STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215193	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resorts of Augsburg	6811 Campfield Road Baltimore, MD 21207

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50385 Based on observations, resident and staff interviews , and record reviews, it was determined that the facility failed to treat residents with respect and dignity in an environment that promotes enhancement of quality of life. This was evident for 3 (Resident #55, #81, #84) out of 4 residents reviewed for dignity during the recertification survey. The findings include: 1. During observation rounds on 4/4/2024 at 8:30 am, the surveyor observed 2 urinals on the floor in resident #55's room. An empty urinal was laying on the floor against the wall closest to the entrance of the room. Another urinal with amber colored fluid was observed laying in between the bedside table and the wall. The resident was yelling for the nurse stating, I need a razor to shave my face. During an interview on 4/4/2024 at 8:32 am with Resident #55, s/he stated that the nurse came to empty the urinal and placed the urinal on the floor. During an interview on 4/4/24 at 8:40 am with Licensed Practical Nurse (LPN) staff # 10, she stated she didn't know who put the urinals on the floor. During a follow-up observation on 4/4/2024 at 8:53 am, the urinals were still observed on the floor in the same locations. Review of resident #55's medical record on 4/4/2024 at 11:32 am revealed the resident has diagnoses that include blindness and dementia. 18819 2. During an observation of the lunch meal on the Water's Edge nursing unit on 04/15/24 at 12:04 PM, the surveyor observed Staff #49 standing over Resident #81 while assisting the resident with eating. Staff #49 was also observed with his/her cell phone in his/her hand while assisting Resident #81 with the lunch meal. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Continued observation revealed that after assisting Resident #81, Staff #49 proceeded to assist Resident #84 with the lunch meal. Staff #49 sat down next to Resident #84 and placed his/her cell phone on the table. Staff #49 was observed interacting with his/her cell phone while assisting Resident #84 with the lunch meal. In an interview with the 04/15/24 day shift charge nurse, Staff #28, at 12:12 PM, Staff #28 stated that Staff #49 was supposed to be going with another resident to an appointment. Staff #28 stated that he/she asked Staff #49 to assist the residents on the Waters Edge unit with the lunch meal.

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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. 30440 Based on administrative and medical record review, and interviews with facility staff it was determined the facility failed to keep a resident safe from neglect when an employee failed assist a resident with Activities of Daily Living (ADL) as required. This was found to be evident for 1 (Resident #1) of 9 residents reviewed for abuse during the survey. Findings include: Intake MD00200445 was reviewed on 4/16/24 at 4:00 PM for allegations of resident neglect. According to the intake report, Geriatric Nurse Assistant (GNA # 85) placed resident # 1 dinner tray in his/her room on the bedside table across the room and out of the resident's reach. Further review of the facility's investigation found a notice of Corrective Action Form dated 12/14/23 indicating the following: GNA # 85 did not follow proper protocol for providing a meal to the resident and did not assist the resident with ADL's as requested by the resident. The facility spoke with the employee on 12/19/23 about termination and sent a letter. An interview was conducted with the DON on 4/16/24 at 5:00 PM and she stated the facility underwent new ownership that became effective as of January 2024. She confirmed that upon her review of the investigation, the employee (#85) was terminated for not adhering to protocols and providing a resident with a dinner meal and ADL assistance. The Administrative team was made aware of all concerns at the time of exit on 4/18/24 at 1:30 PM.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 18819 Based on reviews of the facility investigation and other pertinent information, reviews of a closed medical record, and staff interview, it was determined that the facility 1) failed to report allegations of possible abuse to the local police within 2 hours when a resident (# 255) was identified with an injury of unknown source (fracture). and 2) failed to notify the state agency within 2 hours of a potential abuse/neglect incident. This was evident for 4 (Resident # 69, # 54 and # 10, #255) of 9 residents reviewed for abuse during the recertification survey. The findings include: 1. A review of the facility abuse policy on 04/16/24 revealed under Section V. Reporting, any witnessed or suspected violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property, must be reported immediately to the employee's supervisor. Under Section P. indicated that: Local law enforcement agencies will be notified as appropriate. Under Section VIII. Abuse Coordinator Procedures: K. Should the investigation reveal that abuse, neglect, mistreatment, or misappropriation of resident's/patient's property occurred, the Abuse Coordinator or designee will report such findings to the local Police Department, (if applicable) the Ombudsman, and the New Jersey Department of Health & Senior Services and Risk Management within twenty-four (24) hours. It is to noted that the facility changed ownership on 01/01/24. A review of Resident #255's closed medical record on 04/16/24 revealed that Resident #255 suffered from dementia and was unable to communicate with staff as to the possible cause when Resident #255 was identified with swelling and bruising to the left lower leg on 03/16/24 at 9:30 am. Reviews of facility reported incident (FRI) MD00203805 on 04/11/24 revealed an allegation Resident #255 was observed with bruising to the left knee on 03/16/24. Review of the facility investigation revealed that Resident #255 was identified with swelling and bruising to the left knee, by Staff #12, at 9:30 am on 03/16/24. Resident #255's physician and family were made aware of the new swelling and bruising. On 03/17/24 at 8:45 am, the facility director of nurses (DON) was made aware of the x-rays results which identified a fracture of Resident #255's left tibia and fibula (lower leg). The facility investigation indicated that the DON notified the facility administrator of Resident #255's left tibia and fibula fracture at 11 am. Further review of the facility investigation indicated the facility did not notify the local law enforcement of an injury of unknown source. In an interview with Staff #12 on 04/16/24 at 2:55 PM, Staff #12 stated that he/she was the employee who observed swelling and bruising to Resident #255's left leg area on 03/16/24 at 9:30 am. Staff #12 stated that he/she observed big bruising to Resident #255's left leg. Staff #12 stated that Resident #255 was currently receiving hospice services on 03/16/24. Staff #12 also stated that Resident #255 did not complain of pain, showed signs of being in pain, or could explain how he/she received the swelling and bruising to the left leg. 42782 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review on 04/12/24 at 11:35 AM of the facility's abuse neglect, mistreatment or misappropriation of resident's property policy revealed staff should report all allegations of abuse immediately to their supervisor. On 04/15/24 at 12:15 pm while reviewing the facility's investigation for MD00201069 involving Resident #69 the surveyor read the Administrator was notified of the incident of suspected abuse on 12/29/23 at 9:08 am. Further review of the report revealed the incident was submitted to the state agency on 12/29/23 at 10:02 pm which was outside of the 2-hour window required to report a potential abuse/neglect allegation. 42863 3. According to record review, Resident #54 was diagnosed with major depressive disorder, adult failure to thrive, Alzheimer's disease, severe dementia with behavioral disturbance, peripheral vascular disease, abnormal weight loss. The medical record documented a brief interview for mental status (BIMS) score of 01/15 for the resident from the time of admission through the time of the incapacity evaluation on 02.26.24 indicating severe cognitive impairment. On 04.05.24 at 08:30 AM the surveyor reviewed the intake, MD00200917, a facility related incident report regarding Resident # 54 and the elopement that occurred on 12.24.23 at 19:29. The intake revealed that the resident #54 eloped unwitnessed, from a locked unit via an elevator and was able to exit to the courtyard of the facility, was discovered missing at 7:29 PM and returned to the unit by 8:15 PM by staff members. The incident report was submitted to the state agency on 12.25.23 at 19:20 PM which was more than the required 2 hour minimum for reporting. On 04.05.24 at 09:15 AM the DON stated that the facility report for Resident #54 was incomplete and that the administration team would contact the former owners of the facility to obtain the additional documentation related to the 12.24.23 elopement incident. At the time of the exit conference on 04.18.24 at 1:30 PM the facility had not provided any additional documentation related to Resident # 54's elopement. 4. According to record review, Resident # 10 was diagnosed with severe vascular dementia, cerebral vascular disease, major depressive disorder, and schizoaffective disorder upon admission on 12.27.21. The minimum data set assessment (MDS) completed on 03.05.24 reflected a brief interview for mental status (BIMS) score of 7 out of 15 for Resident #10 indicating moderate cognitive impairment. On 04.08.24 at 09:30 AM the surveyor reviewed the intake, MD00203719, related to a facility reported incident that was submitted to the OHCQ. Resident #10 alleged that a male geriatric nursing assistant (staff # 51) committed sexual abuse towards him/her on 03.11.24 in the morning by allegedly inappropriately touching of the resident. The facility initiated an investigation at 12:15 PM on 03.11.24 and notified the family representative who was present during the start of the initial investigation. The outcome of the facility investigation that was documented in the final incident report stated the allegations were unproven. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04.10.24 at 10:30 AM during an interview with the DON the surveyor was informed that the previous owners did not provide all related documents related to the facility incident reports in the folders that are currently being distributed to surveyors for review. The initial facility report was submitted to OHCQ on 03.11.24 at 5:00 PM electronically per the copy of the document provided to the surveyor by the facility. However, Resident #10 reported the allegation on 03.11.24 at 12:15 PM to the nurse manager, staff #50. There was a delay in the facility reporting the alleged abuse to OHCQ based on the documentation reviewed by the surveyor. The facility failed to report an allegation of neglect related to the elopement of resident #54 and an allegation of abuse towards resident # 10 to OHCQ within the two-hour timeframe requirement. These areas of concern related to the timely submission of facility related incident reports were discussed with the facility administrative team during the survey process and at the time of exit on 4/18/24 at 1:30 PM.

