STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215110	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Western MD Hospital Center	1500 Pennsylvania Avenue Hagerstown, MD 21742

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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 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** 45139 Based on medical record review and staff interview, it was determined the facility failed to 1.) to have a process in place to ensure that the resident's wishes for resuscitation were communicated to staff so that the staff would know immediately what action to take during an emergency. This resulted in harm to Resident #96, who had a do not resuscitate (DNR) order, receiving cardiopulmonary resuscitation (CPR). The resident was resuscitated, remained at the hospital for 8 days, and returned to the facility with a chest tube inserted in each lung; 2.) reveal evidence that the resident was informed of their right to formulate an advanced directives by failing to document discussions regarding advanced directives and the outcome of the discussion in the resident's medical record and failed to ensure Do Not Resuscitate orders were followed. This was evident for 1 (Resident #6) of 2 residents reviewed for advanced directives, and 1 (Resident #96) out of 1 resident reviewed for choices during a survey. The findings include: Advanced Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law related to provision of health care when the individual was not able to make their own decisions. 1. On [DATE] at 8:38 AM, a medical record review revealed Resident # 96 was a long-term resident of the facility. Further review revealed Resident #96 was on a vent to help him/her breathe. On [DATE] at 3:00 PM, a review of Resident #96 ' s hard chart revealed a Medical Order for Life-Sustaining Treatment (MOLST) form, dated [DATE]. A review of the MOLST form revealed that Resident #96 was not to receive CPR. Further review revealed orders for the resident to receive assistance with breathing, but resuscitation attempts did not include CPR and allowed death to occur naturally. A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form documents a resident's specific wishes for life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment options for a specific patient. (continued on next page)

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

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

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F 0578 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:40 AM, a review of progress notes dated [DATE] at 8:00 AM; revealed that Resident # 96 became apneic, unresponsive, and no pulse was detected. CPR was initiated for 3 cycles of 100 compression. Further review revealed that the MOLST form was reviewed by staff and determined that Resident #96 ' s code status was do not resuscitate. CPR was stopped and the local emergency medical service transported Resident # 96 to the hospital. On [DATE] review of a Physician's note dated [DATE] revealed that the resident was resuscitated with CPR by nursing staff regained his/her pulse and blood pressure, and then transferred to the hospital. On [DATE] at 9:00 AM, continued review of progress notes, nursing note dated [DATE] at 4:23 PM, revealed that Resident #96 was admitted to the hospital and had bilateral chest tubes placed. On [DATE] at 12:00 PM, review of progress notes revealed resident #96 was discharged from the hospital and returned to the facility on [DATE]. On [DATE] at 9:20 AM, during an interview with RN supervisor #13, she reported that she was working on the unit during the incident involving Resident #96 on [DATE]. She reported that the usual procedure is that someone is designated to retrieve the resident's hard cart and the MOLST form is verified before starting CPR. On [DATE] at 12:41 PM, review the facility policy titled Cardiopulmonary Resuscitation (CPR) Criteria, Standards, and Licensed Nurse Protocol. (revised date [DATE]) section V. Procedures revealed, The licensed nurse/licensed clinician will assess the situation, review the code status, and determine the need to call a code blue and initiate CPR if the patient/resident is a Full code. On [DATE] at 2:32 PM during an interview with the administrator, she reported that the root cause analysis of the incident was the failure of the staff to verify the MOLST form before initiating CPR and she expects nurses to verify a resident ' s MOLST form status before starting CPR. In addition, she reported training to correct the situation had begun and was still in progress. 37276 2. On [DATE] at 12:00 PM, an initial review of Resident #6's medical record Resident #6's EMR (electronic medical record) and paper medical record failed to reveal evidence that Resident #6 had an advanced directive in place. On [DATE] at 11:30 AM, a review of Resident #6's medical record revealed the resident resided in the facility for long term care since February 2020. Review of the resident's most recent quarterly assessment with an assessment reference date (ARD) of [DATE] revealed documentation indicating Resident #6 was cognitively intact. Section C, Cognitive Patterns, Staff Assessment for Mental Status documented Resident #6's short term memory and long-term memory was okay, the resident was able to recall the current season, the location of his/her own room, staff names and faces, that the resident was in a nursing home and Resident #6 was independent in making decisions regarding tasks of daily life. Further review of Resident #6's medical record failed to reveal evidence that Resident #6 had an advanced directive, and no documentation was found to indicate the facility periodically informed the resident of his/her right to formulate an advanced directive, or the resident's potential response. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:14 PM, an interview was conducted with Social Worker(SW)(Staff #6). During the interview, the SW stated information about formulating an advanced directive was included in the admission packet which was provided to the resident upon admission to the facility and discussed with the resident during the initial care plan meeting. The SW stated if the resident had an advanced directive, the SW would ask for a copy, and the advanced directive would be placed in resident's medical record. If the resident did not have an advanced directive, the SW would educate the resident on what an advanced directive meant and, if s/he wanted an advanced directive and needed help, the SW would assist the resident to complete an advanced directive. The SW stated that the resident's advance directives and MOLST (Maryland Orders for Life-Sustaining Treatment) were reviewed with the resident at least annually as part of the care plan meeting. Following the interview, the SW was made aware of the above concerns and the surveyor requested documentation of any discussions the SW had with Resident #6 advising the resident of his/her right to formulate an advanced directive. In response, the SW confirmed Resident #6 did not have an advance directive, and indicated that the resident's right to formulate an advanced directive had been discussed with Resident #6, however it was unlikely these discussions had been documented in the resident's medical record. As of the time of the exit from the facility on [DATE], no additional documentation was provided to indicate the facility periodically informed Resident #6 of his/her right to formulate an advanced directive.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259 Based on record review and interviews, it was determined that the facility staff failed to report an allegation of abuse to the Office of Health Care Quality in a timely manner. This was evident for 1 (Resident #31) out of 6 residents reviewed for abuse during the survey. The findings include: The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. A record review on 5/21/24 at 11:29 AM revealed that Resident #31 was admitted to the facility in August 2022 with diagnoses including Dementia. Continued review showed an MDS assessment dated [DATE] that documented that Resident #31 had severe cognitive impairment. Further review on the same day of a facility-reported incident related to Resident #31 with MD00202413 was conducted. The review showed that an allegation of abuse was reported to the Nursing Home Administrator (NHA) on 2/7/24 at approximately 4:20 PM. A subsequent review of the investigation into the allegation of abuse on 6/3/24 at 7:46 AM contained a statement: After reviewing these notes, the Administrator decided on 2/9/24 at 8:15 AM a self-report would be sent, and an investigation would be completed. Review of the facility Abuse, Neglect, Injury of unknown origin, & Misappropriation of Property revealed a statement that The NHA or Quality Director and/or designee will notify the appropriate agencies of such an incident within 24 hours (within 2 hours for serious bodily injury or allegation of abuse). However, the review failed to show that the facility first reported the allegation of abuse to the state agency immediately but not later than 2 hours. During an interview with the NHA on 6/4/24 at 10:17 AM, she reported that she was not in the building when the allegation was first reported to the social worker on 2/7/24. The NHA confirmed that the allegation of abuse was not reported to the state agency until 2/9/24.

