped and got RN # 1. RN # 1 came into the room, looked at the resident and left to get a pulse oximetry monitor. When she/he left the room, Resident # 43 turned completely white, his/her lips turned white and his/her eyes didn't roll back forward. I ran out of the room and shouted that I needed the nurses. RN # 1 ran into the room, jumped on his/her chest and started CPR. RN # 4 went to get the crash cart (a crash cart is a wheeled container carrying medicine and equipment for use in emergency resuscitations). There was no backboard on the crash cart, so they asked me to go get one. I ran to the Short-Term Rehab Unit to get a backboard and to asked them to call a code. When I came back into the room, RN # 1 had pulled Resident # 43 onto the floor and was still doing chest compressions. RN Supervisor # 7 arrived and told RN # 1 to stop CPR because Resident # 43 was a DNR, and we could only perform comfort measures. RN Supervisor # 7 asked us to put Resident # 43 back onto the bed. When we put him/her back into the bed, I noticed that he/she was not breathing anymore. RN Supervisor # 7 was interviewed on [DATE] at 12:45 PM. RN Supervisor # 7 stated that around 6:00 PM on [DATE] she/he heard that a resident was in distress. RN Supervisor # 7 stated: When I ran to the unit, I went straight to the chart, and opened the chart. I went to the rack and got the chart. When I opened the chart, I realized that Resident # 43 was a DNR, so I went to the room. When I went to the room, I saw Resident # 43 lying on the floor and I saw RN # 1 struggling to put the backboard underneath the patient. I told her/him no, don't do that, that patient is a DNR. I told her/him that we need to put Resident # 43 on the floor and put some oxygen on him/her. The Director of Nursing and the Chief Nursing Officer were made aware of the findings on [DATE] at 10:38 AM and confirmed that facility staff had failed to honor Resident # 43's DNR advance directive.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37979 Based on medical record review and staff interview, it was determined that facility staff failed to ensure that a resident received the assistance of two staff when providing care. This failure resulted in the resident's fall from bed, hematoma and transfer to the emergency room . This was evident for 1 of 5 residents (Resident # 162) reviewed for abuse during the survey. The findings include: Resident # 162's medical record was reviewed on 6/11/2019. The resident had relevant diagnoses of, but not limited to, persistent vegetative state and unspecified coma. Resident # 162 's Minimum Data Set (MDS) Assessment was evaluated on 6/11/2019. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility with the information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Resident #162's MDS Assessment, with an Assessment Reference Date of 02/04/2019, was coded to reflect that the resident was totally dependent on the assistance of two staff members in order to be turned and positioned in bed. Resident # 162's care plan was reviewed on 6/11/2019. 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 # 162's care plan revealed a care plan focus, initiated on 09/09/2016, that stated Resident # 162 was to have the assistance of two staff members when he/she was turned and repositioned in bed. Continued record review revealed a Nursing Assessment entered into the medical record on 2/11/2019 at 9:45 AM by Licensed Practical Nurse (LPN) # 3. The Nursing Assessment read : GNA (Geriatric Nursing Assistant) informed nurse that resident fell out of bed during care. Resident was seen on his/her back in a neutral position on the right side of his/her bed, responsive with large raised bump and hematoma noted over left forehead. Resident sent out to hospital via stretcher. Resident # 162's hospital discharge paperwork was reviewed on 6/11/2019. The discharge paperwork stated that Resident # 162 was seen and evaluated for a traumatic hematoma of the forehead. Continued records review revealed a physician's order entered into the medical record on 2/12/2019 that read : Apply ice every 8 hours for hematoma to forehead for two days. Review of the Treatment Administration Record (TAR) revealed that ice was placed on Resident # 162's forehead every 8 hours from 2/12/2019 until 2/14/2019. A review of the facility's investigation on 6/11/2019 revealed a written statement from GNA # 4, dated 2/15/2019. The written statement read: On 2/11/2019, I was giving Resident # 162 a bed bath. I rolled him/her over towards me to fix his/her diaper. My foot slipped and I lost my balance and he/she fell from the bed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN # 3 was interviewed on 6/13/2019 at 2:00 PM. LPN stated that GNA # 4 came up to me when I was in another resident's room getting his/her vital signs. GNA # 4 told me that he/she was giving Resident # 162 a bath by himself/herself and that when he/she went to turn the resident, the resident fell out of bed. GNA # 4 asked me to say that I was in the room helping him/her with the bath when this happened. GNA # 4 and I went to Resident # 162's room. I saw Resident #162 lying on the floor. I think he/she was on his/her back. I didn't see any bruising. I went to get Unit Manager # 4 and told him/her that Resident # 162 fell out of bed. When Unit Manager # 4 came into the room, he/she asked what happened. GNA # 4 said that he/she and I were bathing the resident, that I was on one side of the bed and he/she was on the other side. GNA # 4 said that when I turned the resident towards him/her, his/her foot slipped on something on the floor, he/she lost hold of the resident and the resident fell out of bed. After that, we assessed the resident again, decided how we were going to transfer him /her back into the bed and decided to send Resident # 162 to the hospital. When Unit Manager # 4 left the room, I told GNA # 4, I can't lie for you, you have to tell them the truth. LPN # 3 stated that he/she left the room to continue his/her work and that GNA # 4 continued to provide care for other residents. LPN # 3 said that after Unit Manager # 4 returned from the morning meeting, he/she approached /him/her and told him/her that GNA # 4 had asked him/her to say that he/she was in the room with /himher and providing care for the resident at the time of the fall, but she was not. Unit Manager # 4 was interviewed on 6/13/2019 at 5:00 PM. Unit Manager # 4 stated: LPN # 3 came up to me at the nurse's station and said that Resident # 162 fell . I was so shocked he/she was on the floor. When I went into the room, Resident # 162 was lying flat on his/her back. and I asked, 'how did this happen'. GNA # 4 said that he/she was changing the resident with LPN # 3. She/He said that when he/she was holding Resident # 162, his/ her shoes slipped and he/she lost hold of the resident. We assessed the resident and got him/her back into bed with the Hoyer lift. I started the process of calling the family and getting the resident sent out for a scan. Awhile later, I'm not sure how long, LPN # 3 approached me and said that GNA # 3 wanted him/her to cover him/her, and that he/she was not in the room with him/her with Resident #162 fell . I immediately called the ADON and told him/her what LPN # 3 had just told me. The ADON was interviewed on 6/13/2019 at 5:06 PM. The ADON stated that Unit Manager # 4 and the Nurse Educator had informed him/her that GNA # 3 had stated that he/she was providing care alone when Resident # 162 fell . The ADON stated: I went to GNA # 3 and requested his/her statement. The ADON stated that GNA # 3 was suspended pending investigation. GNA # 3 admitted that he/she had asked LPN # 3 to lie. We called him/her back on 2/15/2019, and he/she was terminated. The Quality Assurance Nurse was interviewed on 6/13/2019 at 5:45 PM. The Quality Assurance Nurse stated that the facility investigated Resident # 162's fall and determined that the fall was caused by staff member noncompliance with Resident # 162's care plan. GNA # 4's employee file was reviewed on 6/13/2019 at 4:00 PM. Review revealed an Employee Memorandum, dated 2/11/2019, that stated that the employee was suspended due to unsatisfactory job performance and a violation of facility policy