STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095022	A. Building B. Wing	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitions Healthcare Capitol City	2425 25th Street SE Washington, DC 20020

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews for two (2) of 75 sampled residents, the facilty's staff failed to treat residents with respect and dignity, as evidenced by: allowing one (1) resident to lay on soiled linen until the change of shift, and by not providing incontinent care and not removing facial hair for one (1) resident. Residents # 169 and #197 Findings include . 1. The facilty staff failed to treat Resident #169 with dignity and respect by allowing her to lay in bed on soiled bed linen (a fitted sheet) until the change of shift. Resident #169 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Quarterly Minimum Data Set completed on 12/18/2019, Resident #169 had a Brief Interview for Mental Status (BIMS) score of 15 which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident required extensive assistance with 2 person physical assistance with transfer and toilet use, and one person physical assistance with personal hygiene and bed mobility. Under Section H Bowel and Bladder the resident was coded as having occasional urinary incontinent and frequently incontinent of bowel. During a face-to-face interview with Resident #169 on 2/19/2020 at approximately 10:30 AM. The resident stated that she called for assistance to use the bedpan. The CNA instructed her to use her incontinent brief. Continued interview revealed that the CNA eventually helped her use the bedpan, after arguing with her. Further interview revealed that after the CNA Employee #32 helped her use the bedpan, the CNA Employee #32 made her aware that there was a brown stain on her fitted sheet. When queried about the brown stain, the resident said It was stool because I had an upset stomach all that day. The resident then stated, I asked the CNA to change the fitted sheet, but the CNA said, No, I'll change it before I leave in the morning. According to Employee #2, DON, on 02/19/19 at 4:00 PM, the CNA Employee #32 was suspended because she allowed Resident #169 to lay on soiled linen until the change of shift. (continued on next page)

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	Facility staff failed to provide Resident #169 with dignity when she was left to lay on soiled bed linen. 2A. The facility's staff failed to treat Resident #197 with dignity and respect by not providing incontinent care. Observation on 02/09/20 at 7:10 AM showed Resident #197 sitting on a bare mattress naked and holding pajama in front of her body. Also noted was a fluid soaked fitted sheet lying on the bed. This writer informed Employee #11 at 7:15 AM that the resident was naked, her bed was soiled and she needed to be changed. The employee stated, she was going to send someone to the room to take care of the resident. According to Section H0300 (Urinary Continence) of the quarterly Minimum Data Set (MDS) dated [DATE] the resident is coded for occasional incontinence. During a face-to-face interview on February 09, 2020 at approximately 10:30AM. Employee #10 acknowledged the finding. 2B. The facility's staff failed to provide Resident #197 with dignity and respect by not removing facial hair. On February 20, 2020 at approximately 11:00 AM Resident #197 was observed sitting on the seat of her rollator (walker) across from the Nurses' Station. While speaking to the resident this writer observed thick facial hair around the resident's mouth and chin. The resident was asked whether she wanted the hair around her mouth and on her chin and she responded, No. I need somebody to take it off. Employee #10 was asked to observe the resident's face immediately after the aforementioned observation. The employee observed the resident's face and asked the resident, Do you want it (hair) off? While pointing to the hair on the Resident#197's face. The resident said, Yes. The employee then stated, I will get someone to take it (hair) off right away. During a face-to-face interview with Employee #10 on February 20, 2020 at approximately 11:30 AM, the employee acknowledged that the staff failed to respect Resident #197's dignity by not removing the resident facial hair.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview for two (2) of 75 sampled residents the facility's staff failed to ensure that one (1) resident was provided with a Bariatric bed to promote safety with bed mobility, and to ensure one (1) resident was clothed, cleaned and dry. (Residents' #23 and #197). Findings include . 1. The facility's staff failed to ensure that Resident#23 was provided a Bariatric bed to promote safety with bed mobility. Observation of Resident #23's room on 02/10/20 at 10:00 AM showed the resident lying in bed. When asked if he had any concerns, the resident pointed to his bed and stated, Yes, I weigh 337 pounds, and this bed is too small for me. I'm scared to move over in the bed. Continued observation revealed that Resident #23 attempted to pull himself to the left side of the bed. However, he was unsuccessful because the bed did not have room for him to change position in the bed safely. Review of the resident's current medical record on 02/10/20 starting at 2:00 PM showed that the resident was admitted on [DATE] with multiple [DIAGNOSES REDACTED]. Continued review of the medical record lacked documented evidence Resident #23 had been assessed for the use of a bariatric bed for safety and bed mobility. During a face to face interview on 02/10/20 at 3:00 PM, Employee #2(DON) and Employee #7 (Unit Manager) acknowledged the finding. The facility's staff failed to assess Resident #23 for the need of a Bariatric bed to ensure safety with bed mobility. 