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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. 45139 Based on pertinent documentation review and interviews, it was determined that the facility failed to provide documentation that a thorough investigation of potential abuse was completed. This was evident for 3 (Resident #98, #15, and #9) out of 6 residents reviewed for abuse during the survey. The findings include: 1) On 5/22/24, review of facility report revealed that Resident # 98, a long-term resident of the facility, reported an allegation that he/she received abuse from a facility staff member. On 5/29/24 at 9:37 AM, review of social service progress notes dated 7/27/22, revealed that Resident #98 reported to social worker that he/she had received maltreatment by staff. Further review revealed that the resident was unable to provide any further identifying information and that the allegation was reported to nursing staff and administrator who was the abuse coordinator. The facility reported this allegation to the Office of Health Care Quality (OHCQ). On 5/22/24 at 12: 30 PM, the Administrator provided a 1-page document of the facility's findings in their investigations of Resident #98 allegation of abuse. Further review revealed the documents were a summary of the abuse allegation reported to OHCQ. However, she reported she could not provide any of the employee statements or resident interviews that comprised the investigation. On 5/29/24 at 9:45 AM, the Administrator reported she had no additional information or documentation regarding the abuse allegation reported by Resident #98. She reported she was not the administrator at the time the investigation occurred. The Administrator failed to locate the investigation file. 50573 2) Review of Resident #9's medical record on 5/20/24 revealed the resident has resided at the facility for several years, was alert and oriented and able to verbally communicate. Resident #9 was dependent on staff for transfers out of bed and mobility due to weakness. Review of MD00188264 revealed that on 1/23/23 Resident #9 reported to the psychologist (Staff #54) an allegation of abuse related to an incident during the administration of a medication. The facility reported it to the Office of Health Care Quality (OHCQ) and then initiated an investigation. On 5/21/24 at 2:10 PM surveyor requested the investigation documentation for MD00188264 from the Nursing Home Administrator. On 05/22/24 at 8:45 AM, the Nursing Home Administrator (Staff #1) told the surveyor that she is still looking for additional information on the abuse allegation for Resident #9. On 05/22/24 at 12:30 PM, the Nursing Home Administrator (Staff #1) provided documents for the abuse allegation on Resident #9 and stated she had no additional information. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 12:32 PM, review of the documentation provided by the facility revealed the final report submitted to OHCQ which concluded no evidence to substantiate the allegation of abuse. Further record review on 5/22/24 of the documentation provided for MD00188264 revealed two facility report sheets from psychologist (Staff #54) to the facility management about the incident based on what Resident #9 had explained. These reports included the full name of Resident #9, Licensed Practical Nurse (Staff #41), and the first name of a GNA who was a witness to the event. No supporting documentation was found to indicate interviews were conducted with staff or residents regarding this allegation. No documentation was found that identified the full name of the GNA who was a witness to the event. On 05/31/24 at 04:21 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #18), and Nursing Home Administrator (Staff #1) regarding the failure to provide documentation of interviews conducted as part of the facility investigation. 3) Review of Resident #15's medical record revealed the resident has a past medical history of brain damage, weakness, stiffness of right and left ankle, and a mood disorder that can affect a person's feelings, thoughts, and behavior. Review of MD00190623 revealed that on 3/23/23 staff identified a blister on the resident's leg that was of unknown origin, the facility submitted a report to the Office of Health Care Quality (OHCQ) and then initiated an investigation. Review of the final report indicated an investigation was completed and abuse was not substantiated. On 5/21/24 at 2:10 PM surveyor requested the investigation documentation for MD00190623. On 5/23/24 the Nursing Home Administrator reported she was still looking for investigation documentation. On 5/31/24 at 9:00 AM review of the documentation provided by the facility revealed the final report submitted to OHCQ and a report from the police department. Review of the final report revealed that there was no indication that the injury was caused by abuse. The police report concluded there was no indication that the blister was caused by abuse or neglect and it required no criminal investigation. No documentation was provided to indicate which staff were interviewed during the investigation or what they reported. On 05/31/24 at 08:59 AM, review of final report revealed that the facility attempted to interview Resident #15 on how the blister happened, but the resident was unable to report how it happened. On 05/31/24 at 04:21 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #18), and Nursing Home Administrator (Staff #1) regarding the failure to have evidence that a thorough investigation was completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on records review and interviews, it was determined that the facility failed to develop a comprehensive care plan with measurable objectives and timeframe to meet the resident's medical needs. This was evident for 4 (Resident #6, #34, #9 and #24) out of of 24 residents reviewed during 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. 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. 1) On 5/21/24 at 3:15 PM, a review of Resident #6's medical record revealed the resident resided in the facility for long term care since February 2020 and had multiple diagnosis which included a seizure disorder. Review of Resident #6's most recent quarterly assessment, with an assessment reference date (ARD) of 4/13/24, revealed in Section I: Active Diagnose of seizure disorder or epilepsy. Review of Resident #6's May 2023 Electronic Medication Administration Summary (eMAR) revealed a 9/27/22 order for Lamotrigine (anticonvulsant) tablet by mouth 3 times a day for seizure disorder, which was documented as given every day as ordered from 5/1/24 to 5/21/24, and an order for Levetiracetam (anticonvulsant) tablet by mouth 2 times a day for seizure disorder, which was documented as given every day from 5/1/24 to 5/21/24 as ordered. Review of the physician orders also revealed an 11/2/22 order for seizure precautions. Continued review of Resident #6's care plans failed to reveal evidence a comprehensive care plan with measurable goals had been developed to address the resident's seizure disorder and use of anticonvulsant medications. The above concerns were discussed with the unit nurse manager (Staff #3), Registered Nurse (RN), on 5/22/24 at 1:31 PM. Staff #3 acknowledged the concern and offered no further comment at that time. 48259 2) A record review on 5/28/24 at 11:25 AM revealed that Resident #34 was admitted to the facility in January 2023 with diagnoses including dementia, depression, and a history of Post-traumatic stress disorder (PTSD). Continued review showed an MDS assessment dated [DATE] that documented that Resident #34 had severe cognitive impairment. Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event. People may experience a range of reactions after trauma, and those who continue to experience problems may be diagnosed with PTSD. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A trigger is a psychological stimulus that prompts a recall of a previous traumatic event, even if the stimulus is not traumatic or frightening. A subsequent review on 5/28/24 at 1:35 PM found a care plan for Resident #34 that contained a statement that [Resident #34] has a history of PTSD. The goal of the care plan stated, [Resident #34] will not experience the trigger of PTSD. The intervention stated, Staff will avoid the trigger and allow [Resident #34] to cooperate. However, the review failed to show Resident #34's potential triggers, which may re-traumatize the Resident, along with interventions to address the possible triggers. During an interview on 5/29/24 at 2:57 PM with Staff #3, a unit nurse manager, she stated that Resident #34's care plan for PTSD was not person-centered and should have contained his/her specific triggers to avoid re-traumatization. In a subsequent interview on 5/31/24 at 11:47 AM, Staff #2, the assistant director of nursing, reported that Resident #34's responsible party was contacted after the surveyor's intervention and the Resident's care plan for the history of PTSD was updated. 50573 3) Review of Resident #9's medical record on 5/20/24 revealed the resident has resided at the facility for several years, was alert and oriented and able to verbally communicate. Resident #9 was dependent on staff for transfers out of bed and mobility due to weakness. An interview with Resident #9 on 05/20/24 at 3:02 PM revealed that she/he has been experiencing frequent tooth pain. Review of the minimum data set (MDS) with an assessment reference date (ARD) of 1/5/24 revealed in Section L Oral/Dental status that the resident was experiencing mouth or facial pain, discomfort or difficulty with chewing. Review of Resident #9's medical record revealed that on 1/19/24 Licensed Social Worker (Staff #6) documented a care plan update progress note that indicated dental issues were discussed, and the goals to resolve the dental care issue and to find dental care for the resident. However, review of the resident's care plan failed to reveal documentation to indicate the dental issues or the need to identify a dentist for the resident were added to the care plan. Further review of Resident #9's medical record on 05/22/24 at 09:40 AM revealed that there was frequent documentation that noted the resident experiencing tooth pain in February and March 2024. Review of the 3/30/24 MDS assessment revealed that the resident had been experiencing mouth pain under the oral/dental status section. Further review of the medical record revealed a Care Plan Update note, dated 4/3/24,written by Social Worker (Staff #6) that documented that a care plan meeting was held and the resident opted not to attend. No documentation was found in this note to indicate the dental concerns were addressed during this meeting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #9's medical record on 05/22/24 at 11:43 AM revealed that there was no documentation of a dental care plan and tooth pain was not covered under Resident #9's current pain care plan. On 05/31/24 at 04:28 PM, the surveyor reviewed concern to the Director of Nursing (Staff #18), and Assistant Director of Nursing (Staff #2) regarding the failure to update the resident's care plan related to frequent tooth pain. 48470 1) Resident #24 had been residing in the facility since 2020. A review of the facility matrix on 5/20/24 at 12:29 PM identified the resident as having a pressure ulcer/injury. On 5/22/24 at 2:35 PM, Resident #24's care plan for pressure ulcer was reviewed and revealed a care plan goal that stated, resident will maintain and/or maximize healing process related to wounds. No other care plan goal related to the resident's pressure ulcer was documented with a measurable objective and time frame. Earlier that day at 2:21 PM, the Wound Nurse/Registered Nurse (RN Staff #9) was interviewed about her process with wound care. When Staff #9 was asked about wound measurements, she stated, I would have to say they are not done. She further indicated that floor nurses assess residents with wounds and perform treatments but are not responsible or trained in measuring them. Staff #9 further reported that she used to measure the wounds to track progress but does not anymore because of lack of time since she had been given other roles in the facility. Staff #9 also confirmed that she was responsible for formulating and updating the resident's care plan regarding wound care. At the time of survey Exit on 6/4/24 at 5:09 PM, the concern was discussed with the Director of Nursing, Assistant Director of Nursing, Director of Quality, Chief Medical Officer, Minimum Data Set Coordinator, and the Nursing Home Administrator (joined via phone call) that the care plan did not have measurable objectives and timeframe to meet the resident's needs. All staff acknowledged the concern.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139 Based on pertinent document review and interviews, it was determined that the facility failed to implement physician orders for 15-minute safety checks. This was evident for 1 (Resident #98) out of 1 resident reviewed for behavioral or emotional care during the survey. The findings include: On [DATE] review of medical record revealed that Resident #98 was a long-term resident of the facility with a history of depression and previous suicide attempts, while a resident at the facility. On [DATE] at 12:16 PM, review of a progress note dated [DATE], revealed nursing staff discovered Resident #98 in his/her room with a cord wrapped around his/her neck and the resident refused to surrender the cord when the nursing staff attempted to remove it. Further review revealed the resident was transferred to a local hospital for psychiatric evaluation. On [DATE] at 9:29 AM, review of physician's orders with a start date of [DATE], revealed an order, Every 15 minutes checks for safety document in three ring binder in Nurses station. On [DATE] at 9:30 AM a review of orders revealed that the above order remained active until the Residents death on [DATE]. On [DATE] at 12:38 PM, the administrator provided documentation of the 15 minutes checks for Resident # 98. Review of the documentation revealed 15-minute check sheets for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. The review failed to reveal any 15-minute checks documented following the order on [DATE]. On [DATE] at 1:36 PM, during an interview with the Administrator the above concerns were discussed. The administrator reported that she was not at the facility at the time of the suicide attempt. She reported that the facility no longer documents 15 minutes checks in a nursing binder. She reported that the 15-minute safety checks are now recorded in the electronic health record. The facility failed to provide any documentation of 15-minute checks during the time the order was in place for dates other than the ones listed above prior to the end of the survey.