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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. 30440 Based on administrative and medical record review and interviews with facility staff, it was determined the facility failed to complete a thorough investigation into abuse allegations for a resident with an injury of unknown origin. This was found to be evident for 1 (Resident # 1) of 9 residents reviewed for abuse during the survey. Findings include: Intake # MD00199866 was reviewed on 4/15/24 at 9:00 AM for allegations of abuse for an injury of unknown origin. Review of the facility's investigation revealed resident # 1 was admitted with the following but not limited diagnosis: Osteoarthritis (Degenerative Joint Disease). According to the investigation on 11/23/23 the resident's assigned GNA (Geriatric Nurse Assistant) stated that at approximately 8:00 PM while providing care, she noticed that the resident right lower leg was swollen and rotated outward. The nurse confirmed this finding after her assessment and the resident was sent to the emergency room for further evaluation. The resident returned with diagnosis of fracture of right tibia and fibula. An interview was conducted with the DON on 4/15/24 at 9:50 AM and she was asked to explain the facility's process of investigating for an injury of unknown origin and she stated the following: All injuries of unknown origin are reported from staff to DON, then an investigation is begun to include staff interviews, and the resident if possible. Review of the medical record and notification of the physician. An assessment is done by the provider/physician. Pertinent team members will meet to determine the root cause. The DON stated that an injury of unknown is looked at as abuse and the police are notified. She added that if staff can tell the administration team what happened through the investigation, then the police will not be notified if the explanation is definitive. All the information is documented within the investigation. The DON was made aware that law enforcement was not notified per the facility's investigation. She was asked to provide documentation of staff and resident interviews to the survey team. During another interview on 4/16/24 at 10:55 AM with the Interim Administrator (Staff # 9) and the DON, they stated that the current administration signed ownership of the facility in January 2024 and that the previous owner did not leave a copy of staff and/or resident statements and were unable to provide the survey team with documentation of interview statements by staff or residents. All concerns were discussed with the administration team at the time of exit on 4/18/24 at 1:30 PM.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48167 Based on resident medical record review and interviews it was determined the facility failed to provide a resident and his/her representative a complete summary or complete written summary of the resident's initial baseline care plan. This was evident for 1 resident (#17) out of 53 residents reviewed during the survey. The findings include the following: A facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility and any updated information based on the details of the comprehensive care plan, as necessary. Review of resident #17's medical record on 04/08/2024 at 01:45 PM revealed that resident (#17) was admitted to the facility on [DATE] and there was no evidence or documentation found that resident (#17) or his/her representative was provided a complete summary or a complete written summary of resident #17's initial baseline care plan that included all the requirements as stated above. During an interview on 04/09/2024 at 04:05 PM the Director of Nursing staff (#2) stated that she was not able to find documentation stating or showing that a complete summary or complete written summary of resident #17's initial baseline care plan was provided to resident (#17) or his/her representative.

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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. 30440 Based on administrative and medical record review, and interviews with facility staff it was determined the facility failed to develop a care plan for a resident at risk for wandering. This was found to be evident for 1 (Resident # 73) of 7 residents reviewed for accidents during the facility's survey. 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 care. MD00172344 was reviewed on 4/10/24 at 10:30 AM for allegations that Resident # 73 was observed out of the building in the adjacent parking lot. Further review of the resident medical record on the same date at 11:15 AM revealed the resident has the following but limited diagnosis: Vascular Dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). Review of a wandering assessment that was done on 5/18/21 upon admission, indicated a score of nine (9). A score of 9 indicates the resident is at risk to wander. There was no care plan in place for wandering at this time. An interview was conducted with the DON on 4/10/24 at 2:00 PM and she was asked to provide the survey team with a copy of the resident wandering care plan. She was unable to provide this documentation to the survey team. She provided a copy of resident # 73 elopement care plan that had an initiation date of 9/19/21. The DON stated that the care plan was initiated after the resident was observed outside of the building in the parking lot. The DON acknowledged that a care plan should have been developed at the time the wandering assessment was completed upon the resident's admission on 5/18/21 to address the specific concerns. All concerns were discussed with the administration team at the time of exit on 4/18/24 at 1:30 PM.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 49304 Based on record review and interview with facility staff, it was determined that facility nursing staff failed to follow professional standards of nursing when documenting medications. This was evident for 1 of 9 residents (Resident #260) reviewed for abuse. The findings include: It is the standard of nursing practice to document administered medications immediately after administration. Failing to do this results in an inaccurate record where it cannot be determined when a medication was actually given and has the potential to result in medication errors (such as a resident receiving a dose twice, or two doses of a medication being given too close in time). On 4/8/24 at 8:39 AM, review of the facility's investigation packet for MD00199456 revealed a written statement from Geriatric Nursing Assistant (GNA #5) dated 11/11/23 that stated while they were giving out breakfast, they noticed Resident #260's right wrist was swollen, and immediately reported it to the charge nurse [LPN #48]. On 4/10/24 at 8:21 AM, review of the medical record revealed a Progress Note written by LPN #48 dated 11/11/23 at 6:22 PM that stated, Resident #260 was noted this morning with a swollen right wrist and complained of pain. The resident was unable to state what happened. The Nurse Practitioner (NP) on call was notified who ordered an x-ray to rule out a fracture. The resident is stable at this time and pain managed during the shift. On 4/11/24 at 2:00 PM, record review of the medication administration record (MAR) for the month of November 2023 revealed on 11/11/23, Resident #260 was documented with 10/10 pain during the Pain Assessment for night shift. Furthermore, the resident was ordered Tylenol Oral Tablet 325mg, Give 2 tablets by mouth every 6 hours as needed for pain. The medication was ordered on 6/1/23 at 11:56 AM and the order was active until it was discontinued on 11/12/23 at 5:27 AM. For the month being reviewed [November 2023], from 11/1/23 to 11/12/23, there was no documented administration of the medication in the patient's medical record. On 4/12/24 at 1:48 PM, in an interview with the Director of Nursing (DON), she was made aware that Resident #260 was confirmed via x-ray to have sustained a right wrist fracture and there was no documentation of pain medication being administered for almost an entire day. The surveyor requested the DON to look into this and provide any documentation. No such records were provided to the survey team by the time of survey exit. The first dose of pain medication documented for Resident #260 after their swelling was noted at breakfast on 11/11/23 and with documented complaints of pain was on 11/12/23 at 6:53 AM. The Administration Team was made aware of all concerns at the time of survey exit on 4/18/24 at 1:30 PM.