specified for not following the care plan and terminated on 12/15/2019. The findings were reviewed with the Director of Nursing (DON), ADON, the Chief Nursing Officer and the Quality Assurance Nurse on 6/13/2019 at 5:50 PM who confirmed that facility staff failed to ensure that Resident # 162 received the assistance of two staff members when being turned and repositioned in bed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 30428 Based on interviews and review of medical records and facility documentation, it was determined that the facility failed to 1). report allegations of abuse to the state survey agency timely and 2). ensure the timely reporting of a staff member's nonadherence to a resident's plan of care. This was found to be evident for 2 out of 8 facility reported incidents (FRI) reviewed during the annual survey regarding Resident # 151 and and Resident #162. The findings include: 1. Review of the FRI MD00134136 revealed an incident, an allegation of sexual abuse, that occurred on 11/24/18 regarding Resident #151. Further review of the facility investigation revealed that the incident was not reported to the state agency until 11/27/18. The Chief Nursing Officer (CNO) and the Director of Nursing (DON) were interviewed on 6/13/19 at 2:34 PM. The CNO stated that they were aware that it was a late report. The staff at the time documented the incident, but did not feel it should be reported. Once the CNO was notified and the DON found out about it, it was reported to the state agency. The CNO further stated that they completed training with the staff regarding the incident. 37979 2. Resident # 162's medical record was reviewed on 6/11/2019. The resident had relevant diagnoses of, but not limited to, persistent vegetative state and unspecified coma. Resident # 162 's Minimum Data Set (MDS) Assessment was evaluated on 6/11/2019. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident and to modify the care plan based on the resident's status. Resident #162's MDS Assessment with an Assessment Reference Date of 02/04/2019 was coded to reflect that the resident was totally dependent on the assistance of two staff members in order to be turned and positioned in bed. Resident # 162's care plan was reviewed on 6/11/2019. 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 # 162's care plan reveals a care plan focus, initiated on 09/09/2016 that stated that Resident # 162 was to have the assistance of two staff members when he/she was turned and repositioned in bed. Continued record review revealed a Nursing Assessment entered into the medical record on 2/11/2019 at 9:45 AM by Licensed Practical Nurse (LPN) # 3. The Nursing Assessment read: GNA (Geriatric Nursing Assistant) informed nurse that resident fell out of bed during care. Resident was seen on his/her back in a neutral position on the right side of his/her bed, responsive with large raised bump and hematoma noted over left forehead. Resident sent out to hospital via stretcher. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN # 3 was interviewed on 6/13/2019 at 2:00 PM. LPN stated GNA # 4 came up to me when I was in another resident's room getting his/her vital signs. GNA # 4 told me that he/she was giving Resident # 162 a bath by himself/herself and that when he/she went to turn the resident, the resident fell out of bed. GNA # 4 asked me to say that I was in the room helping him/her with the bath when this happened. GNA # 4 and I went to Resident # 162's room. I saw Resident #162 lying on the floor. I think he/she was on his/her back. I didn't see any bruising. I went to get Unit Manager # 4 and told him/her that Resident # 162 fell out of bed. When Unit Manager # 4 came into the room, he/she asked what happened. GNA # 4 said that he/she and I were bathing the resident, that I was on one side of the bed and he/she was on the other side. GNA # 4 said that when I turned the resident towards him/her, his/her foot slipped on something on the floor, he/she lost hold of the resident and the resident fell out of bed. After that, we assessed the resident again, decided how we were going to transfer him /her back into the bed and decided to send Resident # 162 to the hospital. When Unit Manager # 4 left the room, I told GNA # 4, I can't lie for you, you have to tell them the truth. LPN # 3 stated that he/she left the room to continue his/her work and that GNA # 4 continued to provide care for other residents. LPN # 3 said that after Unit Manager # 4 returned from the morning meeting, he/she approached him/her and told him/her that GNA # 4 had asked him/her to say that he/she was in the room with him/her and providing care for the resident at the time of the fall, but he/she was not. The findings were shared with the Director of Nursing on 6/13/2019 at 4:30 PM who confirmed that facility staff did immediately report that GNA # 3 had not provided two caregiver assistance, as directed by the resident's plan of care.

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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. 31985 Based on administrative record review, medical records review and interviews with facility staff, it was determined that the facility failed to 1). complete a thorough investigation when residents were noted to have an injury of unknown origin and 2). review staff interviews prior to terminating an investigation of a resident's unknown injury 3). implement corrective action to prevent further incidents of allegation of abuse from occurring. This was found to be evident for 4 (R #164, #111, #162 and #151)) of 7 intakes reviewed during the facility's annual Medicare/Medicaid survey. The findings include: 1. Intake # MD00137920 was reviewed on 6/5/ 19 for an injury of unknown origin. Review of the facility's investigation for an unknown injury for resident # 164 revealed that the resident was noted to have a raised hematoma bruise to the left forehead and a small bruise to the right side of the lip. Review of the medical records revealed that the resident was readmitted to the facility in December 2017 for long term care and with diagnoses which included dementia with behavioral disturbances, and mood disorder. Further review of resident's medical records revealed a Minimum Data Set assessment, dated 2/2/19, which revealed a Brief Interview for Mental Status (BIMS) (a structured evaluation aimed at evaluating aspects of cognition in elderly patients) score of 3. A score between 0 and 7 indicates severe cognitive impact. Review of the facility investigation for the injury of unknown origin to Resident #164 revealed that, on 3/10/19, a Geriatric Nursing Assistant (GNA) staff # 19 was passing out breakfast trays and when he/she turned on Resident# 164's light, he/she observed a large bruise on her/his forehead. Staff # 19 called his/her co-worker (staff # 20) to show him/her the resident's hematoma. They both went to the resident's nurse to make him/her aware. Record review revealed that the resident was transferred to an acute care hospital for further evaluation. Review of the facility policy on abuse revealed that all statements should be signed and dated by the person making the statements. Further review of the witness statement form revealed the following: the questions should be modified to reflect the details of the incident, it is recommended that all persons interviewed be asked the same basic questions and then any follow up questions that will guide the person to give a complete statement. Review of the investigation revealed witness statements of all nurses, GNAs, and supervisors that worked on the resident's unit on 3/9/19 and 3/10/19. Further review of the witness statements revealed incomplete information such as interviewer and title, date and time of interview. Further review of the witness statements revealed missing signatures of the interviewer and the date of the interview. Facility investigation failed to reveal any additional follow up questions to the witness statement. Review of the witness statements by staff # 18 and # 21 revealed the following: Staff # 18 stated that, when it was the resident's bed time, 4 GNA's were in the room. Staff # 21 stated that 3 GNA's were in the room putting the resident to bed. There was no documentation regarding follow up questions about the inconsistencies. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) and the Chief Nursing Office (CNO) on 6/10/19, they were asked to explain what is included in a thorough investigation. The DON and CNO 3 stated that it begins with the witness statements that are used as a guide and follow up questions should be asked. When the surveyor asked about the inconsistencies with the 2 GNA statements, the CNO stated that follow up questions should have been asked. The surveyor reviewed witness statements regarding the investigation with the CNO,and he/she acknowledged that the statements should be completed with all information and signatures. She/he stated that the witness statements were unacceptable. All concerns related to investigation of allegations of injury of unknown origin were discussed at the survey exit on 6/18/19. 30440 1 a). Intake # MD00130624 was reviewed on 6/5/ 19 for injury of unknown origin. Upon review of the facility's investigation, resident # 111 was noted to have a bruise to the left upper arm. The facility ordered an x-ray of the left shoulder. According to the investigation, the resident c/o pain when the nurse attempted to transfer the resident from the wheelchair to the bed, so that an x-ray could be obtained. The x-ray results showed a finding of left shoulder and hip fracture. Resident # 111 was admitted to the facility with the following, but not limited to, diagnoses: Osteoarthritis of Knee, Vitamin D Deficiency, Age Related Osteoporosis and Unsteadiness on Feet. Review of the facility's investigation revealed that an interview was conducted with the resident's husband on behalf of the resident. Statements were obtained from staff, but no interviews were conducted with other residents. An interview was conducted with the Director of Nursing (DON) and Chief Nurse Officer (CNO) on 6/10/19 at 2:10 PM, and they were asked to explain what they considered a thorough investigation. The DON and CNO stated that the investigation starts with statements by staff who were working at the time of the incident and anyone on the floor. The DON further stated that an initial report is done, police are called and interviews were completed 72 hours back. They both were asked if resident interviews were conducted and the DON stated that Resident #11's roommate was not able to be interviewed. The DON and CNO stated that there were no cognitively intact residents on the MCU(Memory Care Unit). The Surveyor asked the DON and CNO if other residents in the facility was interviewed and they both stated no. The DON and CNO confirmed that other residents should have been interviewed and was not. 37979 2. Facility Reported Incident MD00131357 was reviewed on 06/11/2019. The Incident Report revealed documentation that, on 9/5/2018, Resident # 162 was noted with a bruise to the left upper arm. The resident underwent an X-ray that showed a dislocation of the left shoulder. On 9/6/2018, the resident was transferred to the ER where it was determined that he/she had not sustained a shoulder dislocation, and that the bruising was due to chronic weakness of the rotator cuff and supporting muscles. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 162's medical record was reviewed on 6/11/2019. Record review revealed that the resident had relevant diagnoses of, but not limited to, persistent vegetative state and unspecified coma. Continued review of Resident # 162's medical record revealed a Nursing Assessment note entered into the medical record on 9/5/2018 at 3:35 PM. The Assessment note revealed documentation that Resident # 162 was noted with swelling and purple bruising to the left upper arm and elbow. An X-Ray was ordered, and the results obtained on 9/5/2018 at 7:32 PM indicated that the resident sustained a left shoulder dislocation. On 9/6/2018, Resident # 162 was transferred to the emergency room and underwent a CT Scan. The scan results indicated that the resident had not sustained a dislocation and that the bruising was related to chronic muscle weakness. The staffing assignments for Resident # 162's unit were reviewed on 6/12/2019. The staffing assignment revealed that Geriatric Nursing Assistant (GNA) # 8 and GNA # 4 were assigned to care for residents on the unit, with GNA # 4 directly assigned to care for Resident # 162. The facility's investigation was reviewed on 6/11/2019. The investigation included statements from GNA# 8 and GNA # 4. On 9/5/2018, GNA # 4 submitted a witness statement that he/she last saw the resident on 9/4/2018 and did not provide care for the resident. On 9/6/2018, GNA # 4 submitted a witness statement that, on 9/5/2018, he/she was giving the resident a bath and noticed swelling and bruising to the resident's left upper arm. On 9/5/2018 at 3:00 PM, GNA #8 submitted a witness statement that, on 9/52018, he/she was not assigned to care for Resident Group # 3; did not see Resident # 162 at all; did nothing for the resident and had no idea how the bruising and swelling may have occurred. On 9/6/2018, GNA # 8 submitted another witness statement that on 9/5/2018 he/she was assigned to care for resident Group 2; and that he/she last saw the resident when he/she cleaned him/her and changed his/her incontinence briefs around 2:00 PM. Unit Manager # 4 and the Director of Nursing (DON) were interviewed on 6/12/2019 at 11:30 AM. Unit Manager # 4 stated that he/she could not recall which GNA informed him/her that there was a bruise or swelling on Resident # 167's arm on 9/5/2018. She/he indicated that he/she was responsible for obtaining the GNAs statements. The DON revealed that the statements would have been reviewed by himself/herself or the Assistant Director of Nursing (ADON). The DON stated that he/she was not in the facility at the time of the incident, so it would be his/her expectation that the Assistant Director of Nursing (ADON) would review the statement, note the discrepancy and further investigate. The ADON was interviewed on 6/11/2019 at 11:41 AM. The ADON stated that he/she reviewed the GNAs initial statements on 9/5/2018, but did not review the statements that were collected on 9/6/2018. The ADON stated that he/she did not review the 9/6/2018 statements and did not note the difference in the two statements because he/she closed the investigation when he/she learned that Resident # 162 had not sustained a dislocation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings were shared with the Director of Nursing on 6/13/2019 at 4:30 PM and confirmed that facility staff did not review staff interviews prior to terminating an investigation into Resident # 162's injury of unknown origin. 30428 3. Review of the FRI MD00134136 revealed an incident between Resident #151 and Resident #1 that was reported to occur on 11/24/18. The allegations included Resident #151 'touching another resident inappropriately.' The other resident was identified as Resident #1. On 2/8/19, another incident between Resident #151 and #1 was reported again. It was alleged that Resident #151 was 'touching another resident inappropriately.' The other resident was identified as Resident #1. Both allegations were substantiated by the facility, as there were eye witnesses to both incidents by alert residents and staff. A review of Resident #151's medical record revealed diagnoses that included major depressive disorder. Resident #151 was also assessed on 10/30/19 as having a brief interview of mental status (BIMS, assessment used to get a quick snapshot of how well you are functioning cognitively at the time of the assessment) of 13, meaning s/he was cognitively intact. However, according to the resident's medical record s/he had certifications of incapacity to make informed decisions about medical care. A review of Resident #1's medical record revealed diagnoses including dementia and Alzheimer's disease. Resident #1 was assessed on 8/6/18 as having a BIMS of 5 meaning s/he was severely impaired cognitively. Review of the first FRI MD00134136 investigation revealed that the facility social worker, (staff #14) spoke to Resident #151 on 11/29/18. She/he advised him/her that the his/her behavior towards Resident #1 was not acceptable. According to the facility