2. The facility staff failed to ensure Resident#197 was clothed, cleaned and dry. Observation on 02/09/20 at 7:10 AM showed Resident #197 sitting on a bare mattress naked and holding pajama in front of her body. Also noted was a fluid soaked fitted sheet lying on the bed. This writer informed Employee #11 at 7:15 AM that the resident was naked, her bed was soiled and she needed to be changed. The employee stated, she was going to send someone to the room to take care of the resident. However, at 7:30 AM the resident was still unchanged. According to Section H0300 (Urinary Continence) of the quarterly Minimum Data Set (MDS) dated [DATE] the resident is coded for occasional incontinence. During a face-to-face interview on February 09, 2020 at approximately 10:30 AM. Employee #10 acknowledged the finding.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview for five (5) of 11 sampled residents, whose personal funds are managed by the facility, the facility's staff failed to follow generally accepted accounting principles when depositing a money order made out to one (1) resident and to ensure five (5) residents who have Resident Fund Management System (RFMS) accounts gave the facility staff authorization to manage their funds. Residents' #187, #112, #116, #181 and #238 Findings include . 1. Review of the medical record for Resident #187 showed that she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the Admission Minimum Data Set ((MDS) dated [DATE], showed Section C (Cognition Patterns) C1000 Cognitive skills for daily decision making were recorded as 15 which indicated that the resident was cognitively intact. During a face-to-face interview with Resident #187, on February 10, 2020, at 2:58 PM, she stated that the facility cashed a money order that was sent to her as a Christmas gift. The resident also said, the money order was addressed to me, but the facility staff cashed it and applied the money to my balance without my consent. The Resident further stated that she requested a refund from the business office but was unsuccessful. A face-to-face interview was conducted with the Business Office staff (Employees # 1, #25 and #26) on 2/13/2020 at approximately 4:00 PM. The group shared that the Resident#187 money order came in an envelope addressed to the facility via U.S. Mail from the Resident's niece. The envelope was opened and the money order for $100.00 was then scanned and applied to the resident's balance owed to the facility in error. Employee #1 then stated, It was an honest mistake and the facility will refund the resident her money. The writer was provided a copy of the scanned money order. The money order was addressed to Resident #187 and lack documented evidence that the resident signed it over to the facility. A face-to-face interview was conducted with Employee #27 on 2/14/2020 at approximately 11:45 AM. The employee provided the writer with a copy of a receipt showing that the facility had refunded the resident her money with interest ($100.03). The facility staff failed to follow generally accepted accounting principles by depositings a money order made out to Resident#187. 2. Facility staff failed to ensure four (4) residents who have Resident Fund Management System (RFMS) accounts gave the facility staff authorization to manage their funds. Residents' #112, #116, #181 and #238 (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities trial balance as of January 31, 2020, and February 16, 2020, showed the previously mentioned residents had asterisk (*) next to their names indicating that the residents had transferring accounts (automatic transfer of care cost payments due to the facility) that were missing signatures on the application and authorization form (s). Review of the residents business office file showed the following: Resident #112 -RFMS Authorization and Agreement to Handle Resident Funds form was signed by the resident, however, there was no date to convey when the form was signed and there were no witness signatures. Resident #116 -RFMS Authorization and Agreement to Handle Resident Funds form was signed by the resident, however, there was no date to convey when the form was signed and there were no witness signatures. Resident #181-RFMS Authorization and Agreement to Handle Resident Funds form was signed by the resident, however, there was no date to convey when the form was signed and there were no witness signatures. Resident #238- RFMS Authorization and Agreement to Handle Resident Funds form was not signed by the resident, there was no date or witness signatures. There was no evidence that facility staff ensured that four (4) of the 11 sampled resident accounts had signed authorization and agreement forms properly completed giving the facility permission to manage their funds. During a face-to-face interview with Employee # 27 on 2/16/2020 at approximately 10:30 AM, he acknowledged the findings.