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a closed medical record and staff interview, it was determined that the facility nursing staff failed to update a resident's physician prescribed wound care treatment orders after the facility wound consultant updated the treatment orders after a weekly assessment. This was evident for 1 (Resident #257) 4 residents reviewed for pressure ulcers during the recertification survey. The findings include: Review of Resident's #257's closed medical record on 04/09/24 revealed that Resident #257 was admitted to the facility on [DATE]. Resident #257 was seen by the facility wound consultant on 09/26/23 and was identified with a left heel deep tissue injury and a bilateral sacrum wound. The wound consultant noted Resident #257's wounds to be chronic and require continued topical wound dressing therapy. The wound consultant gave orders instructing the nurses to apply a betadine dressing to the left heel and apply medihoney, calcium alginate and a foam dressing to the bilateral sacrum wounds daily. Resident #257 was seen in the facility by the facility wound consultant on 10/03/23, 10/10/23, and 10/17/23 who noted improvement in Resident #257's left heel and bilateral sacrum wounds at each visit. On 10/24/23, the facility wound consultant assessed Resident #257's wounds at the bedside. The facility wound consultant changed the dressing to Resident #257's left heel by instructing the nurses to now apply Betadine to eschar only, and apply hydrogel to the granulation zone only, and cover with a Non-adherent or ABD pad, and wrap the area with Kling. On 10/31/23, the facility wound consultant assessed Resident #257's wounds at the bedside. The facility wound consultant changed the dressing to Resident #257's bilateral sacrum wounds instructing the nurses to apply medihoney, calcium alginate apply border foam dressing to the open/granulating wound daily. The wound consultant also ordered the nursing staff to apply Nystatin mixed with dimethicone lotion to the Moisture-associated skin damage (MASD)/fungal periwound, three times a day, and with each incontinent episode. On 11/07/23, the facility wound consultant continued the same 10/31/23 daily treatment to the bilateral sacrum wounds and instructed the nursing staff to apply betadine to the left heel. The facility wound consultant indicated that there was no change to Resident #257's wounds since 10/31/23. A review of Resident #257's medication and treatment orders failed to reveal the nursing staff had updated Resident #257's wound care instructions after each wound care assessment. A review of Resident #257's medication and treatment administration records and physician orders from 09/20/23 through 11/07/23 revealed that the nursing staff were documenting that; 1) the medication Santyl External ointment was being applied to the sacrum area every day, 2) applied medihoney to the left buttock wound every day, and 3) applied skin prep to bilateral heels every shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #257's closed medical record failed to reveal the nursing staff had changed Resident 257's wound care treatment orders after the 10/24/23 and 10/31/23 wound consultant visit. The nursing staff also failed to update the physician orders following the wound consultant's 10/24/23 and 10/31/23 wound assessments. In an interview with the facility wound care consultant on 04/18/24 at 3:19 PM, the nurse surveyor informed the wound consultant that the nursing staff were documenting that they were applying Santyl and medihoney to the bilateral sacrum wound and applying skin prep to the left heel during the time Resident #257 was admitted to the facility. The wound consultant stated that this was news to him/her.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30440 Based on administrative and record review it was determined the facility failed to provide adequate supervision for residents at risk for wandering. This was found to be evident for 2 (Resident # 73 and # 54) of 10 residents reviewed for wandering during the facility's survey. Findings include: 1. Intake MD00172344 was reviewed on 4/10/24 at 10:30 AM for allegations that resident # 73 was observed outside of the building in the adjacent parking lot. On 4/10/24 a review of resident # 73's medical record revealed the resident has the following but not limited diagnosis: Aphasia (a language disorder caused by damage in the brain that controls language expression and comprehension) following nontraumatic intracranial hemorrhage and Hemiplegia and Hemiparesis (muscle weakness or partial paralysis on one side of the body) following nontraumatic intracerebral hemorrhage affecting left non-dominant side. 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. The Brief Interview for Mental Status (BIMS) is an assessment that measures a person's cognitive ability using a scoring system that ranges from 0-15 points; 0-7 suggests severe impairment, 8-12 suggests moderate cognitive impairment and 13-15 suggests that cognition is intact. Review of the 5-day assessment dated [DATE] Section (C) for cognition patterns on 4/10/24 at 11:00 AM revealed a BIMS score of (99) which means the resident couldn't be assessed and was incomplete. Review of a wandering assessment that was done on 5/18/21 upon admission, indicates a score of nine (9). A score of 9-10 indicates the resident was at risk to wander. There was no care plan in place for wandering at this time. Review on 4/10/24 of the facility's investigation and several signed type statements from staff revealed the following: A signed typed statement by a Registered Nurse (RN) (#36) revealed on 9/19/21 at about 3:00 PM a GNA informed RN (# 36) that resident # 73 was observed outside by the church area and had to assist the resident back to the floor. The resident's family visited and when the family was about to leave the resident attempted to follow. The GNA no longer works for the facility and attempts to contact the GNA were unsuccessful. A written statement by the maintenance staff # 46 revealed that on 9/19/21 he was instructed to assess doors and alarms by chapel. All doors are properly secured and functioning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Interim Administrator (#9) and current DON (# 2) and Regional DON (# 8) on 4/10/24 at 2:00 PM and the interim administrator stated that the current administration team was new. The facility signed new ownership in January of 2024. He further stated that he was unable to provide additional information regarding this incident. He was asked about the layout of the facility and explained that all units on the second floor have an access code to gain entry and to exit, with one unit designated as a locked unit. The first floor is not a locked unit. Resident # 73 resided on the first floor at the time of the incident. An interview was conducted with nurse (#36) on 4/10/24 at 2:55 PM and he stated that he has worked at the facility for approximately twenty years. He was asked to provide an account of the incident and stated the following: He is very familiar with resident # 73 and while working on 9/19/21 during the day shift a GNA reported to him that