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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. 37276 Based on medical record review and interviews it was determined that the facility failed to provide services consistent with professional standards of practice to prevent the development of pressure ulcers and promote healing of existing pressure ulcers/injuries. This was evident for 1 (Resident #6) of 2 residents reviewed for pressure ulcers. The findings include: Pressure ulcers, also known as pressure sore or decubitus ulcer, is any lesion or injury caused by unrelieved pressure that results in damage to the underlying tissue and staged according the their severity from Stage 1 (area of persistent redness), Stage 2 (superficial loss of skin such as an abrasion, blister or shallow crater), Stage 3 (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage 4 (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). On 5/21/24 at 11:04 AM, a review of the facility's Matrix (used to identify pertinent resident care) revealed documentation that Resident #6 had a Stage 3 pressure ulcer. On 5/22/24 at 11:30 AM, a review of Resident #6's medical record revealed a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 4/13/24 which documented Resident #6 had one unhealed Stage 3 pressure ulcer. Further review of Resident #6's medical record revealed documentation that Resident #6 had a left lower (LL) buttock pressure wound. Resident #6's May 2024 eMAR (electronic medication administration record) Summary revealed a 5/10/23 order for Baza Protect (moisture barrier cream) with ABD pad (abdominal gauze pad) to left buttock one time per day, every day, 7:00 AM - 3:00 PM, change daily & PRN (as needed) if wrinkled, soiled or falls off. The order was signed off every day as ordered from 5/1/24 to 5/21/24, except on Wednesday, 5/15/24. Further review of Resident #6's May 2024 eMAR Summary revealed a 5/5/23 order for general observation and complete skin assessment, one time per day, every week on Tuesday and Saturday at 7:00 AM. The order was signed off as completed on Thursdays and Sundays, not Tuesday and Saturday as ordered. The facility failed to ensure the order was accurately transcribed to reflect assessments were to be done on Tuesday and Saturdays. The order was signed off as completed on Thursday 5/4/24, 5/11/24, and 5/18/24 and on Sunday, 5/7/24, and 5/21/24. In addition, there was no evidence a skin assessment had been completed as ordered on either Saturday 5/13/24 or on Sunday 5/14/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of Resident #6's medical record failed to reveal documentation that described the stage of Resident #6's left lower buttock pressure wound, or evidence that with each dressing change or at least weekly, an evaluation of the resident's LL buttock pressure wound measurements was conducted which included the size, depth, and/or the presence of any undermining or tunneling of the wound. A review of a printed copy of Resident #6's Skin Condition/Wound Progression notes for his/her LL buttock wound recorded from 2/1/24 to 5/21/24 revealed on 2/2/24 at 9:40 AM, the nurse documented Resident #6's wound condition was Pressure Ulcer/Injury, the wound was discovered on 9/13/22 and the wound onset was 9/13/22. Continued review of Resident #6's Skin Condition/Wound Progression notes recorded between 2/1/24 and 5/22/24 revealed wound progress notes written on February 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 16, 17, 18, 20, 21, 23, 24, 25, 26, and 27, 2024, wound progress notes written on March 1, 2, 3, 4, 5, 6, 7, 9, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 31, 2024, and wound progress notes written on April 1, 2, 3, 4, 5, 6, 8, 9, 12, 13, 14. 15, 16, 17, 18, 22, 23, 24, 26, 27, 38, and 30, 2024. There was no documentation in the skin/wound progress notes to indicate Resident #6's left lower buttock wound was a pressure ulcer, and/or the stage of the pressure wound. In addition, there was no documentation in the wound progress notes to indicate wound measurements had been obtained and/or included in the wound assessment. Review of Resident #6's Skin and Progress Check History notes from 4/28/24 to 5/21/24 revealed skin and progress check notes written on 4/28/24, and 4/30/24, and May 4, 5, 6, 7, 10, 11, 12, 16, 17, 18, 19, 20 and 21, 2024 documented the type of issue was Pressure Ulcer/Injury on Left Lower buttocks. The progress notes failed to include the stage of Resident #6's left lower buttock pressure wound, or evidence of pressure wound measurements. On 5/22/24 at 2:21 PM, during an interview, Staff #9 (Registered Nurse (RN), stated she was the facility's part-time wound nurse. Staff #9 stated that as the wound nurse, she performed the initial wound assessments for residents admitted to the facility, followed residents with skin issues in the facility, and recommended wound treatments. Staff #9 indicated that when there was a special wound treatment, such as a wound vac., she would guide the staff so that the nurse would know what to do, otherwise the nursing staff did the resident wound treatments. Staff #9 stated that she did not measure resident wounds every week and indicated that resident wound measurements were not being done. Staff #9 stated nurses did wound progress checks every day and the nurses were responsible for assessing the wounds, however, the nurses were not required to measure the wounds. Staff #9 indicated that, in order to avoid inconsistency in wound measurements, measuring the residents' wounds use to be her role, however since being given other responsibilities, she has been unable to do it. Staff #9 stated that she does not have time to measure the wounds and the nurses had been instructed to not measure the wounds. The facility staff failed to ensure complete and accurate medical records by failing to ensure wound treatment orders were accurately transcribed, and the facility failed to ensure evaluation of Resident #6's LL buttock pressure wound included wound measurements. 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's care plans revealed a care plan, Wounds - Pressure Injuries with the goal, Resident will maintain and/or maximize healing process related to wound(s). Current areas will heal by 5 mm (millimeters) per month until resolved barring any complications, [Resident #6] will have no new areas of skin breakdown, and the interventions, 1) conduct twice weekly skin assessments by floor staff on Tuesday/Saturday day shift, twice weekly assessment, observe with each dressing change. Observe for change in color/skin integrity/size of wound and report any deterioration to clinician as indicated, 2) treatments as ordered; nursing to change dressings and monitor for placement, 3) Monitor areas for s/s infection; report increased redness, swelling, drainage, and/or foul order to WM (wound management) RN (registered nurse) and clinician for follow-up, 4) keep dressing and surrounding tissue clean and dry. Change if found soiled during incontinence care, and 5) Pressure relieving device(s) as ordered; LAL (low air loss) mattress, heel lift boots. The care plan was not comprehensive, or resident centered and failed to indicate the location of Resident #6's pressure injury, or the stage of the resident's pressure wound. The care plan intervention, to conduct twice weekly skin assessments by floor staff on Tuesday/Saturday day shift, twice weekly assessment, observe with each dressing change was inaccurate, as per the documentation in the Resident's May 2024 MAR, the wound was assessed on Thursday's and Sundays. In addition, continued review of Resident #6's medical record failed to reveal documentation to indicate the resident's pressure injury care plan was reviewed following each assessment. The facility's failure to complete an ongoing assessment of Resident #6's left lower buttock pressure injury to include an evaluation of the pressure wound measurements to include the size, depth, and/or the presence of any undermining or tunneling of the wound at least weekly, failure to develop a comprehensive care plan, and failure to evaluate and revise the care plan based on changing goals, preferences and needs of the resident and in response to current interventions put the resident at risk for impaired wound healing. Following the interview on 5/22/24 at 2:21 PM, the wound nurse (Staff #9), was made aware of the above care plan concerns and offered no further comments at that time.