investigation, Resident #151 verbalized understanding. Staff #14 also discussed with Resident #151 that Resident #1 had dementia and limited speech and verbalized what would be appropriate related to their 'relationship.' Staff #14 also discussed with Resident #151 on 11/29/18 that s/he 'would be able to hold [Resident #1's] hand or kiss in a public area but nothing more than that should be done in public. Resident #151 expressed understanding.' As part of the investigation for MD00134136, staff and residents that worked and resided on the same unit as Resident #151 and Resident #1, who were present during the time frame of the allegation, were interviewed. The facility investigation noted that, when Resident #151 was observed touching Resident #1 inappropriately, Resident #1 responded by saying No, No. This statement was obtained from staff #15 who observed the 2 residents' interactions and immediately separated them. Staff #15 documented that, after she/he separated the 2 residents, he/she told Resident #151 that his/her behavior was 'very inappropriate.' Staff #16's statement from the incident was that, when he/she was interacting with Resident #123 on 11/25/18, s/he stated that s/he had seen Resident #151 'touching [Resident #1] inappropriately for some time. ' Resident #123 was assessed on 7/5/18 as having a BIMS of 14, meaning s/he was cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the investigation summary form, the conclusion to the incident form,written and signed by the DON revealed that: ' This is substantiated with the inability to comprehend the consequences of [his/her] behavior.' Again, it was noted that Resident #151 was talked to and the behavior was noted as not acceptable and s/he verbalized understanding. A psychiatric nurse practitioner saw Resident #151 on 11/30/18 after the incident. She/he documented that 'per nursing resident has been inappropriately touching a female resident and continues this behavior even when redirected. S/he also has made inappropriate sexual remarks to staff members.' The assessment continued to document that the resident admitted to the inappropriate behavior and was started on medication for sexual disinhibition. Follow up visits from the psychiatric nurse practitioner on 1/14/19 noted that Resident #151 did not have any inappropriate behaviors noted 'recently' after the medication was started. Resident #151's care plan was reviewed on 6/13/19 at 1:18 PM. A care plan for 'inappropriate behaviors of sexual comments and inappropriate physical contact r/t [relate to] poor judgement' was initiated on 11/26/18. The care plan addressed the need to document behaviors and monitor Resident #151. However, there was nothing specific about monitoring any interactions specific to Resident #1 who the behaviors were identified as directed towards. Review of the FRI MD00136675 that occured on 2/8/19, revealed that Resident #151 'was seen touching another resident inappropriately.' According to the facility investigation, Resident #1 was overheard during the interaction with Resident #151 on 2/8/19 saying 'I don't like that, I'm not like that, I don't do that.' This was reported by Resident #123 who stated that s/he yelled to [Resident #151] 'Stop.' Resident #123 was interviewed on 2/8/19 at 2:05 PM, after the incident that occurred on 2/8/19 as s/he was present in the dining room where the incident occurred. Collective review of the FRI's, investigations, and care plans failed to reveal that an intervention was in place to prevent subsequent incidents from occurring between Residents #151 and #1 until 2/8/19. This concern was reviewed with the Director of nursing (DON), and Chief Nursing Officer (CNO) on 6/13/19 at 2:09 PM during an interview. The DON and CNO jointly had comments regarding the incidents and FRI's. They stated that there were incidents prior to 2/8/19 that were 'near misses,' that staff intervened, but did not elaborate further. Resident #151's initial care plan (related to events from 11/24/19) did not include individualized interventions and Resident #1's care plan failed to have an intervention for monitoring interactions between the 2 residents In addition, during the review of the facility investigation, it was determined that Resident #151 was put on 15-minute checks on 2/8/19 and was eventually transferred to another floor away from Resident #1. However, the facility was only able to provide documentation that the 15-minute checks started on 2/11/9, not on 2/8/19 as ordered, when the second incident was reported, and as part of the facility's intervention to maintain a safe environment for Resident #1. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furthermore, the facility was unable to provide any documentation or proof of interventions that occurred after the first incident on 11/24/18, or the subsequent documented incident on 2/8/19 until 2/11/19 to monitor the activity between the 2 residents and prevent further incidents from occurring. Even though Resident #151 was started on medication for sexual inhibition, there was no indication or documentation of actual monitoring of his/her behavior or monitoring of interactions between Resident #151 and #1, as they both resided on the same unit until 2/12/19. During an interview on 6/13/19, the DON stated that staff was very aware of the 'behavior' of Resident #151, however, there was nothing in either medical record documenting that information until 2/11/19, when the care plan was updated and the 15-minute checks that were implemented. cross reference to F609 and F657

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31985 Based on medical record review, and interview with facility staff, it was determined that the facility failed to develop a person-centered individualized comprehensive care plan as evidenced by failure to develop a care plan to address resident activities, for 1 out of 38 (R #8) residents reviewed during the investigation stage of the long-term care survey process. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. On 6/17/19, Resident # 8's medical records were reviewed and revealed that the resident was readmitted to the facility in April 2018 for long term care, with diagnoses that included Dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and high blood pressure. Further review of the medical record revealed that, at one time, Resident #8 spoke both English and Spanish, but at the time of the survey, the resident spoke Spanish and understood very little English. Review of the yearly activity assessment revealed that the following was very important for the resident; to have snacks in between meals, and to keep up with the news. Further review of the assessment revealed that it was not very important for Resident #8 to attend or participate in religious acivities. On 6/14/19, 6/1719 and 6/18/19, the resident was observed in his/her room looking up at the television screen. During an interview with the resident via Spanish interpreter, it was revealed that the resident liked music and would prefer it to be in the Spanish language. Review of the resident's care plan revealed the following: Focus: Resident mostly declines to attend group activities per preference. Goals: Resident will accept and participate in 1:1 visit as desired. Intervention: Resident wants communion weekly: to provide Spanish speaking volunteer with Sunday communion. Use google translate on IPAD during 1:1 visit, continue to invite the resident to scheduled activities. Resident needs assistance/escort to and from activity functions. During an interview with Chief Nursing Officer (CNO) on 5/17/19 he/she revealed that, based on the care plan, the facility did have a priest come to see the resident and offer communion, but the resident refused communion, he/she further revealed that the resident would only have a visit and not communion. She indicated that the facility ordered books and music in Spanish. During review of the care plan with the CNO, the surveyor asked if the care plan was patient centered and individualized to the resident based on the assessment. She acknowledged that it could be more individualized for the resident and the resident/s diagnoses. All findings discussed during the survey exit on 6/18/19.