resident # 73 was confused and attempted to leave. He was unable to provide the name of the GNA. The nurse #36 stated that the resident was ambulatory and attempted to follow family when they were leaving and needed to be distracted to allow the family to leave. Nurse #36 stated that when the family left the resident was placed in an open dining area near the nurse station on close monitoring after the incident. He stated that the resident had not made attempts to leave since the incident on 9/19/21. He stated that staff had been educated regarding safety precautions for residents at risk. An interview was conducted with the maintenance staff (#46) on 4/11/24 at 9:27 AM and he stated he worked for the facility for [AGE] years. In September of 2021 he was instructed to assess the building exit doors because resident # 73 got out of the building. He stated that no elevators were checked by him, only the exit doors. He further stated that the doors near the chapel were checked because this was the area where the resident was found and that there was an elevator located in the same area. Further review of the resident care plan on 4/11/24 at 10:50 AM revealed an elopement care plan for resident # 73, initiated on 9/19/21 for attempting to leave the facility with family. The interventions include the following: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, preferred books. Identify patterns of wandering: is wandering purposeful, aimless, or escapist? Is looking for something? Does it indicate the need for more exercise? Triggers for eloping are family visits. During another interview with the interim administrator (#9) on 4/11/24 at 11:45 AM he stated that all the security systems in the building that have key codes were installed in 2017. There were no repairs/additions to the key-scan security system after the current provider came in on 5/25/21. All concerns were discussed with the Administration team at the time of exit on 4/18/24 at 1:30 PM. 42863 2. Intake MD00200917 was reviewed by the surveyor on 04.05.2024 at 11:30 AM. Resident # 54 was admitted to the facility with the following but not limited diagnoses: Alzheimer's, dementia with behavioral disturbance, vascular dementia, and major depression disorder. The resident was assessed to have scored a 01 out of 15 on the BIM's assessment upon admission and throughout the current stay at the facility indicating severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the day of the elopement incident, 12.24.23, Resident #54 was described as ambulatory with a steady gait per the record review performed by the surveyor on 04.05.24 at 12:45 PM. The former administrator, staff # 31 submitted the facility report to the Office of Healthcare Quality (OHCQ) on 12.25.23 at 7:20 PM however the elopement incident occurred on 12.24.23 at 07:39 PM. At 12:22 PM on 04.05.24, the surveyor reviewed the progress notes dated: 12.24.23 at 9:00 PM, written by LPN #16 that he/she was notified by a GNA #42, assigned to resident # 54. GNA # 42 was unable to locate the resident at 7:29 PM. LPN #16 and other staff members on the unit began searching for the resident on the unit. LPN #16 notified the nursing supervisor. LPN #16 wrote that the nursing supervisor notified the other nursing units and security. The police were not notified. GNA# 42, assigned to the resident and LPN #16 searched for the resident outside the building. Resident #54 was found sitting on a chair at the ambulance entrance. Resident #54 was described as laughing, unable to explain how she/he got outside the building. The Resident was accompanied by staff back to the unit. The nursing supervisor performed the head-to-toe assessment of resident # 54, found no skin discoloration, no scratches, or bruises, vital signs stable, routine medications administered and were tolerated by the resident. Per the progress note written by LPN # 16, upon return to the unit on 12.24.23 between 8:00 and 8:15 PM, Resident #54 was toileted and placed in bed. One to one direct supervision was initiated. The family and the provider were notified. A review of the medical record and care plan on 04.10.24 at 1:45 PM revealed: Resident #54 had an area of focus as having a behavior problem (wandering, attempting to leave the unit, elopement, entering other resident's rooms, combativeness, aggression towards staff, refusing care) related to unspecified psychosis. The care plan had a initiation date of 01.08.2019, with a revision date of 12.26.2023. The primary goal: the resident would have fewer episodes of wandering, trying to leave the unit, combativeness, and aggression towards staff by the review date. The goals were initiated on 01.08.2019, the revision date was 12.29.23, and the target date was written as 01.02.2024. The interventions listed were (1) administer antipsychotic medications as ordered. Monitor/document for side effects and effectiveness. The goal was initiated on 01.08.2019 and revised on 01.08.2019. (2) The second goal listed on the care plan was: Anticipate and meet the resident's needs and the date initiated: 01.08.2019. (3) Goal #6 stated: intervene as necessary to protect the rights and safety of others. Approach /speak in a calm manner. Divert attention. Remove from situation and take to an alternative location as needed. (Goal #9) Psych services for behavior and medication management initiated on 01.08.2019 and revision on: 08.11.2020. (4) Goal # 10, Staff and visitors to ensure they check that no resident follows them off the unit through doors or elevators without a licensed nurse knowledge. (May refer to signs posted on all exits on the unit). The date goal #10 was initiated: 12.26.23 and revised on 01.08.24. (5) Staff to do more frequent check/rounds on the resident's whereabouts each shift and re-direct as needed. The initiation was 04.27.23 and revision on 01.18.24 per the hard copy of the resident #54's care plan. At 2:07 PM on 04.10.24 the surveyor reviewed the counterpoint health services documentation by staff # 84, psychiatric nurse practitioner documented on 01.09.24. The progress note referred to the last date the resident was seen by psychiatry was on 12.12.23 and was currently being seen in January 2024 as a follow-up for dementia and depression. The psychiatric medications the resident was taking as of 01.09.24 was Seroquel 25 mg QHS. The progress note did not mention any reference to resident#54's elopement that occurred on 12.24.23. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04.05.24 at 08:35 AM while in the conference room speaking to the survey team, the DON stated that all the facility incident reports that was requested by the team leader on 04.04.24 were not available. The folders for the facility incident reports only had the incident report inside but not the proof of staff training, staff and resident interviews, and other related documents related to Resident #54. At 3:00 PM on 04.10.24 the surveyor interviewed GNA # 12 who worked on the 7 AM-7:30 PM shift 12.24.23 on the Sudbrook clinical unit, where resident #54 was located. GNA #12 stated that he/she was not assigned to resident #54 however, was contacted by the nurse supervisor at 7:45 PM on her personal cellphone. GNA #12 stated that the supervisor asked whether the employee had seen resident # 54 at the end of his/her shift. GNA #12 stated that he/she reported to the supervisor that he/she had not seen resident #54 at the end of his/her shift. The surveyor was unable to interview, the 7:00 PM -7:30 AM agency nurse #44 assigned to resident #54 on 12.24.23 when the elopement occurred secondary to the employee not being an active employee. Also, the surveyor was unable to contact (by telephone) the GNA #37, who is currently no longer employed by the facility and who was assigned to resident # 54 on 12.24.23 on the 7 AM-7:30 PM. Additionally, LPN#38 who was Resident #54's assigned