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F 0578 Level of Harm - Minimal harm or potential for 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** Based on observation, record review and staff interview for one (1) of 75 sampled residents, the facility staff failed to complete an Advance Directive for Resident #222. Findings Include . Review of the resident's clinical record showed that the resident was admitted to the facility on [DATE]. The record lacked documented evidence of a completed Advance Directive on the resident's record. Review of Section I (Active Diagnoses) of the annual Minimum Data Set (MDS) dated [DATE] showed [DIAGNOSES REDACTED]. Review of Section C (Cognitive Patterns) showed a Summary Score of 10 for C0500 Brief Interview of Mental Status (BIMS). A summary Score of 10 is an indication that the resident's cognition is moderately impaired and therefore he may be unable to make some decisions. A face-to-face interview was conducted with Employee #12 on February 11, 2020 at 12:30 PM. The employee was queried regarding the resident's Advance Directive. The employee responded He (the resident) may not have one because of his BIMS. The employee was then asked if the resident did not have a Responsible Party (RP). She responded, No and said that she would look through the computer to see if there was any documentation. At 12:50 PM (same day) Employee #12 stated, I spoke with the RP who was out of town but he will follow up to make sure that the form (Advance Directive) is signed. and she acknowledged the finding.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by stained ceiling tiles in nine (9) of 60 resident's rooms, soiled exhaust vents in six (6) of 60 resident's rooms, broken door closures in three (3) of 180 resident's rooms and a bed bumper board observed on the floor in one (1) of 60 resident rooms. Findings included . During an environmental walkthrough of the facility on February 10, 2020, between 10:35 AM and 3:30 PM the following were observed: 1. Ceiling tiles were stained in nine (9) of 60 resident's rooms including rooms #104, #120, #136, #202, #205, #208, #210, #235, #243. 2. Exhaust vents were soiled with dust in resident room ##209, #251, #305, #349, #355, #359, six (6) of 60 resident's rooms. 3. Door closures to the entrance door in resident rooms #104, #204 and #249 failed to function as intended and a trash bag was used to keep the door in place, three (3) of 180 resident's rooms. 4. One (1) bed bumper board was observed loose, detached from the wall, on the floor behind the head bed in room [ROOM NUMBER]. Facility staff acknowledged the finding at the time of the observation on February 19, 2020, at approximately 2:00 PM. These findings were acknowledged by Employee #14 on February 10, 2020, at approximately 3:30 PM.