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 16218 Based on review of medical records and facility investigation documentation and interviews it was determined that the facility failed to ensure respiratory care was provided consistent with professional standards. This was found to be evident for one (Resident #40) out of four residents reviewed for respiratory care. This failure resulted in a determination on 5/31/24 at 9:45 AM of an Immediate Jeopardy for Resident #40. The facility implemented effective and thorough corrective measures following this incident. The facility's plan and action were verified during this survey, therefore this deficiency will be cited as past noncompliance. The date of correction was 5/24/24. The findings include: Review of Resident #40's medical record revealed the resident was admitted to the facility in February of 2024 with a history of stroke and dependence on mechanical ventilation due to respiratory failure. The resident had severe cognitive impairment and was non-verbal. On 5/20/24 the resident was observed resting in bed but did not respond to surveyor's greeting. Tubing connecting the ventilator to the tracheostomy tube was in place with no identified concerns at that time. A tracheostomy (also called a tracheotomy) is an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs. After creating the tracheostomy opening in the neck, surgeons insert a tube through it to provide an airway and remove secretions from the lungs. Residents with prolonged dependence on a ventilator for breathing will often have a tracheostomy. (www.hopkinsmedicine.org) Review of a 4/26/24 primary care physician (Staff #40) progress note revealed ventilator dependent respiratory failure -- stable on current vent settings. Not a candidate for vent weaning/decannulation at this time due to neurologic status remaining largely unchanged. Weaning refers to a process of gradually reducing the amount of ventilator support. Decannulation refers to the removal of the trach tube after it is no longer needed. Review of the progress notes revealed a note, dated 5/14/24 at 4:37 PM, by respiratory therapist (Staff #46) which stated: At approximately 1520 [3:20 PM] while documenting at the nursing station I heard a ventilatory alarming. After getting up and determining where the alarm sound was coming from I made my way to [Resident #40]'s room. When I arrived I witnessed that the patient was in the process of being transferred by two nursing assistants from [his/her] bed to a recliner chair via the hoyer lift and the patient had become disconnected from [his/her] ventilator. I stretched the ventilator to the patient as they were finishing the transfer to the chair and reconnected [Resident #40]. Immediately upon reconnection, the ventilator stopped alarming and the patient began to be ventilated again. The patient did not appear to be in distress at any time that I witnessed. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the progress notes revealed a note, dated 5/14/24 at 5:40 PM, by nurse (Staff #48) which documented: While transferring [Resident #40] from the bed to recliner, the nursing assistant disconnected the trach tube from the patient for the transfer. Vent alarm sounded and respiratory therapist responded to Pt. [patient] room and reconnected the airway to the ventilator. The disconnect time was approximately 2 minutes as per the vent alarm record. Clinical manager was notified. Review of the initial report from the facility for incident MD00205708 revealed that on 5/14/24 the Respiratory therapist reported he heard the vent alarm going off in the resident's room and immediately checked on the resident, when he entered the room, he saw the resident was disconnected from the ventilator while two GNA's [geriatric nursing assistants] were transferring the resident. The respiratory therapist immediately responded to the alarming ventilator and reconnected the ventilator to the resident. The respiratory therapist reported the resident was not in distress after the incident. The nurse assessed the resident after the incident and reported the resident was at baseline. The assigned nurse to this resident educated the GNA on proper ADL care with ventilators. Nursing management was notified, and they took both GNA's off the unit to the nursing manager's office and educated them. The nurse manager and two respiratory therapists were involved in the education. The ADON met with both GNA's after the education and educated them too. Review of a statement dated 5/15/24 and signed by GNA Staff #49 revealed that it was in regard to the incident that occurred on 5/14/24 while transferring a resident. The statement included: I was not aware that I am not supposed to transfer vent residents unless there is a respiratory staff to watch the process. Review of a statement dated 5/14/24 and signed by Staff #48 revealed Nurses aide stated to this nurse that she disconnected the Pt. [patient] vent tube from the patient to transfer [him/her] to the chair. On 5/31/24 at 7:46 AM, after a review of his signed statement, Staff #48 confirmed that the GNA referenced was GNA #49 and that the GNA had said that s/he had un-hooked the resident. On 5/30/24 at 2:30 PM, upon interview, GNA #49 reported she was an agency GNA and had been working at this facility for about 3 months. She confirmed the last time she worked with a resident on a ventilator was 5/14/24. She reported that if transferring a resident on a ventilator she would call staff from the respiratory therapy (RT) department. After review of her statement about the 5/14/24 incident GNA #49 confirmed that she did not call RT that time, and denied having been told prior to that incident that she needed to do so but confirmed that she had received education since then. GNA #49 denied that the tubing was disconnected and stated that it was stretched but it was attached. Review of the Competency: New Employee GNA/CNA staff form for GNA #49 revealed documentation to indicate Competency in regard to: Staff is able to verbalize the safe manner to provide care when working with ventilators and patients & residents with tracheostomies; and Staff is able to discern the difference between the various alarms on the ventilators and the appropriate response. The Respiratory Care Evaluator (RT supervisor Staff #47) signed this form on 2/15/24. On 5/31/24 at approximately 8:00 AM RT supervisor (Staff #47) was interviewed regarding the orientation process. Staff #47 reported that they would have covered that an RT needs to be in the room during a transfer. She also confirmed that there was an RT available on the unit 24 hours per day 7 days per week and they carried radios so they could always be reached. When asked what the Respiratory Care Evaluator Signature indicated, Staff #47 reported it meant they have been oriented. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a statement written by GNA (Staff #52) revealed s/he had precepted GNA #49. The statement included: I fully educated [him/her] on the transfer of [name of Resident #26], a ventilator patient. I neither disconnected the vent or tube feed from the patient. All tubes were in place during the entire transfer. Review of a statement dated 5/14/24 and signed by GNA (Staff #50) revealed that GNA (Staff #49) had requested assistance with providing care for Resident #40 and included the following: .At the verge of the transfer the vent was disconnected. I queried this action but my partner overrode my reservation and against my better judgment I went along. The resultant beeping attracted the prompt arrival of a respiratory therapist who quickly remediated the situation . Review of a statement signed by respiratory therapist (Staff #45) revealed that on 5/14/24 respiratory therapist (Staff #46) had alerted her to the incident and that she reported it to unit nurse manager (Staff #3). The statement indicates education was immediately provided to both GNAs involved. The statement includes the following: [GNA #50] stated that [s/he] told her not to disconnect the patient and her reply was it is only for a second. On 5/31/24 at 10:54 AM respiratory therapist (Staff #45) reviewed her written statement and confirmed it's accuracy. Staff #45 also reported that they do inform the GNAs not to disconnect residents as part of the orientation and that a respiratory therapist will help with moving or transporting a resident. Review of a statement dated 5/14/24 and signed by the unit nurse manager (Staff #3) revealed that upon learning of the event from respiratory therapists (Staff #46 and #45) at approximately 4:00 PM, the unit nurse manager immediately identified the two GNA's involved (Staff #49 and #50). The GNAs were then both educated by RT (Staff #45) on the importance of never disconnecting a resident from the ventilator as this is their 'life support' and could die from being disconnected. Further review of the unit nurse manager (Staff #3)'s statement revealed: [GNA #50] expressed remorse for following [GNA #49]'s lead and not being more forceful in stopping [GNA #49] from disconnecting the resident from the vent. On 5/31/24 at 9:21 AM during an interview with Staff #3 surveyor read this portion of the statement to Staff #3 and when asked if this was accurate, Staff #3 stated: absolutely correct. Staff #3 also confirmed that she was told by GNA #49 that she had disconnected the vent. On 5/31/24 at 7:13 AM GNA #50 reported he is employed by a staffing agency and had worked at this facility 3-4 days per week for the past year. GNA #50 reviewed his written statement and confirmed it's accuracy. GNA #50 reported the GNA who was the lead thought it was ok to transfer the resident without a respiratory therapist and during that process the tubing got extended and it got pulled off. During this interview, GNA #50 denied that the other GNA disconnected the vent but reported that it came off during the transfer and that the section of the statement about overrode my reservation was that he told the other GNA they should have a therapist in the room but the other GNA said no it would be easy. GNA #50 went on to report that he has received education regarding this issue and that he can no longer be assigned as the primary GNA for a resident with a vent. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/31/24 at 10:12 AM during an interview, the respiratory therapist (Staff #46) reiterated what was in the note he wrote on 5/14/24. Staff #46 also reported when he arrived the ventilator was 7 - 8 feet away from the resident, the tubing wasn't stretched out and it was sitting with the ventilator. Staff #46 also reported that staff were supposed to have an RT called in prior to a transfer and indicated that no one said anything about moving the resident to him prior to the incident. Further review of facility documentation revealed a statement that RT (Staff #45) verbally educated GNA #49 on the following: 1. Never disconnect a ventilator circuit or remove a resident from a ventilator during transfer or dressing or removing clothing. Not even for a moment. This also pertains to the trached residents who are on jet neb or room air. Always get a nurse or respiratory therapist for help. 2. Never stretch the ventilator circuit too far from the resident as this can cause a disconnection of the circuit from the resident's trach or it may cause decannulation from the resident's stoma [name of the hole the trach tube is inserted through]. Decannulated trachs may not be immediately visible, it can come out and lay on the chest under the trach dressing. Do not try to insert the trach. 3. Ventilators are needed to keep residents alive. This is how they breathe. They are on a ventilator because they cannot breathe on their own. If disconnected from a ventilator whether accidentally or intentionally, the resident could possibly pass away due to lack of oxygen. 4. There are always respiratory therapists on staff who are willing to help get residents out of bed to handle the ventilators and tubing. Please get them to help with any ventilator residents, even if it is for care while the resident is in bed. This document included the statement I agree that I have been educated by Respiratory Therapist on the topics stated above on May 14, 2024 witnessed by [RT Staff #46 and Unit Nurse Manager Staff #3]. The form was signed by GNA #49 and by Staff #3 on 5/14/24. On 5/30/24 review of the completed facility-reported incident follow-up investigation report regarding the 5/14/24 incident revealed the following statement: Summary of the interviews include that the GNA disconnected the resident from the ventilator to transfer the resident. This was observed by another GNA in the room. Further review of the follow-up investigation report revealed the following corrective action was taken: Agency GNAs are not to be assigned to ventilator-dependent residents and all GNAs receiving education by the respiratory therapist regarding proper care of ventilator/tracheostomy residents. Further review of the facility documentation revealed an Education Sign-in Sheet for GNA Respiratory Education for May 20 - 24, 2024 that included 28 GNA signatures. Review of the list of GNAs who work at the facility revealed 25 employees and 5 agency GNAs. On 5/30/24 at 4:10 PM the NHA confirmed education was completed by May 24, except for one GNA who was on leave and then provided documentation that GNA was educated on 5/28 when she returned to work. NHA also indicated one of the 5 agency GNAs has not worked at the facility since the incident but has been made aware will need to be educated prior to working again. Review of the GNA Respiratory Education sheet revealed the following were covered in the training: (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Never disconnect the ventilator circuit or remove a patient from the ventilator during transfer, or to dress/remove clothing from a patient. Always ask the respiratory therapist for assistance. 2. Vent tubing placement- Make sure that vent tubing moves freely to prevent pulling of the trach while performing patient care. 3. Decannulation - If the trach becomes dislodged during patient care, call for respiratory to re-insert the trach back into the stoma. Do NOT attempt to re-insert the trach yourself. 4. Do NOT silence the alarm on the ventilator by hitting the Silence Alarm button. 5. Suction regulators should not be turned on FULL suction while performing mouth care. Regulators should be turned no higher than 150 mmHg. Regulators should also be turned back down when finished. On 5/30/24 based on review of facility documentation and interview with several GNAs surveyor confirmed the facility completed the GNA training. On 5/31/24 at 8:00 AM the NHA confirmed that they will be following up in Quality Assurance regarding this issue and indicated that they address all their facility-reported incidents in QA. NHA also reported that they will be reviewing their training materials. Review of GNA #49's employee file revealed a Nursing Service Orientation Topic Validation 2023 form that was noted to be blank. On 5/31/24 at 9:28 AM the NHA reported that this form had not been implemented prior to the event on 5/14/24. This form included a section for Respiratory Training/Ventilator Equipment: Types of Tracheostomies & Tracheostomy Care; Ventilator Functionality; T-piece functionality - Aides Should Not Disconnect to Move Patient; Turning and Positioning Safety for Patient with Tracheostomy; Trach Collar, Respiratory Training/Ventilator Equipment and Ventilator Alarm Recognition & Safety: Disconnections etc. On 5/31/24 at 9:30 AM the NHA confirmed that moving forward they will be utilizing the Nursing Service Orientation Topic Validation form and will also be including the training that was completed with all of the GNAs post incident for new hires.