nurse on the 7 AM-7 PM shift was currently on medical leave per the current DON. The surveyor attempted to interview Resident #54 regarding the elopement on 04.05.24 at 10:40 AM without success. The resident was not able to recall the incident and was disoriented to time, place, and date. On 04.11.24 at 11:30 AM the surveyor interviewed GNA #43 who worked 7 PM-7 AM shift on 12.24.23 but was not assigned to resident #54. GNA #43 stated he/she did not observe resident #54 elope from the unit on 12.24.23. GNA #43 stated that she/he was informed that the resident was able to follow another resident's husband off the unit in order to elope which included the resident following the visitor to the elevator after exiting the unit. At 3:53 PM on 04.11.24, the surveyor interviewed RN # 47 regarding the elopement of the resident #54 on 12.24.23 at 07:29 PM. RN #47 stated that she/he was not assigned to the resident. This employee stated that the supervisor for night shift was LPN #16 and she/he (RN #47) was the charge nurse on 12.24.23, the date of resident #54's elopement and that all staff participated in the search for the resident. The facility failed to adequately supervise resident #54 who had been diagnosed with dementia with a history of wandering, and exit seeking behavior therefore the resident was able to elope from the Sudbrook unit on 12.24.23 at approximately 7:29 PM. This deficient practice was reviewed during the survey with the facility administrative team and was reviewed during the exit interview on 04.18.24.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40927 Based on record review and interview it was determined that facility staff failed to notify the provider when a resident reported that their pain medication was ineffective. This was evident for 1 (#26) of 3 residents reviewed for pain management. The findings include: A medical record review for Resident #26 6/25/24 at 12:25 PM revealed the resident was recently diagnosed with a liver mass. The physician documented that the condition can be painful and ordered the resident to have hydromorphone (an opioid to treat pain). Review of the physician's orders revealed the resident had an order for hydromorphone 2mg give 1 tablet every 4 hours for pain levels of 4-6 and a second order for hydromorphone 2 mg give 2 tables every 4 hours for pain levels of 7-10. During an interview with Resident #26 on 06/26/2024 at 9:21 AM s/he reported that s/he was in constant pain. The resident went on to report that s/he had pain medication earlier this morning when the pain level was at an 8, however his/her pain level was still at a 6. When asked the resident stated that the nurse had not returned to see if the pain medication had been effective or not. (It is a standard of practice to reassess the pain level after administering pain medication in 1 hour). The surveyor offered to get the nurse for the resident to which the resident stated they would like to see the nurse. An interview with Licensed Practical Nurse (LPN) #16 at 6/26/24 at 9:34 AM revealed that she was not informed that Resident #26 had received pain medication by the off going nurse and therefore had not followed up with the resident. LPN #16 reported that she had went to the resident's room at 7:00 AM and introduced herself and stated she was making her rounds to check on residents and asked about pain. She was made aware that the resident was continuing to complain of a pain level of 6 after being medicated earlier this morning. She was unable to tell the surveyor about this resident's medical conditions and the need for pain medication. A subsequent interview with LPN #16 on 06/26/2024 10:22 AM revealed that she had went into the resident's room and determined the pain medication had not been effective. However, she failed to notify the physician that the resident's pain medication had been ineffective 1.5 hours after administration. A subsequent review of Resident #26's medication administration record with Unit Manager #8 on 6/25/24 at 9:44 AM revealed the resident was administered 2 hydromorphone 2 mg tablets at 6:55 AM. This meant the resident had to wait about a 1 1/2 before the next dose was due. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/2024 at 11:18 AM in an interview the DON indicated the nurse should document the severity of the pain, location, and effectiveness of the medication and what was given. Staff who give a pain medication at the end of their shift should pass it on and the next shift follow up with effectiveness. The DON also indicated If the nurse was the resident's regular nurse she would expect them to know about his/her condition and if not when the resident complains of pain they should ask the resident about it and explore the medical record. The DON revealed that if a resident continued to have a pain then the nurse would check for a breakthrough medication and if there is none then they should call the physician. On 6/26/24 at 11:30 AM a review of Resident #26's medication administration revealed that after the resident reported his/her pain levels was at a 6 at 9:21 AM, the nurse failed to act until 11:23 AM when she administered another dose of pain medication to the resident. The medication was allowed to be given as early as 10:55 AM. An interview on 06/26/2024 at 12:18 PM with Nurse Practitioner (NP) #17 revealed that she expected staff to notify her if a resident's pain was ineffective and there was no order for a breakthrough pain medication. Cross Reference F658 48167

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 49304 Based on observations and interviews with facility staff, it was determined that the facility failed to ensure staffing information was posted in a prominent place readily accessible to residents and visitors. This was evident for 2 (Watersedge and Sudbrook) of 4 units in the facility reviewed for staffing information. The findings include: On 4/4/24 at 8:18 AM, the surveyor did not observe staffing information posted on the Watersedge unit. On 4/4/24 at 8:30 AM, the survey team did not observe staffing information posted on the Sudbrook unit. In an interview with Geriatric Nursing Assistant (GNA #12), they stated even though it [staffing information] was not posted, we know who our residents are for the day because we always have the same schedule. On 4/15/24 at 11:20 AM, the survey team did not observe staffing information posted on the Sudbrook unit. In an interview with Licensed Practical Nurse, (LPN #28), when asked where staffing information was posted, they stated it was in here [a binder inside the nurse's station]. LPN #54 made a copy of the staffing information and posted it on the bulletin board across from the nurse's station. On 4/16/24 at 2:31 PM, the surveyor did not observe staffing information posted on the Watersedge unit. In an interview with GNA #22, when asked where staffing information was posted on the unit, they stated it was posted on the other side [Sudbrook unit]. Furthermore, they stated, for the past couple weeks they had worked on the unit, there had not been staffing information posted. On 4/17/24 at 9:39 AM, the survey team did not observe staffing information posted on the Watersedge unit. On 4/17/24 at 10:00 AM, in an interview with LPN #28, they stated the expectation is that staffing information is posted on each unit. The surveyor made them aware that there was not a posted staffing sheet on the Watersedge unit at this time. LPN #28 stated it is the nurse's responsibility to post the staffing schedule at the beginning of the shift and that today, LPN #90, was the nurse responsible for posting the staffing information on Watersedge today. The surveyor asked LPN #90 if they posted the staffing information on Watersedge today and she said no. The Administration Team was made aware of the concerns at the time of survey exit on 4/18/2024 at 1:30pm.