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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview for one (1) of 75 sampled residents, facility staff failed to consistently monitor Resident #274 with sexually aggressive behavior from inappropriately touching female residents. Findings included . Resident #274 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Annual Minimum Data Set, dated dated dated [DATE], showed Resident #274 had a Brief Interview for Mental Status (BIMS) score of 13 which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident had no impairment of his upper extremities and used a wheelchair for mobility. Review of Resident #274's record showed a Social Worker note dated, 9/25/2019 at 15:00, Social worker was made aware by nursing that a CNA observed (Resident #274) in a female resident's room with his hand on the female resident private area. At 9:26 AM SW (social worker and Assist Director of Nursing) met with resident to interview him regarding the report from the CNA. During the interview, resident stated, 'I went to the room, nothing happened, I saw she had no draws, I looked but I did't touch her. I know it was wrong going in there and I came out of the room by myself.' Nursing called the police . A review of a care plan initiated 9/26/19 showed Resident #274 was placed on 1:1 monitoring s/p (status [REDACTED]. The 1:1 monitoring was discontinued on 10/1/19. A review of PsychoGeriatric Services, LLC Late entry note for 10/1/19 generated on 10/2/19 showed Chief complaint: Patient seen to evaluate mental status and adjust medications for behavioral disturbance. Chief Complaint: C/O (Complaint of) of sexual abuse . he was evaluated d/t (due to) report of inappropriate sexual conduct with another female resident. Patient initially denied entering into the patient's room or touched her vaginal, Though after cues was able to answer the question admitting the claim and did not volunteer any further information. It appears that this patient has engaged in this type of behavior in the past. Noted that he was doing well while on [MEDICATION NAME] and [MEDICATION NAME] but both were discontinued apprentice and not sure why . Chart reviewed, no report of agitation or aggression. Patient was counseled and he verbalized understanding. Currently on 1:1 . for safety per facility protocol. Diagnosis: [REDACTED].Major Neurocognitive DisorderUnspecified, without behavioral disturbance - F03. 90. Treatment plan/recommendations Plan: Supportive therapy provided. Reviewed SE (side effects) and Risk/ Benefits analysis, Psychiatric team will monitor mood and behavior, Patient encouraged to participate in activities on the unit. Will d/c (discontinue) 1:1 . Start [MEDICATION NAME] 10mg qd (every day) for mood disorder. Nursing staff to maintain close monitoring of patient every shift, and redirect promptly if necessary. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	SW (Social Worker) note dated 12/19/2019 at 10:02 AM showed, SW met with met with resident at 8:39 AM today s/p alleged inappropriate touching of female resident on 12/18/2019. Upon interview resident stated, I stuck my hand in her pants. I made a mistake, the police told me I will go to jail for doing that. SW counseled resident re the behavior and he expressed understanding. Resident is currently on 1:1 montioring . A review of another care plan initiated 12/18/19 showed Resident #274 was placed on 1:1 monitoring s/p (status [REDACTED]. A face-to-face interview was conducted with Resident #274 on 2/12/20 at approximately 3:00 PM concerning him inappropriately touching female residents' vaginal area. The Resident responded, Yes I want to touch the P____y . The resident was asked where were staff when this happened? The resident responded, I don't know. Transition Healthcare Hourly Resident Monitoring Log showed the following: 9/26/19 to 9/30/19 - showed continuous monitoring of Resident's behavior was checked at the allotted space. 10/1/19 - showed 1:1 started at midnight and discontinued at 8:00 AM. 12/18/19 to 2/14/20 - showed 1:1 started at 12/18/19 4:00 PM and was continuous through this time period. A face-to-face interview was conducted on 2/13/20 at approximately 4:14 PM with Employee #8 concerning the Psych Recommendation on 10/2/20 for Nursing staff to maintain close monitoring of patient every shift, and redirect promptly if necessary. Employee #8 stated, The resident was on 1:1 for a month and that was discontinued on 10/2/19. Prior to the incident on 12/18/19, the resident was being watched by staff and redirected when necessary. There was no monitoring log presented for the Resident's close monitoring from 10/2/19 to 12/17/19. There was no documented evidence to show that facility staff proteceted Resident #233 from being touched in a sexual manner by Resident #274. Resident #274 was not monitored every shift from 10/2/19 to 12/18/19 to prevent him from further inappropriately touching of female resident's vaginal area. On February 13, 2020, approximately at 4:14 PM, Employee #8 acknowledged the findings.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of the facility's Abuse policy and staff interviews, the facility failed to instruct staff to report allegations of abuse immediately but not later than two hours in their abuse policy. The census on the first day of survey was 346. Findings include . Policy Title: OPS-346 Abuse, Neglect, Mistreatment, Exploitation, and Misappropriation of Resident Property Revised 12/10/18 stipulates: VII. Reporting/Response A. All alleged incidents involving abuse, neglect, exploitation or mistreatment, including injures of unknown origin and misappropriation of resident's property will be reported immediately to the facility administrator . Appropriate state survey agencies and other officials in accordance with state law will be notified within 5 working days of the incident by the facility administrator or his/her designee . Facility staff failed to develop and implement an abuse policy that includes reporting immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. During a face-to-face interview on 2/10/2020 at 12:29 PM, Employees #2 and #28 acknowledged the findings.