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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. 31985 Based on medical record review and interviews with the resident and staff, it was determined that the facility staff failed to 1). follow the interventions on the care plan to prevent skin break down, 2). to ensure that residents and responsible parties (RP) were included in the development and review of a resident's care plan and 3). update a resident's care plan related to reported allegations of sexual misconduct This was true for 3 of 38 (#93, #136 and #151) residents reviewed during the investigative stage of the survey. The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. 1. On 6/11/19, Resident # 93's medical records were reviewed and it was revealed that the resident was admitted to the facility in August 2018 with diagnoses which included: weakness, dementia and abnormalities of gait and mobility. Review of the wound nurse documentation revealed documentation that, on 10/16/18, the resident developed a facility acquired pressure ulcer caused by shearing. Further review of the note revealed that the resident had a shear to the sacrum with scant amount of draining. Review of the weekly pressure ulcer tracking documentation revealed that, on 10/23/18, the resident had a suspected deep tissue injury (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) to the sacrum. Review of the medical record revealed a care plan, dated 9/20/18, and the focus included: at risk for alteration in skin integrity related to shearing of the skin, requires assist with bed mobility. The intervention was stated as: Lift and boost Resident #93 in bed to avoid shearing. During an interview with the wound nurse (staff # 10) on 6/12/19, the surveyor asked how the resident developed a pressure ulcer. She replied that it was a pressure ulcer caused by shearing or sliding instead of lifting the resident. Review of the facility's pressure ulcer treatment and prevention policy revealed the following: Review the resident's care plan to assess for any special needs of the resident. After a review of the care plan interventions with the wound nurse, the surveyor asked if staff would have followed the care plan to lift and boost the resident in bed, instead of sliding, could the pressure ulcer have been prevented, she replied maybe. The findings were discussed with the Director of Nursing, Chief Nursing Officer and the administrator during the survey exit. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	38083 A review of the attendance sheets revealed that care plan meetings were conducted in June and November 2018, as well as February 2019 and May 2019 for Resident #136, however, documentation on 6/6/2018, 11/28/2018 indicated that the residents' RP did not attend the care planning meeting in person and no documentation was found that the RP was present via a conference call, or that a copy of the care plan was sent by mail. Further review of the medical record failed to reveal any documentation as to why Resident#136 did not participate in care plan meetings. Review of the resident's MDS annual assessment, dated 11/30/2017, indicated that the resident was rarely/never understood, and family or significant other not available during the assessment. Interview with the administrator on 6/18/2019 at 3:16 PM, revealed that, though the facility does have interpreter services available, he wasn't aware the service had not been used for Resident #136. Interview with LPN (staff #1) on 6/6/2019 at 11:13 AM revealed the resident had a language barrier and did not want to attend the meeting. The family RP was not available to translate in Korean or be in attendance for the care plan meetings, except for the care plan meeting on 11/28/2018 which was signed by the (RP) to have attended. Staff LPN (staff#1) did not have anyone at the time of the care plan meetings to translate in Korean, except for the date of 11/28/18, when the RP did attend. Interview with the Memory Care Unit (MCU) director (Staff #14) on 6/18/18 at 10:47 AM revealed the residents RP communicates over the phone with staff in regards to concerns or needs of the resident. The residents RP is mailed the care plan. if RP was not involved at the time of the care plan review. However, there was no documentation on 6/6/18 or 11/28/18 that the RP was made aware of the care plan or if an updated copy was mailed. 30428 3. During the review of the facility reported incidents related to Resident #151, his/her care plan was reviewed related to the incidents that occurred. The first incident occurred on 11/24/18. Review of Resident #151's care plan on 6/13/19 at 1:18 PM revealed that a care plan was initiated on 11/26/18 for 'inappropriate behaviors of sexual comments and inappropriate physical comments and inappropriate physical contact r/t (related to) poor judgement.' The interventions included: to monitor behavior clues. Look for time, location, activity at time, environmental factors, others and their responses, monitor resident during group activities for behaviors and whenever possible, seat resident with other male residents or in a group with close monitoring available.' The care plan failed to reveal any interventions specific to interactions between Resident #1 and Resident #151 (who was the target of Resident#151's inappropriate physical contact), and or interventions to monitor the interactions between the 2 residents. The plan only addressed regarding general inappropriate behaviors that Resident #151 may display. The DON and the CNO were interviewed on 6/13/19 at 2:09 PM, regarding the interventions in the care plan for addressing Resident #151's inappropriate behavior. The DON and the CNO concurred that there was not an individualized care plan adressing Resident #151's inapropriate physical touching with Resident #1. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another incident was reported to occur on 2/8/19 between Resident #151 towards Resident #1. The intervention that was put in place in Resident #151's care plan included to: ' monitor Resident [#151] for closeness to Resident [#1]. Redirect resident to another area. Sit them at different tables for lunch and socialization.' It was not until the reported second incident on 2/8/19 and the implementation of the care plan on 2/11/19 that an individualized care plan was put in place regarding interactions between Resident #151 and #1. cross reference to F609 and F610

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38083 Based on medical record review, observation and interview with facility staff, it was determined that the facility failed to1) provide activities for an individual based on their assessment, cultural needs, and language/communication and 1a) ensure residents were given an opportunity to attend activities. This was evident for 3 (Resident # 136, # 8 and #126) of 4 residents reviewed for activities in the investigative stage of the survey. The findings include: 1). Resident #136 was observed on their unit on [DATE], [DATE], and [DATE]. During the observations, the resident was not seen in activities. An interview was attempted with the resident on [DATE] at 9:55 AM, however, it appeared that the resident was unable to comprehend the surveyor's questions. An activity on the unit was conducted on [DATE] at 10:10AM. The resident was observed in the room where an activity was being conducted, but did not engage with the participants. Review of the medical record of Resident # 136 was conducted on [DATE] at 12:16 PM.The Minimum Data Set (MDS) assessment fndings indicated that the resident was rarely understood, and family/significant other were not available at the time of the assessment. Interview with the Licensed Practical Nurse (LPN) staff #1, on [DATE] at 10:55AM, revealed that, although the resident's primary language was Korean, an interpreter had never been involved with the resident for an assessment or interview. During an interview with the Memory Care Director (staff #14) on [DATE] at 11:45 AM, s/he confirmed that the resident's primary language was Korean. S/he also stated that facility had not provided the resident with a Korean interpreter to determine what type of activity that the resident preferred, or what materials (music, magazines, and movies) that the resident would enjoy. The Administrator and the Director of Nursing were made aware of this concern at the exit interview on [DATE] at 3:36 PM. 31985 a). Review of Resident #8's medical record revealed that the resident resided at the facility for more than a year and that the resident's primary language was Spanish. Review of the [DATE] Minimum Data Set Assessment (Section F Preferences for Customary Routine and Activities) revealed documentation that an interview was conducted with family/ significant other during which it was noted that it was very important for Resident#8 to keep up with the news, read books, and listen to music. The resident also enjoyed snack time. Review of the activity notes revealed that the resident's family indicated that the resident enjoyed music and dancing and would likely respond well to social groups that involve entertainment. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan related to activities revealed the following: [resident] mostly declines to attend group activities per preference and does have a diagnosis of dementia. Care plan interventions included: continue to invite the resident to scheduled activities, encourage ongoing family involvement. Invite family to attend special activities. Provide activities calendar, notify the resident of any changes. On [DATE] through [DATE], the surveyor made multiple observation of the resident in thei room. No observations were made of the resident participating in any group activities, reading books, or listening to music. On [DATE], review of the resident's activity documentation provided by the activity director from [DATE] through [DATE] revealed that the resident's activities consisted of: visits from the family, visits from the refreshment carts and a 1:1 visit. There was no documentation that music to listen to or books were provided by the facility. During an interview with the Chief Nursing Officer (CNO) on [DATE], the surveyor discussed the lack of activities for this resident. The surveyor asked if the facility had any activities that were tailored to interest Resident #8, whose primary language was Spanish. He/she replied that he/ she was not sure, and would let me know. A follow up interview with the CNO revealed that, moving forward, the activity department would provide books and music in Spanish and include the resident in more activities. 2) On [DATE], the surveyor observed the activity department doing an activity called Old Tools, it was an activity about items in the past with an open discussion about each item and the residents were able to participate. The surveyor was unable to locate Resident # 126 in the activity room as Resident # 126 was in her/his room. During an interview with the resident, the surveyor asked why she/he did not go to activities today, the resident replied I did not know an activity was being held. The surveyor discussed what the activity for this morning was and the resident stated: I would have like that Review of the resident care plan reveal the following: I am at risk for deceased activity involvement due to preference of group activities. The goal includes I will participate in out of room activities weekly. During an interview with staff # 17, on [DATE], the surveyor asked how residents were notified about activities and he/she replied that the he/she would go around each morning and inform residents of the activity schedule for that day. The surveyor asked if he/she went to notify Resident#126 about the morning activity, and he/she replied I went by the room and the resident was getting dressed.The surveyor asked if he/she returned to invite her/him and he/she replied no, I did not. Staff # 17 acknowledged that she should have returned to the resident's room and invited her/him to the morning activity. All information concerns discussed at the survey exit on [DATE].