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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. 50385 Based on medical record reviews and staff interviews, it was determined that the physician or medical director did not address the pharmacist medication regimen recommendation. This was evident for 1(Resident #26) of 5 residents reviewed for medication regimen reviews. The findings include: On 4/12/24 at 11:00 am, the surveyor reviewed the monthly Pharmacist Medication Regimen Review (MRR) for October of 2023 for Resident #26. On the October 2023 MRR there was a recommendation by pharmacist #81 to draw a Thyroid Stimulating Hormone (TSH) lab and Thyroxine (T4) lab that was ordered but not completed. The TSH lab test measures the level of the thyroid stimulating hormone in the blood and the T4 lab measures the amount of thyroxine, a thyroid hormone, in the blood. There was no action or note in the medical records by the physician or medical director addressing the pharmacist's recommendation. On 4/12/24 at 2:58 pm, an interview was conducted with the Director of Nursing (DON). The DON stated that they were unable to locate a response from the physician or a follow-up pharmacy review that was addressed by the physician for the MRR conducted in October 2023. On 4/15/24 at 11:00 am, the DON presented this surveyor with an outcome to the MRR dated 10/3/23 in which the pharmacist documented on 4/12/24 that a mistake was made on the October 2023 pharmacist MRR recommendation. The pharmacist documented, Disregard recommendation. Lab order noted in error. Only a CBC (Complete Blood Count) was ordered which was drawn.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 48167 Based on interviews and observations it was determined the facility failed to provide resident (#41) with an accurate menu of meals being served and offering resident (#41) food preference choices as well as other alternative food options. This was evident for 1 resident (#41) out of 53 residents reviewed during the survey. The findings include: During an interview on 04/05/24 at 11:09 AM resident (#41) stated that the facility gives him/her what they want to give him/her, there are no menus given to him/her and he/she does not have any choices when it comes to the food. Resident (#41) stated the facility just puts the tray in front of you and if you do not like it then you get nothing else offered to you. During an interview on 04/10/24 at 11:15 AM Dietary Manager staff (#7) stated that the facility is on week 2 of their menu cycle, menus are to be reviewed with the resident by the facility caregivers and each resident has a menu in their room with an alternative menu to choose from if resident does not want what is being served for that meal. Staff (#7) also stated that staff are to call down to the kitchen two hours before a meal is trayed and prepared if the resident would like something else. During an interview on 04/10/24 at 11:50 AM Registered Nurse staff (#35) stated that the residents are served the trays the kitchen sends to us and if residents do not want the tray after we serve them, then staff can call down to kitchen to order what the resident wants but it may take some time for it to be sent. Staff (#35) showed this surveyor a menu that was posted in the kitchen area on floor one Powdermill that was week 1 of the facility menu cycle and staff (#35) further stated that it was not the correct meals that the residents get served. Staff (#35) stated that there are no menus in the residents' rooms, and they do not use menus to offer residents choices before meals are sent up from the kitchen. During observation rounds on 04/10/2024 at 11:52 AM with Registered Nurse staff (#35) the facility week 2 menu cycle was found posted in the kitchen on floor one Powdermill not week 1 cycle menu. During observation rounds on 04/10/24 at 11:59 AM it was observed that that there was no weekly or alternative menus in resident #41's room for resident (#41) to use to reference his/her meals of choice. During an interview on 04/10/24 at 12:01 PM Dietary Manager staff (#7) stated that the menu cycle week 1 that was posted in the kitchen on floor one Powdermill was wrong, someone should be changing the menu every Sunday and it should be menu cycle week 2. On 04/10/24 at 12:20 PM this surveyor made Dietary Manager staff (#9) and Regional Director of Nursing staff (#8) aware of the above findings and they both stated that this would be corrected and looked into.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 48167 Based on interview and observation it was determined the facility failed to provide resident (#41) with drinks that are consistent with resident needs as stated on his/her meal ticket. This was evident for 1 resident (#41) out of 53 residents reviewed during the annual survey. The findings include the following: During an interview on 04/10/2024 at 12:10 PM resident (#41) stated and pointed out they do not send what is on my paper that I am supposed to get, and this happens all the time, referring to the meal ticket that was placed on resident #41's meal tray. During a dining observation on 04/10/2024 at 12:10 PM it was observed that residents #41's meal ticket stated that he/she should receive a total of 8 oz of apple juice and resident (#41) only received one 4 oz. container of apple juice on his/her tray. On 04/10/2024 at 12:15 PM Dietary Manager staff (#7) was made aware of the above findings and resident (#41) was given another 4 oz container of apple juice on his/her tray to drink.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48167 Based on observations and staff interviews it was determined the facility failed to: 1) store food in accordance with professional standards for food safety; 2) ensure that staff are preparing food under sanitary conditions; and 3) ensure that appropriate testing supplies were not outdated to evaluate the safe operation of the facility kitchen dishwasher. This was evident during the kitchen observation of the recertification survey. The findings include: 1) An initial tour of the facility kitchen was completed on [DATE] at 08:00 AM with Dietary Manager staff (#7) and the following was observed. Review of the following items failed to reveal an expiration date: One can of medium sliced beets One can of lightly seasoned tomato sauce Several (amount) spice containers of spices One gallon container of deluxe style mayonnaise One gallon container of ranch dressing. Additionally, the following items were found to be expired: Three containers of Thickened Orange Juice from concentrate moderately thick honey consistency had an expiration date of [DATE]. Two containers of Redi-Shred Hashbrown Potatoes had an expiration date of [DATE] One container of sugar Free low calorie breakfast syrup had an expiration date of [DATE]. During an interview on [DATE] at 8:28 AM with Dietary Manager staff #7 confirmed the findings and stated the above listed items should have been labeled with an expiration date. Staff (#7) also stated that the above listed items were expired and would be discarded right away. 2) During observation rounds of the facility kitchen on [DATE] at 1:16 PM Dietary Manager staff (#7) and Dietary Aide staff (#19) were observed not wearing a hair net. Staff (#7) was made aware of this observation. During observation rounds of the facility kitchen on [DATE] at 11:47 AM it was observed that there were no hairnets to apply before entering the kitchen. (continued on next page)

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Resorts of Augsburg	6811 Campfield Road Baltimore, MD 21207

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation rounds of the facility kitchen on [DATE] at 11:47 AM Lead [NAME] staff (#80) was observed not wearing a beard restraint and his/her beard was exposed. Dietary Manager staff (#7) was made aware of this observation. During an interview on [DATE] at 11:49 AM Lead [NAME] staff (#80) was asked why there were not any hairnets near the entry of the kitchen and he/she stated that someone may have used the last one and discarded the box. Staff (#80) was also asked if staff wear beard coverings/restraints and he stated that they do not use beard coverings in the kitchen. During observation rounds and interview on [DATE] at 11:51 AM Dietary Manager staff (#7) was observed not wearing a hairnet or beard restraint. Staff (#7) stated he has never worn a hairnet because he has no hair. It was observed that staff (#7) had scalp hair, facial hair, and a beard. 3) During observation rounds of the facility kitchen on [DATE] at 1:50 PM it was observed that the Hydrion ph and sanitizer test strips that were being used by Dietary Manager staff (#7) to test the facility kitchen dishwasher water sanitation concentration level had expired on [DATE]. All concerns were discussed with the Administration team on [DATE] at 1:30 PM

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304 Based on review of employee files and online sources and interviews with facility staff, it was determined that the facility failed to ensure Geriatric Nursing Assistant (GNA) staff had active, current certification. This was evident for 1 of 5 GNAs (GNA #11) reviewed for staff qualifications during the survey. The findings include: The Maryland Board of Nursing (MBON) is the agency charged with the regulatory oversight of the practice of nursing in the State. The MBON's mission is to preserve the field of nursing by advancing safe, quality care in Maryland through licensure, certification, education, and accountability for public protection. All nursing assistants must be certified in order to work. The primary source verification of certification status is found in the Look Up A License feature of the MBON website. This secure program is updated daily. On [DATE] at 1:07 PM, review of the Look Up A License feature on the MBON website showed the certification status for GNA #11 as non-renewed and with an expiration date of [DATE]. On [DATE] at 1:10 PM, in an interview with the Director of Nursing (DON), she stated she could not explain why GNA #11 was currently working with expired certification but would look into it. On [DATE] at 1:46 PM, in an interview with the DON, she stated that GNA #11's certification was expired, and that they were on the way to MBON now. The Administration Team was made aware of the concerns at the time of survey exit on [DATE] at 1:30pm.