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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. 37276 Based on medical record review and interview with staff it was determined that the facility failed to ensure that irregularities identified by the pharmacist were reviewed by the attending physician, and that the attending physician documented in the medical record that the review has been completed and what, if any, action has been taken to address it; and failed to develop policies and procedures that included time frames for the physicians to complete this review. This was evident for 2 (Resident #6 and #9) of 5 residents reviewed for unnecessary medication. The findings include: 1) On 5/24/24 at 9:00 AM, a review of Resident #6's electronic health record (EHR) reveal Medication Management - Medication Regimen Review (MM-MRR) notes that documented the pharmacist's results of the MRR and the pharmacist's recommendations for identified irregularities. 1a) On 9/14/23, in a MM-MRR note, the pharmacist wrote that on 8/18 and 9/11, under chronic pain syndrome, the physician documented that Resident #6 was on Oxycodone (narcotic) and Gabapentin (treats nerve pain) for pain. The pharmacist wrote that the resident was on a significant routine dose of Morphine and recommended Morphine be included in the facility's pain evaluation with monitoring of side effects, efficacy and drug interactions, as well as considering tapering, and to please evaluate all. Continued review of the resident's medical record failed to reveal documentation that the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action has been taken to address it. 1b) Review of Resident #6's pharmacist medication regimen review progress notes revealed on 12/18/23 in a MM-MRR results note, the pharmacist recommended a follow-up with the resident's anemia issue and possible history of OBS (occult blood stool). In the note, the pharmacist indicated that recent notes or labs were not found and recommended the physician consider a PPI (proton pump inhibitor) (reduce stomach acid) until colonoscopy due to Eliquis (anticoagulant). Continued review of the resident's medical record failed to reveal documentation that the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action has been taken to address it. 1c) On 1/16/24, in a medical progress assessment note, the attending physician documented the resident had GERD (Gastroesophageal reflux) (heartburn) and a PPI was added for recent frequent chest pain complaints. The physician also documented Resident #6's Cologuard (non-invasive stool DNA test that screens for colon and rectal cancer), was positive, colonoscopy is indicated and will be ordered. Continued review of the resident's medical record failed to reveal evidence that a PPI had been prescribed for Resident #6 at that time. In addition, there was no documentation that the attending physician reviewed the pharmacist's identified irregularity, or that the physician was responding to the pharmacist's recommendations from 12/18/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/24, in a MM-MRR note, the pharmacist documented that Resident #6's most recent progress notes indicated the resident was to start PPI therapy and the pharmacist had not seen a new order for the PPI. The pharmacist also wrote that the November pharmacy recommendation had not received a documented response. Review of a MM-MRR note on 11/25/24, for Resident #6 the pharmacist wrote No issues found during review, however, the review of Resident #6's MM-MRR notes revealed the pharmacist wrote for the physician to consider a PPI on 12/18/23. Continued review of the medical record failed to reveal documentation to indicate the attending physician reviewed the pharmacist's recommendation and the physician's potential response. 1d) On 2/24/24, in a MM-MRR note, the pharmacist recommended follow-up with a positive Cologuard test and intention to start PPI from progress note on 1/16/24. The pharmacist documented the resident was on Eliquis and recommended CBC (complete blood count) and BMP (basic metabolic panel) lab work at this time to determine if PPI would be beneficial, and that it did not appear that a PPI had ever been started. Continued review of the resident's medical record failed to reveal documentation that the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action has been taken to address it. On 5/24/24 at 12:45 PM, during an interview, the unit nurse manager (Staff #3), was made aware that the review of the resident's medical record failed to provide documentation to indicate the attending physician reviewed the irregularities that were identified by the pharmacist, and what if any action had been taken by the physician to address it. Staff #3 acknowledged the concerns at that time. On 5/24/24 at 2:04 PM, the above concerns were discussed with the Chief Medical Officer (Staff #10). During the interview, Staff #10 stated that the medication regimen review process had recently changed, as they had identified a problem with the previous process. Staff #10 indicated that the pharmacist now writes a note in the Pharmacy Recommendation Tab of the EHR and the provider responds to the pharmacist in their own pharmacy recommendation note. Staff #10 indicated she was responsible for the tracking of the MRR, and a PIP (Performance Improvement Plan) was done in April for changes to process. 50573 2) Review of Resident #9's medical record on 5/20/24 revealed the resident has resided at the facility for several years. Review of medical on 05/28/24 at 09:05 AM revealed that the resident had been ordered both ibuprofen and warfarin. Warfarin is a medication that thins blood and international normalized ratio (INR) is a blood level monitored while taking warfarin. The blood level is determined by a lab test using blood and it reveals how thin or thick blood is to evaluate if the Warfarin dose needs to be increased or decreased. Ibuprofen is a common pain medication that can affect the INR level if taken with warfarin. Further review of medical record on 05/29/24 at 10:10 AM revealed that the monthly medication review (MMR) are being done each month. (continued on next page)

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	215110	A. Building B. Wing	06/04/2024

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Western MD Hospital Center	1500 Pennsylvania Avenue Hagerstown, MD 21742

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of medical record revealed from the monthly pharmacy recommendation, or MMR, on 11/25/23 the pharmacist (Staff #57) documented: it is notable that patient is using PRN (as needed) medications several times a day for Ibuprofen, Tylenol, tums. Also the INR has been increasing and Warfarin dose has been adjusted downward. It appears the Ibuprofen may be contributing to drug interactions and side effects (Ie. possible reason for tums use). Recommend evaluate at this time to consider alternative pain therapies and discontinue ibuprofen. Further review of the medical record failed to reveal documentation that the primary care provider reviewed and addressed the recommendation from 11/25/23. Further review of the monthly pharmacy recommendation revealed that on 12/17/23 the pharmacist (Staff #57) documented, MRR completed. Please see the 11/25/23 Pharmacy recommendations to address. Further review of the medical record failed to revealed documentation that the primary care provider reviewed and addressed the recommendation from 12/17/23 Further record review of the monthly pharmacy recommendation revealed that on 1/16/24 the pharmacist (Staff #57) documented, MMR completed. Patient is noted to have unstable INR. Of note, [s/he] uses PRN ibuprofen, which may cause a drug interaction with INR fluctuation. Recommend consider discontinue the ibuprofen/NSAID use. Further review of the medical record failed to revealed documentation that the primary care provider reviewed and addressed the recommendation from 1/16/24 An interview with Primary Care Provider, OD (Staff #40) on 05/29/24 at 03:27 PM revealed that the pharmacist (Staff #57) will notify Staff #40 when a recommendation has been made. Further interview with Staff #40 revealed that the facility has had many different procedures over the years on how physicians are notified of pharmacy recommendations. The current process consists of pharmacists documenting the MMR in the electronic medical record platform used at the facility and the physicians can reply to the notes or create a new note following it. Review of the Drug Regimen Review for Comprehensive Care policy, that was provided during the survey, failed to reveal a date that it was established. Review of the procedures section of this policy revealed The attending physician will review the pharmacist's recommendations but fails to include a time frame for the physicians to respond to pharmacists recommendations or that this response needs to be documented in the medical record. On 05/31/24 at 4:25 PM, the surveyor reviewed the concern with the Director of Nursing (Staff #18), and Nursing Home Administrator (Staff #1) regarding the failure to have a system in place to ensure that physicians reviewed and addressed monthly pharmacy recommendations. As of survey exit on 6/4/24 at 5:00 PM, the facility failed to have provided additional documentation regarding this concern.