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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. Based on review of the facility's incident report and staff interviews, one (1) of 75 sampled resident, the facility staff failed to thoroughly investigate an allegation of sexual abuse to one (1) female resident. Resident # 99. Findings include . An incident report dated May 14, 2019 at 19:15. Titled, Alleged Abuse .report to the charge nurse . incident description (Resident #99) sister reported to charge nurse that she thinks her sister had been sexually abuse. She said that Resident who is nonverbal had been demonstrating with her hands and head that she has been abused sexually by putting her fingers in her mouth pointing towards her vagina and the door . Immediate Action: police department is notified . (Officer) arrived . (Physician) notified . statements are being collected from staff that worked on that floor from Sunday night 5/12//19 to this evening (5/14/2019), investigation is ongoing. Review of the facility's investigation failed to show that the resident roommate was included in the investigative process to get her account or information related to the allegation. Facility staff closed the investigation as unsubstantiated. There was not enough evidence (such as, a documented interview with the resident's roommate) to show that the incident was thoroughly investigated. On 2/20/2020, approximately at 11:15 AM, Employee #2 acknowledged the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for three (3) of 75 sampled residents, the facility's staff failed to develop patient-centered Care Plans for: (1) the use of oxygen for one (1) resident; (2) the resistant /refusal of ADL (activity of daily living) care for one (1) resident; and (3) the [DIAGNOSES REDACTED].#106, #220 and #235). Findings include . 1. The facility failed to develop a patient-centered Care Plan for Resident #106 use of Oxygen. Review of a physician's orders [REDACTED]. According to the Annual Minimum Data Set, dated dated dated [DATE], the resident was coded for receiving Oxygen Therapy. However, review of the comprehensive care plans failed to show a comprehensive person-centered care plan for the resident's continuous use of Oxygen. A face-to-face interview was conducted with Employee #4 at approximately 3:00 PM on February 20, 2020. The employee reviewed the care plans and acknowledged that the facility staff failed to develop a patient-centered Care Plan for Resident # 106's continuous use of Oxygen. 2. The facility failed to develop a patient-centered Care Plan for Resident #220 use of Oxygen. Resident #220 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Section C400 of the quarterly Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 15 which is an indication that the resident is cognitively intact and able to make decisions. Under Section G0110 Activities of Daily Living (Functional Status), the resident is totally dependent on physical assistance from two or more persons for all aspects of care: bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. The resident was observed lying in bed on February 10, 2020, at 2:37 PM when she stated to the surveyor, I need to talk with you, my absorbent brief is only changed once every 8 hours. Interview conducted on February 12, 2020, at 1:30 PM with Employee #19 concerning Resident #220 absorbent brief changed only once a shift. The employees stated, The resident's absorbent brief is changed when the resident request to be changed. She refuses when CNA (Certified Nursing Assistant) goes to change her. Interview conducted on February 12, 2020, at 1:40 PM with Employee #20 concerning Resident #220 absorbent brief being changed only once a shift. The employee stated, The resident (will) refuse or ask that staff to come at a given time for her brief to be changed. I am her CNA I go back to her several times for the day for her to verbalize (when) she is ready to be changed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident # 220's Care Plans showed there was documented evidence of goals and interventions to address the resident's resistant /refusal of activity of daily living care. A face-to-face interview was conducted with Employee #19 at approximately 2:00 PM on February 12, 2020. When asked about the care plan that shows resident resistant /refusal of ADL care plan, Employee #19 reviewed the record and acknowledged the findings. 3. The facility failed to develop a patient-centered Care Plan to address Resident # 235's [DIAGNOSES REDACTED]. Review of Resident # 235's current medical record on 02/19/20 at 1:00 PM showed that the resident was admitted on [DATE] with several [DIAGNOSES REDACTED]. Continued review of the medical record showed a Care Plan dated 12/24/19 that failed to outline how the staff provided care to address Resident # 235's [DIAGNOSES REDACTED]. During a face-to-face interview on 02/19/20 at 3:00 PM, Employee #7, Unit Manager, acknowledged the finding.