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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. 48167 Based on administrative and medical record reviews and staff interview, it was determined that the facility failed to: 1) accurately maintain medical records for a resident (# 19); and 2) maintain a completed copy of an investigation into an allegation of staff to resident abuse; 3) provide complete access to closed resident electronic medical records; and 4) identify and maintain accurate electronic medical records by having nursing staff members signing off resident care that was performed by the assigned staff member. This was evident for 8 of 8 records reviewed for accuracy of medical records during an recertification survey. The findings include: 1) Review of resident (#19) medical record on 04/10/2024 at 3:30 PM revealed residents (#19) current care plan had a focus area stating that resident (#19) was at risk for wandering and elopement related to his/her medical diagnosis of Alzheimer Dementia. This focus area was initiated on 07/26/2022 and last revised on 01/18/2024. On 04/10/2024 at approximately 4:00 PM the Director of Nursing staff (#2) provided the survey team with a list of all facility residents that were at risk for wandering and elopement. On review of the resident list, resident (#19) was not listed. During an interview on 04/10/2024 at 4:20 PM the Director of Nursing staff (#2) was made aware that residents (#19) current care plan states he/she was at risk for wandering and elopement and was also not listed on the facility list of residents that were at risk for wandering and elopement as provided. Staff (#2) stated that resident (#19) was not a risk for wandering and elopement and the care plan needed to be corrected. On 04/12/2024 at approximately 10:30 AM the Director of Nursing staff (#2) provided this surveyor with a copy of residents (#19) Elopement Evaluation that was completed on 04/11/2024 at 11:30 AM. On review of the evaluation it indicated that residents (#19) score was 3 and was not at risk for elopement at time of the assessment. The Director of Nursing staff (#2) also provided this surveyor with a copy of resident (#19) revised care plan. On review of the revised care plan provided, it stated that on 04/11/2024 that focus area stating that resident (#19) was at risk for wandering/elopement related to a his/her medical diagnosis of Alzheimer Dementia was resolved. 18819 2) A review of the facility investigation into facility reported incident (FRI) MD00198544 on 04/10/24 only revealed a police report case number. The allegation of staff to resident abuse was made by a family member on 10/02/23 for Resident #259. The facility file did not contain investigation reports, staff interviews, evidence that the alleged staff to resident physical abuse was conducted or reported to the State Survey Agency or local Ombudsman. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the facility director of nurses (DON) on 04/10/24 at 2:20 pm, the DON confirmed that the facility had changed owners on 01/01/24. The DON also stated that s/he was only able to locate the police report case number document. The DON also stated that s/he could not locate any other documents or information that the former owners and staff had conducted an investigation related to the allegation of staff to resident abuse on 10/02/23. 3) During a review of complaints MD00173689, MD00184359, MD00194492, MD00199492, and facility reported incidents MD00195163 and MD00198544 during the recertification survey, the facility was unable to grant surveyor full access to residents #252, #253, #256, #257, #258, and #259's closed electronic medical records. Specifically, the Documentation Survey Record V2 for each discharged resident prior to 01/01/24. The Documentation Survey Record V2 is the electronic document where each GNA (geriatric nursing assistant) documents the care they provided to each resident during a particular shift. The surveyor can validate or not validate the care provided to each resident during a particular shift. In an interview with the facility DON on 04/17/24 at 1:39 pm, the DON stated that the facility was unable to give the surveyor access to any resident's closed record prior to 01/01/24. The DON also stated that the facility did not have the ability to grant surveyor access to any discharged resident's closed record prior to 01/01/24 when the new company purchased the facility. 4) Reviews of facility reported incident (FRI) MD00203805 on 04/11/24 revealed an allegation Resident #255 was observed with bruising to the left knee on 03/16/24. Review of the facility investigation revealed that Resident #255 was identified with swelling and bruising to the left knee, by Staff member #12, at 9:30 am on 03/16/24. Review of Resident #255's electronic medical record revealed documentation Staff #53 had charted Resident #255's morning care on 03/16/24. In an interview with Staff #53 on 04/16/24 at 11:21 AM, Staff #53 stated that he/she was not assigned nor provided care for Resident #255 on the morning of 03/16/24. Staff #53 stated that Staff #12 was assigned to Resident #255 the morning of 03/16/24. Staff #53 stated that Staff #12 charted care provided to Resident #255 under his/her computer access login information on the morning of 03/16/24. Staff #53 stated that he/she did not sign out of the computer after he/she had completed charting and left the computer logged in and available for other staff to use. In an interview with Staff #12 on 04/16/24 at 2:55 pm, Staff #12 confirmed that he/she was assigned to and charted in the electronic medical record for Resident #255 using Staff #53's computer access on 03/16/24. Staff #12 stated that he/she was assigned to Resident #255 during the day shift on 03/16/24. Staff #12 stated that he/she was the employee who identified the swelling and bruising to Resident #255's left knee area on 03/16/24 at 9:30 am. Staff #12 stated that he/she does have his/her own computer access to the residents electronic medical records but computer access may not work at times.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 30440 Based on administrative record review and interviews with facility staff it was determined the facility failed to have an effective Quality Assurance Performance Improvement (QAPI) program in place to address identified quality deficiencies. This was found to be evident during the facility's survey. The findings Include: During the facility's current survey conducted on April 4, 2024, thru April 18, 2024, deficient practice was identified in the following areas: Quality of Care with one example of a resident (# 17) who did not receive pain medication with a suspected fracture, Supervision of residents with a history of wandering, Functioning call bell system and Neglect and Abuse allegations. An employee (# 85) was terminated in December 2023 for not following protocols for providing Activities of Daily Living (ADL's) assistance to a resident (#1). During an interview with the DON on 4/18/24 at 10:00 AM she was informed that the facility provided the survey team with attendance sheets for monthly meetings conducted by the Quality Assurance (QA) committee for December 2022, January 2023, February 2023, April 2023, June 2023, January 2024, and February 2024. The DON was asked to explain how identified concerns are brought to the QAPI team and what process was put in place to ensure that these identified concerns do not occur again, and she stated the following: She stated that all concerns are brought to the QAPI team for review. A root cause analysis is completed, and an improvement plan is then implemented. All staff are educated, specific to the identified areas of concern. The DON was asked to provide documentation of staff education and facility's improvement plan that was implemented after the occurrence in December 2023 regarding resident # 1. The DON acknowledged that neglect and abuse should have been presented to the QA team in January 2024 following the incident and it was not done and was unable to provide documentation to the survey team. In addition, the DON was unable to provide documentation of identified concerns and processes that were implemented from the period of July 2023 through November of 2023. She stated that corrective measures will be put in place. All concerns were discussed with the Administration team at the time of exit on 4/18/24 at 1:30 PM.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 30440 Based on administrative record review and interviews with facility staff it was determined the facility failed to ensure that the Quality Assessment and Assurance (QAA) committee met at least on a quarterly basis to address identified concerns and evaluate the effectiveness of their action plan. This was found to be evident during a review of the facility's Quality Assurance Performance and Improvement (QAPI) meeting attendance sheets during the survey. Findings include: The survey team requested copies of the QAPI monthly attendance sheets for January 2023 thru February 2024 on 4/18/24 at 10:00 AM. The facility provided copies of QAPI attendance sheets for the following months: December 2022, January 2023, February 2023, April 2023, June 2023, January 2024, and February 2024. During an interview with the DON on the same date at 11:00 AM she was asked how often the QAPI committee members meet to address all identified concerns that are brought before the team, and she stated that stated that the standard for the internal team members is that they are to meet monthly. She went on to say that all other vendors or outside resources are invited quarterly. Some of the vendors or outside resources are the Pharmacy, Behavior Health Group, and Outside Imaging Group. The DON acknowledged that the facility did not meet the standard requirements for meeting monthly and on a quarterly bases for the months of July 2023 thru November 2023. All concerns were discussed with the Administration team at the time of exit on 4/18/24 at 1:30 PM.