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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. 30440 Based on administrative record review and interviews with facility staff, it was determined that the facility failed to have a nurse assess a resident when the resident complained of pain during toileting by a GNA. This was found to be evident for 1 (Resident #111) of 6 intakes reviewed during the facility's annual Medicare/Medicaid survey. Findings include: Intake # MD00130624 was reviewed on 6/5/ 19 for injury of unknown origin. Upon review of the facility's investigation, resident # 111 was noted to have a bruise to the left upper arm. The facility ordered an x-ray of the left shoulder. According to the investigation, the resident c/o pain when the nurse attempted to transfer the resident from the wheelchair to the bed so that the x-ray could be obtained. The x-ray results showed a finding of left shoulder and hip fracture. Resident # 111 was admitted to the facility with the following but not limited diagnoses: Osteoarthritis of Knee, Vitamin D Deficiency, Age Related Osteoporosis and Unsteadiness on Feet. An interview was conducted with GNA, staff # 8 on 6/11/19 at 12:10 PM and the DON was present. The GNA gave an account of the incident that occurred with resident # 111 on 8/21/18. The GNA stated that s/he was assigned to the resident on 8/21/18. The surveyor asked the GNA if resident # 111 complained of pain and s/he stated the resident speaks in another language and was unsure if the resident c/o pain. The GNA went on to say that s/he was unable to ascertain if the resident was complaining of pain when s/he kept speaking in his/her language during care. The GNA stated that s/he had only cared for the resident once and that s/he was not familiar with the resident. An interview was conducted with GNA, staff # 9 on 6/11/19 at 1:06 PM. The GNA gave an account of the event that occurred with resident # 111 on 8/21/18. The GNA stated s/he took the resident to the bathroom and when s/he went to sit the resident down on the toilet, the resident let out a yelp. The GNA further stated that the resident had a history of arthritis and per his/her usual will say, oh my during care, but on this date the resident had a higher yelp of pain. The GNA went on to say that s/he stuck his/her head out of the bathroom door but did not see anyone close by. The GNA stated that after s/he finished providing toileting care for the resident, she made the nurse, staff #11 aware of the resident pain. The GNA stated that resident # 111 did not fall while in the bathroom. An interview was conducted with the DON and Corporate Nurse # 3 on 6/10/19 at 2:25PM, and they were made aware of the interview that was conducted with staff # 8 and # 9 and the concern that involved Resident# 111's complaints of pain and the facility staff's inability to determine if the resident was in pain due to the language barrier. The DON stated that GNA # 9 did not want to leave the resident alone. The DON confirmed that there was a call light in the bathroom and that it could have been pulled by staff to get assistance if needed. Corporate Nurse # 3 stated that the expectation of the GNA is to get a nurse to assess the resident before continuing to provide care, when a resident complains of pain.

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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. 30428 Based on medical record review and interview with facility staff, it was determined that the facility failed to follow up on a recommendation from the physician for an ophthalmology visit. This was evident during the review of 1 of 38(R#98) resident medical records reviewed during the investigative process. The findings include: During the initial tour, on 6/5/19 at 10:54 AM, the surveyor attempted to interview Resident #98. S/he stated that s/he was not feeling that well and the interview was postponed to a later date. On 6/7/19 at 8:58 AM, Resident #98's medical record was reviewed. His/her diagnosis was noted to include a history of pneumonia, muscle weakness and a need for assistance with personal care. Review of the physician's progress note, completed on 3/18/19, documented that the resident had a vision deficit and will see an ophthalmologist. Further review of the medical record failed to reveal a referral to an ophthalmologist. The DON and Chief Nursing Officer (CNO) were notified of the concern and physician's note found in Resident #98's medical record on 6/11/19. On 6/12/19 at 3:30PM, the CNO reported to the survey team that the physician came in on 6/11/19, reviewed the resident again, and s/he was now on the list to be seen by the ophthalmologist.

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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. 31985 Based on medical record review and staff interview, it was determined the facility staff failed to prevent the development of a pressure ulcers for a functionally impaired resident (Resident #93). This was evident for 2 of 8 residents reviewed for pressure ulcer during the investigative stage of the survey. A pressure ulcer also known as bed sore or decubitus ulcer is any lesion caused by unrelieved pressure or shearing that results in damage to the skin and underlying tissue. Pressure ulcers are staged according to the severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater) or Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon). Pressure is one of the main causes of a decubitus ulcer. Lying on a certain part of your body for long periods may cause your skin to break down. The findings include: On 6/11/19, Resident # 93's medical records were reviewed. This review revealed that the resident was admitted to the facility in August 2018 for long term care and with diagnoses which included generalized weakness and abnormalities of gait and mobility. Further review of the medical records revealed that the resident was dependent on staff for turning and positioning. Review of the weekly skin checks revealed that, on 10/4/18, the resident had redness to the sacrum and skin was intact. Review of the wound nurse note, dated 10/16/18, revealed shear to the sacrum with scant drainage. Review of the weekly pressure ulcer tracking records revealed that, on 10/22/18, the resident had a deep tissue injury to the sacrum that was acquired in the facility. A deep tissue injury is a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. Further review of the weekly pressure ulcer tracking records revealed that, on 10/30/19, the area on the resident's sacrum was classified as unstageable. An unstageable bed sore is defined as, full thickness tissue loss in which the base of the ulcer is covered. During an interview with the wound nurse staff # 10 on 6/12/19, the surveyor asked if the resident was admitted to the facility with a sacral pressure ulcer, and the wound nurse acknowledged that the resident did not have a sacral ulcer prior to admission to the facility. The surveyor asked the cause of the pressure ulcer and she replied it was caused by shearing or staff sliding the resident up in bed instead of lifting the resident off the bed. The findings were discussed with the Director of Nursing, Chief Nursing Officer and the administrator during the survey exit.