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37276 Based on medical record review and staff interviews, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary medication by failing to adequately monitor a resident for behavior, side effects, or adverse consequences related to a resident's use of psychotropic medication. This was evident for 1 (Resident #6) of 5 residents reviewed for unnecessary medications. The findings include: On 5/21/24 at 3:15 PM, a review of Resident #6's medical record revealed the documentation that the resident resided in the facility for long term care since February 2020 and had diagnoses that included bipolar disorder (manic depression) (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). Review of Resident #6's May 2023 Electronic Medication Administration Summary (eMAR) revealed a 9/27/22 order for Mirtazapine (Remeron, an antidepressant) Tablet by mouth one time per day for bipolar disorder that was documented as given every day as ordered from 5/1/24 to 5/21/24. Continued review of the resident's medical record failed to reveal documentation to indicate the facility staff conducted ongoing monitoring of Resident #6 for the resident specific behaviors for which a psychotropic medication had been prescribed and there was no documentation to indicate the resident was monitored for the side effects of the antidepressant medication. On 5/22/24 at 1:31 PM, during an interview, the unit nurse manager (Staff #3) stated that when a resident received psychotropic medication, the physician wrote the order for the psychotropic and for the behavior monitoring. Staff #3 indicated she was not sure how that was attached to the electronic health record (EHR). Staff #3 stated that as far as she knew, the doctor wrote the order, and the order should populate into the resident's administration record so the nurses could document on something that flows. At that time, Staff #3 was made aware of the above concerns related to failing to monitor Resident #6 for behavior and potential antidepressant medication side effects, and Staff #3 offered no further explanation at that time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 37276 Based on record reviews and interviews, it was determined that the facility failed to maintain complete and accurate medical records for its residents. This was evident for 3(Resident #6, #21, and #96) of 24 residents reviewed during the survey. The findings include: 1a) On 5/20/24 at 11:24 AM Resident #6 was observed to have his/her hands in a cupped position indicating possible contractures (fixed resistance to passive stretch of a muscle). There was no splint or device in place in either of the resident's hands and soft palm protectors were observed on the resident's bedside table. On 5/21/24 at 3:15 PM, a review of Resident #6's medical record revealed the resident resided in the facility for long term care since February 2020 and had multiple diagnosis, including traumatic spinal cord dysfunction and contractures of muscle of his/her right lower leg, left lower leg, right upper arm and left upper arm. Resident #6's quarterly assessment with an assessment reference date (ARD) of 4/13/23 documented Resident #6 had a functional limitation in range of motion (ROM) in both upper extremities and a functional limitation in ROM in both lower extremities and the resident received restorative nursing. Review of Resident #6's May 2024 eMAR (electronic medication administration record) revealed a 9/28/22 order for bilateral palm protectors 4 hours at a time, 2 times/day, evening as needed. There was no documentation in the eMAR to indicate the palm protectors had been applied to Resident #6 during the review period of 5/1/24 to 5/22/24. On 5/24/24 at 3:42 PM, during an interview, the occupational therapist (Staff #27) stated that when Resident #6 was admitted to the facility, the resident was evaluated by therapy, noted to have hand contractures and issued palm protectors. When made aware there was no documentation to indicate the palm protectors had been applied to the resident, Staff #27 indicated Resident #6 received restorative nursing, and the restorative aides applied the palm protectors to the resident for 4 hours at a time, two times a day. The OT stated that problem was with the way therapy entered the order into the EHR, which prevented accurate documentation in the eMAR, and therapy had just recently become aware of the problem 1b) Further review of Resident #6's electronic medication administration (eMAR) record revealed a 9/26/22 order for Silver Nitrate (medication used for cauterization) (process of burning the skin to stop bleeding or prevent a wound infection) as needed: cleanse area with Normal Saline (NS), pat dry. Apply A & D ointment around site to keep silver nitrate from migrating to healthy tissue. Touch Hypergranulation tissue with silver nitrate stick(s); apply DSD [dry sterile dressing] over area for a minimum of 24 hours. There was no indication in the order to as to where the Silver Nitrate was to be applied. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concerns with the Silver Nitrate order were discusses with the unit nurse manager (Staff #3) on 5/22/23 at 3:50 PM. At that time, Staff #3 acknowledged the concern and indicated she would follow-up with physician. 2a) On 5/20/24 at 11:32 AM, Resident #21 was observed to have both hands bent in a cupped position, indicating possible contractures and there was no splint or device in place in either of the resident's hands. Review of Resident #21's medical record revealed the resident had diagnosis which included spastic quadriplegic cerebral palsy and contracture of unspecified joint. Review of Resident #21's annual MDS 3/23/24 revealed documentation that Resident #21 had passive range of motion and splint, or brace assistance performed 3 times for at least 15 minutes and in the last 7 days. Review of Resident #21's May 2024 eMAR revealed a 2/1/24 order for pillow rolls/bolsters on bilateral upper extremity's 4 hours each shift as needed for contracture management as needed. Following the order, there was no documentation in the eMAR to indicate the order had been implemented and the pillow rolls/bolsters applied to Resident #21's upper extremities in May 2024. On 6/4/24 at 12:58 PM, during an interview the Therapy Services Manager (Staff #25) and the Restorative Nurse/MDS Coordinator (Staff #5), were made aware that there was no documentation in the resident's May 2024 eMAR to indicate pillow rolls/bolsters were employed for management of Resident #21's contractures. At that time, Staff #25 reported that Resident #21 received restorative nursing care for management of his/her contractures, and because of the limitations of the EHR software, restorative aides were not able to accurately document in the EHR. Staff #5 stated that the documentation makes it look like they were non-compliant, when they actually were, and indicated the problem was due to cut off time for documenting in the EHR. 2b) Further review of Resident #21's May 2024 eMAR summary revealed an 8/7/23 order for 1 mineral oil rectal enema rectally as needed one time per day. The order indicated the enema could be given once a day, however the order failed to include an indication as to the reason the enema could be administered to the resident. Following an interview on 6/4/24 at 12:58 PM, Staff #5 was made aware of the concern that Resident #21's enema order failed to have a clear indication of when the enema was to be administered as needed, and Staff #5 acknowledged the concern at that time. 45139 3) On 5/23/24 at 3:00 PM, the chart of Resident # 96, a long-term resident of the facility, was reviewed. A review of the chart revealed several Maryland Orders for Life-Sustaining Treatment (MOLST). The recent MOSLT was dated 1/02/2024. Further review revealed a prior MOLST dated 1/9/23 that failed to reveal a diagonal line through the sheet, the word void, and the physician or nurse practitioner's signature. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maryland MOLST (Maryland Orders for Life-Sustaining Treatment) is a portable and enduring medical order form covering options for cardiopulmonary resuscitation and other life-sustaining treatments. Medical orders are based on a patient's wishes about medical treatments. Per the MOLST instructions, to void the MOLST order form, a physician or nurse practitioner shall draw a diagonal line through the sheet, write VOID in large letters across the page, and sign and date below the line. Keep the voided order form in the patient's active or archived medical record, On 5/24/24 at 2:42 PM, the above concerns were discussed with the Medical Director (Staff # 10). She confirmed the presence of more than one MOLST in Resident # 96's chart. In addition, she confirmed that the old MOLST was not voided correctly. She is aware of the correct way the MOLST is to be voided and stated she would educate her staff.