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42782 Based on observations and interviews it was determined that the facility staff failed to maintain infection control practices as evidenced by having uncovered linen carts, a pillow and two pads for side rails on the floor in the linen closet, and the soap and hand sanitizer dispensers were empty in the Soiled Utility Room on the unit Sudbrook. This deficient practice was evident for one linen closet and one utility room observed during the survey. The findings include: On 04/17/24 at 9:38 am the surveyor and Infection Preventionist/Educator #6 opened the door to the linen closet on Waters Edge Unit and observed the linen was not covered and a pillow and a box of gloves were on the floor inside the linen closet. Infection Preventionist/Educator #6 verbalized the linen cart is not removed from the closet. The cart is brought upstairs, and the linen cart is refilled. On 04/17/24 at 9:47 am the surveyor observed two blue side rail pads on the floor in the linen closet on Sudbrook. Infection Preventionist/Educator #6 verbalized they should not have been on the floor. On 04/17/24 at 10:01 am Geriatric Nursing Assistant #53 verbalized the two blue side rail pads could have come from a resident's room and they usually don't have them lying around. On 04/17/24 10:07 AM observation of the Soiled Utility Room South side of Sudbrook unit revealed the hand sanitizer dispenser and both soap dispensers were empty. On 04/18/24 10:14 am during an interview with Facilities Maintenance Manager/Environmental Services Director #77 the staff are supposed to let him know when the hand sanitizer/soap dispensers are empty, and they are supposed to check them every other day. The environmental services staff are supposed to check and fill out the soap and hand sanitizer dispensers.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48167 Based on observations and interviews it was determined the facility failed to maintain a working call bell system. This was evident for 1 resident (#5) out of 7 residents and 2 rooms (#113 and #127) out of 6 rooms during the survey. The findings include: During observation rounds on 04/05/2024 at 9:20 AM on the facility's first floor nursing station, Meadowood, call lights were noted to be going off. The call lights were observed for approximately 25 minutes. This surveyor observed the nurses' station on Meadowood for possible staff, no one was present at that time. The monitor for the call lights at the nursing station read system failure for Rooms #113 and #127. During an interview and observation on 04/05/2024 at 9:51 AM resident (#5) call bell was pressed by this surveyor and call bell did not work. During an interview on 04/05/2024 at 10:00 AM Regional Administrator staff (#9) was made aware of the above observations by this surveyor. Staff (#9) stated that he would check into the call bell system right away.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42782 Based on observation and interviews it was determined that the facility staff failed to notify maintenance personnel of maintenance problems on the unit Sudbrook. The deficient practice was evident on 1 unit. The findings include: On 04/17/24 at 9:38 am while the surveyor was on the unit Sudbrook with Infection Preventionist/Educator #6 the surveyor attempted to turn the light on in the linen closet and the light did not come on. On 04/17/24 at 9:49 am while on the unit Sudbrook near the nursing station, the surveyor observed the right side of the food cart open, and the trays were exposed. The surveyor attempted to close the door several times to no avail. During an interview with Licensed Practical Nurse #28 he/she verbalized the staff should have reported the issue to the kitchen immediately. The aides and nurses collected the trays and put them on the cart. When Dietary Aide #67 reached the unit to retrieve the food cart the surveyor asked if he/she was aware the right door did not close Dietary Aide #67 reported Certified Dietary Manager #7 was made aware of the problem on the previous day. On 04/17/24 at 9:55 am Geriatric Nursing Assistant (GNA) #68 verbalized trying to close the door on the right side of the food cart multiple times, and it did not close. GNA #23 verbalized the door on the food cart would not close after placing the trays on the food cart. On 04/17/24 at 10:07 am the surveyor was in the Soiled Utility Room on the South Side of Sudbrook and the light did not come on in the room where the trash chute was located. On 04/17/24 at 10:14 am the surveyor asked LPN #54 what the process was for the staff to follow when there was a maintenance issue on the unit. LPN #54 verbalized they have a red folder for staff to write maintenance problems on the unit. Maintenance comes to check the book daily. The surveyor checked the maintenance log to see if the food cart and two non-working lights on the unit were documented and they were not. On 04/18/24 10:07 am during an interview with Facilities Maintenance Manager/Environmental Services Director #77, the surveyor asked if the department had a maintenance schedule and what was the process for notifying the department of maintenance issues. Facilities Maintenance Manager/Environmental Services Director #77 verbalized the maintenance schedule consists of filter changes, checking smoke detectors, checking the generators etc. Fire drills are done once a month and disaster drills are done once a year. There is a book for water treatment. The staff have two cell phones and receive calls and emails about maintenance issues. There is one tech for long term care, but he can pull a tech from another part of the facility if needed ant they make rounds and check the red maintenance logs daily.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 49304 Based on review of facility policy and employee files and interviews with facility staff, it was determined that the facility failed to ensure staff participation in mandatory abuse training. This was evident for 1 of 5 Geriatric Nursing Assistants (GNA #43) reviewed for abuse training during survey. The findings include: On 4/16/24 at 10:43 AM, review of the facility's policy entitled, Residents/Patient Rights- Abuse, Neglect, Mistreatment or Misappropriation of Resident/Patient's Property, revealed, All employees, including management staff and volunteers, will receive training upon orientation and annually. On 4/16/24 at 2:46 PM, review of employee files revealed GNA #43 was hired on 6/23/23 and did not reveal documentation of participation in any type of abuse training. On 4/17/24 at 1:30 PM, the facility provided a copy of GNA #43's printed Relias transcript of completed online trainings. The document entitled, Training Hours, revealed GNA #43 did not participate in any type of abuse training. Furthermore, review of the Reporting Abuse Training Attendance Sheet conducted on 2/8/24 by Staff #6 and Staff #24 did not reveal GNA #43's signature of participation. In an interview with Staff #9 on 4/17/24 at 4:07 PM, he stated the employee files provided to the survey team contained any, and all documents related to that employee. Furthermore, he stated that anything pertaining to an employee would be inside the employee's file and would not need to be requested separately. In an interview with the Director of Nursing (DON) and Staff #9 on 4/18/24 at 9:52 AM, when asked about the training clinical staff, such as nurses and GNA's, must receive before providing care to residents, the DON stated all clinical staff must participate in twelve mandatory competencies including an abuse training. The DON and Staff #9 were made aware that GNA #43, who was hired on 6/23/23, had no documentation in her employee folder demonstrating abuse training, had no abuse training on her Relias Training Hours transcript, and did not sign the attendance sheet from February 2024's abuse training provided by the facility. The Administration Team was made aware of all concerns at the time of survey exit on 4/18/24 at 1:30 PM.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 18819 Based on the review of employee records and staff interview, it was determined that the facility failed to provide documentation that a Geriatric Nursing Assistance's (GNA) was given abuse training at least once every 12 months. This was evident for 1 of 4 GNA employee records (Staff #25) reviewed during the sufficient and competent nursing staffing task during the recertification survey. The findings include: A review of facility reported incident MD00198544 on 04/09/24 revealed an allegation Resident #259 was the victim of staff to resident verbal abuse on 09/30/23. The surveyor was unable to review the facility investigation due to staff being unable to locate the investigation documents. A review of Staff member #25's employee records failed to reveal that Staff member #25 was provided abuse training one year prior to the alleged 09/30/23 incident. Further review of Staff member #25's educational records revealed that Staff member #25 received Recognizing, Reporting, and Preventing Abuse training last on 08/30/2022. In an interview with the facility director of nurses (DON) on 04/11/24 at 10:22 am, the DON stated that the current facility ownership did not have access to employee educational records prior to the sale of the facility on 01/01/24. The DON was unable to provide the surveyor with documentation that staff member #25 had received abuse training that occurred in 2023.