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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. 31985 Based on the review of a facility reported incidents, review of pertinent records and interview with facility staff, it was determined that the facility failed to 1). protect residents from injuries This was evident for 4 out of 11 residents (R #164, #98, #111 and #162) reviewed for accidents and 2). ensure that staff members were reeducated on proper turning and repositioning techniques prior to caring for a resident This was evident for 3 of 6 employee files reviewed during survey investigation. The findings include 1. On 6/4/19, facility reported incident MD00137920 was reviewed. This review revealed a facility reported injury of unknown origin sustained by Resident # 164 on 3/10/19. Review of the incident revealed that Staff # 19 was passing out breakfast trays and when he/she went into the resident's room to set the resident up for breakfast, he/she saw a bruise on the resident's forehead. Staff # 19 called his/her co-worker into the room to observe and they both went to inform the resident's nurse. Staff #19 further reported that that the bruise had gotten larger. Review of the investigation revealed that the resident's nurse went to assess the resident and found a hematoma measuring 1 centimeter by 2 centimeters from the resident's hairline to above the eyebrow, the size of an egg. Further review reveals a small bruise to the right size of the lip. Review of the nursing note revealed that, at approximately 11AM on 3/10/19, Staff # 18 and Staff # 20 completed care and got the resident up in a chair for the day. Further review of the nursing notes revealed that Resident #164 had a change in condition and was less responsive, requiring transfer to an acute care hospital. Review of the facility witness statements of staff who worked on the memory unit revealed documentation that the resident did not have any bruising to the face or lips until it was discovered by Staff # 19 passing out trays, nor did the resident have a fall. Review of the nursing notes failed to have any documentation of any injury to the resident's face prior to 3/10/19. During an interview with the Director of Nursing, on 6/12/19, the surveyor asked if he/she had any additional information of the resident's injury, he/she replied it is baffling, all staff denied the resident had a fall, staff reported that the resident was fine on 3/9/19. The DON also reviewed the facility's recorded activity from the hallway, and from a review of the film , minimal activity was noted outside of the resident's room. He/she further revealed that a staff member was under investigation because of his/her statements. During an interview with the DON and the Chief Nurse Officer (CNO) on 6/12/19, the surveyor discussed the concern that a resident, who did not have any injuries per staff documentation and statements, developed an egg size hematoma and a bruised lip requiring transfer to an acute care hospital due to a change in mental status. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All concerns related to Resident #164's injury discussed during the survey exit on 6/18/19. 30428 1) a During the initial tour on 6/5/19 at 10:54 AM, surveyor attempted to interview Resident #98 regarding FRI MD00134526. S/he stated that s/he was not feeling that well, but did recall the incident and would like to discuss it further at another time. On 6/7/19 at 8:58 AM, Resident #98's medical record was reviewed. His/her diagnoses included a history of pneumonia, muscle weakness and a need for assistance with personal care. A review of the resident's most recent BIMS showed the resident scored at a 15, (13-15 result is cognitively intact). A review of the FRI noted that, on 12/13/18, Resident #98 reported to the day shift Unit manager that Staff # 7 (from the previous shift) had thrown the call light and hit him/her in the eye. The resident was assessed and noted to have a swollen and red/bruised area to the crease of the right eye. The Resident further noted that, when it occurred s/he had cried out loudly and Staff # 7 just walked out of the room. Administration viewed the camera footage and found that Staff # 7, who was assigned to care for the resident, was the only employee, other than the supervisor, that was noted to go in and out of the resident's room. Resident #98 was re-interviewed on 6/12/19 at 8:45 AM regarding the incident that occurred on 12/13/18. S/he easily recalled the incident and stated, referring to Staff # 7, that 'she threw it across the bed (the call light) and it hit me. She/he stated that Staff # 7 didn't know until it hit me until she came in later and said, 'oh my GOD' and ran out. Surveyor asked Resident #98 at the time the incident occurred if s/he felt afraid and s/he said 'slightly.' However, s/he does not currently feel afraid and feels the facility took care of the situation and had no further concerns. Review of the employee's file on 6/7/19 at 11:37 AM revealed that he/she had his/her annual training on abuse and dementia, background check and active license in place. In addition, he/she was noted to have at least 1 infraction related to customer service concerns yearly since hire in 2015. Interview with the facility CNO on 6/7/19 at 11:50 AM revealed that the facility substantiated the allegation of abuse secondary to the resident's cognition at the time of the incident, the actual sustained injury of the resident and the employees work file that showed previous occurrences related to customer service. The facility terminated Staff # 7 and promptly reported the employee to the board of nursing. 37979 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Facility Reported Incident MD00131357 was reviewed on 06/11/2019. The Incident Report stated that, on 9/5/2018, Resident # 162 was noted with a bruise to the left upper arm. The resident underwent an X-ray that showed a dislocation of the left shoulder. On 9/6/2018, the resident was sent to the ER where it was determined that he/she had not sustained a shoulder dislocation, but that the bruising was due to chronic weakness of the rotator cuff and supporting muscles. Resident # 162's medical record was reviewed on 6/11/2019. Record review revealed that the resident had relevant diagnoses of, but not limited to, persistent vegetative state and unspecified coma. Resident # 162 's Minimum Data Set (MDS) Assessment was evaluated on 6/11/2019. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident and to modify the care plan based on the resident's status. Resident #162's MDS Assessment, with an Assessment Reference Date of 8/9/2018, was coded to reflect that the resident was totally dependent on the assistance of two staff members in order to be turned and positioned in bed. The Chief Nursing Officer (CNO) was interviewed on 06/11/2019 at 4:30 PM. The CNO stated that facility staff had determined that Resident # 162's bruising may have been caused by staff incorrectly turning and repositioning the patient. The CNO stated that the facility decided to reeducate all nursing staff members on proper turning and repositioning techniques as the investigation did not identify an individual staff member who may have been involved. Continued review revealed that on 9/6/2018 facility staff conducted an educational in-service to address proper turn and repositioning techniques. Facility staffing assignments and employee files were reviewed on 06/11/2019. This review revealed that: Staff # 7 was not retrained and was assigned to directly care for Resident # 162 on 9/6/2018, 9/8/2018, 9/9/2018, 9/10/2018, 9/11/2018 and 9/13/2018. Staff # 6 was not retrained and was assigned to directly care for Resident # 162 on 9/7/2018 and 9/12/2018. Staff # 5 was not retrained and was assigned to Resident # 162's unit on 9/6/2018, 9/72018, 9/9/2018, 9/10/2018, 9/12/2018 and 9/13/2018. In an interview on 6/13/2019 at 10:49 AM, the Director of Nursing (DON) was made aware of the findings and stated that GNA # 5 and GNA # 6 were still employed by the facility and had not been retrained on proper turning and repositioning techniques.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 40927 Based on medical record review and staff interview, it was determined that the physician failed to review orders for accuracy and failed to write, sign and date medical visit progress notes in resident medical records on the day that the resident was seen. This was evident for 1 (#2) of 11 residents reviewed in final sample and 1 (#6) of 3 residents reviewed for accidents 2 (#8, #9) of 3 residents reviewed. The findings include: 1) A record review on 9/10/19 at 10:00 AM, revealed physicians' order summaries dated 7/31/19 and 9/3/19, that documented 2 conflicting orders for oxygen therapy. Both orders were dated 7/3/19 and entered by Licensed Practical Nurse (LPN) #2, one order was for continuous oxygen through a nasal cannula (through the nose) at 2 liters of oxygen per minute and the second order was for oxygen 2 liters per minute through nasal cannula when his/her blood oxygen level is below 90%. Review of the physician's progress notes revealed that the attending physician noted on 7/5/19 and 7/22/19, I have reviewed the patient's current medications including medication names, dosages, frequency, and route of administration for all prescriptions. Review of the progress notes for Certified Registered Nurse Practitioner (CRNP) dated 7/26/19, 7/29/19, 8/2/19, 8/9/19, 8/12/19, 8/13/19, 8/16/19, 8/23/19, 8/27/19, 9/3/19 each documented, I have reviewed the patient's current medications including medication names, dosages, frequency, and route of administration for all prescriptions. Furthermore, an Order Summary Report for Active orders as of 8/1/19, was signed, by the attending physician, as approval for the orders on 8/11/19. An Order Summary Report for Active orders as of 9/1/19, was signed, by the attending physician, as approval for the orders on 9/6/19. There was no clarification noted regarding discrepancy between the two oxygen orders. During an interview with the CRNP # on 9/10/19 at 1:30 PM, he stated that he does not review all the medications, just the ones that are flagged as being new. On 9/10/19 at 12:00 PM, Director of Nursing (DON) and [NAME] President of Clinical Services were made aware of and acknowledged the concerns. (Cross Reference F842) 15701 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) A review of the medical record for Resident #6 on 9/11/19, revealed multiple delayed visit notes by the resident's attending physician. The physician's progress note for a visit/date of service of 8/19/19 was created/signed and uploaded on 8/24/19. The physician's visit of 8/21/19 was signed and uploaded on 8/25/19. The physician's visit of 8/26/19 was signed and uploaded on 8/28/19. The physician's visit of 8/30/19 was signed and uploaded on 9/2/19 and the physician's visit of 9/6/19 was signed and uploaded on 9/10/19. Additionally, a Certified Registered Nurse Practitioner (CRNP) note was found with an 8/15/19 as the date of service that was signed and scanned into the electronic record on 8/21/19. 3) Resident #8's medical record was reviewed on 9/11/19. The last physician's visit in the electronic medical record was dated 8/16/19 but was not signed and uploaded until 8/22/19. 4) A review of Resident #9's medical record on 9/11/19 noted that the last physician's progress note was dated 8/16/19 and was signed and uploaded on 8/22/19. The Chief Clinical Officer was notified on the delay in documentation of the physician and CRNP progress notes on 9/11/19 at 4 PM. She was informed that there was not any additional hand written progress notes found in the paper chart.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37979 Based on medical record review, a review of facility documentation and staff interview, it was determined that the facility failed to have a system in place to verify that staff had been educated to verify a resident's code status and Maryland Order for Life Sustaining Treatment (MOLST) prior to initiating or not preforming cardiopulmonary resuscitation (CPR). The findings include: Cardiopulmonary Resuscitation (CPR) refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased. A DNR directive instructs health care providers not to perform (CPR) if a patient stops breathing or if their heart stops beating. The MOLST is a portable and enduring medical order form covering options for CPR and other life-sustaining treatments. Facility Reported Incident MD00140887 was reviewed on [DATE]. The Incident Report stated that, on [DATE], CPR (Cardio Pulmonary Resuscitation) was initiated on Resident # 43 and discontinued when it was determined that the resident had formulated a DNR (Do Not Resuscitate) advanced directive. The patient subsequently expired. The facility CPR policy was reviewed on [DATE]. The Facility's CPR policy states that CPR should be administered in accordance with a resident's MOLST. Employee files were reviewed on [DATE]. Review of these files did not reveal any documentation that employees had completed instructional education to consult the MOLST prior to initiating or not initiating CPR. The Chief Nursing Officer (CNO) was interviewed on [DATE] at 10:38 AM. The CNO stated that all oncoming staff members were trained to consult the MOLST prior to initiating or not initiating CPR during orientation. The CNO stated that the information was contained in a slide within the Nurse Educator's PowerPoint presentation. The CNO stated that the facility did not maintain any documentation to indicate that staff members had received or understood the education. The CNO stated that, as of [DATE], all facility staff had been reeducated on the proper procedures prior to starting CPR or life sustaining measures with accompanying documentation. The Nurse Educator was interviewed on [DATE] at 11:15 AM. The Nurse Educator stated that the MOLST and CPR education was contained in a PowerPoint presentation and that staff received verbal education on the topic. The Nurse Educator stated that there had been no system in place to document that staff had received or understood the education. The Nurse Educator stated that all staff had been reeducated on the proper procedures to follow prior to starting CPR or life sustaining measures and that a documentation process had been initiated. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The findings were shared with the Director of Nursing at exit.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 40927 Based on record review and staff interview, it was determined that the facility failed to have a process in place to ensure that Geriatric Nursing Assistance were evaluated every 12 months to ensure competency. This was evident for 2 (#5 and #4) of 3 staff reviewed for competency. The findings include: 1) A record review for Geriatric Nursing Assistant (GNA) #5 on 9/11/19 at 2:00 PM, revealed that dementia training was completed on 8/25/17 and the GNA's next training was completed 16 months later on 12/1/18. In addition, the employee performance review was completed on 8/15/18 and 13 months later on 9/9/19. 2) A record review for GNA #4 on 9/11/19 at 2:10 PM, revealed they had a performance evaluation on 8/15/18 and 13 months later on 9/9/19. Director of Nursing and [NAME] President of Clinical Services were made aware of and acknowledged concerns on 9/12/19 at 9:05 AM.

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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. 40927 Based on observation, resident interview, record review, and staff interview, it was determined that the facility staff failed to maintain accurate records for a resident's respiratory treatments. This was evident for 1 (#2) of 11 residents reviewed for care plans. The findings include: An observation of Resident #2 on 9/10/19 at 10:55 AM, revealed that the resident was not using continuous oxygen. During an interview with Resident #2 on 9/10/19 at 11:05 AM, he/she stated that they only wear the oxygen when feeling short of breath. A medical record review on 9/10/19 at 10:00 AM, revealed physicians' order summaries dated 7/31/19 and 9/3/19, that documented an order, dated 7/3/19, entered by Licensed Practical Nurse (LPN) #2, for continuous oxygen through a nasal cannula (through the nose) at 2 liters of oxygen per minute. An interview with Licensed Practical Nurse (LPN) #2 on 9/10/19 at 11:15, confirmed that the resident was not receiving continuous oxygen, but was being weaned. When shown the order for continuous oxygen and that she had signed it off for 9/10/19, she reported she was aware that the order was incorrect and should be updated. The Director of Nursing (DON) acknowledge the concerns on 9/10/19 at 12:00 PM. (Cross Reference F711)