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, for five (5) of 75 sampled residents, the facility's staff failed to update Care Plans for : (1) one (1) resident, who fell during care; (2) 1 to 1 monitoring for safety for one (1) resident; (3) two (2) residents, who had a resident-to-resident verbal interaction; and (4) one (1) resident's [MEDICAL TREATMENT] information (Residents' #81, #235, #246, #297 and #322). Finding include . 1.The facility's staff failed to update Resident # 81's Care Plan after he fell during care. Resident #81 admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the resident's current medical record showed that while the facility's staff was providing care for Resident #81, he pulled down the left side rails of his bed and fell . Continued review of the medical revealed that the resident had no apparent injuries from the fall on 02/12/20. Review of Resident # 81's Annual Minimum Data Set ((MDS) dated [DATE] showed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) resident was coded with a score of 15 which indicated the resident was cognitively intact. Section G (Functional Status) resident was coded as 4 which indicated the resident was totally dependent on staff for locomotion on and off the unit. Section J1800 (Falls) the resident was coded as 1 which indicated the resident had a fall since admission, entry, or reentry, whichever is more recent. Review of the previously mentioned resident's Care Plan showed a Focus Area for Falls that lacked documented evidence that the facility's staff updated the Care Plan with goals, approaches, and interventions to address the fall that occurred on 02/12/20. During a face-to-face interview conducted on 2/14/20, at approximately 11:00 AM, Employee #9 reviewed Resident # 81's Care Plan and acknowledged the finding. 2. The facility's staff failed to update Resident # 235's Care Plan to include goals and interventions to address 1 to 1 monitoring for safety. Review of Resident # 235's current medical record on 02/19/20 starting at 1:00 PM showed that the resident was admitted on [DATE] with several [DIAGNOSES REDACTED]. Continued review of the medical record revealed a physician order [REDACTED]. Further review of the medical record revealed a Care Plan dated 12/24/20 that lacked documented evidence that the facility staff failed to revise the previously mentioned Care Plan to include goals and interventions to address the 1 to 1 safety monitoring for Resident #235. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility staff failed to revise Resident #235 Care Plan to include goals and interventions for 1 to 1 monitoring for safety. The facility's staff failed to update Resident # 235's Care Plan to include goals and interventions to address 1 to 1 monitoring for safety. 3. The facility's staff failed to update Residents' #246 and #297 Care Plan to address a resident-to-resident verbal interaction. Resident #246 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a face-to-face interview on 02/12/20 at 10:32 AM, Resident #245 was asked about an incident that occurred between her and another resident (Resident #297). Resident #245 stated (Resident # 297) threaten me .disrespected me. He pushed his walker behind me and went behind me. He went off on me . I had protection with me, a short cheese knife. I don't have it anymore. They (the facility) took it. I used to cut cheese with it. There was no physical altercation between us. Resident #297 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 02/20/20, at approximately 1:00 PM, Resident #297 decline to be interviewed by the State Agency Representative. During a face-to-face interview with Employee #6 on 2/20/20 at 11:17 AM, she stated, They (the residents) are on the same unit. They use to be friends. We keep them away from each other. They both know that they have to stay away. They don't smoke at the same time. Whoever gets to the smoking area first, the other one has to wait. Customer Service is aware of this. Review of Resident # 246's and # 297's Care Plan(s) showed that the facility's staff failed to update the previously mentioned residents' Care Plans with goals, approaches, and interventions to address the resident-to-resident altercation that occurred on 10/24/19. During a face-to-face interview on 02/20/20 at 11:17 AM, Employee #6, Unit Manager, acknowledged the finding. 4. The facility staff failed to update Resident # 322's Care Plan with the [MEDICAL TREATMENT] Center information. Resident #322 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review Resident # 322's Quarterly Minimum Data Set ((MDS) dated [DATE] showed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) the resident was coded with a score of 09 which indicated that the resident was not cognitively intact. Section I (Active Diagnoses) the resident was coded as I1500 [MEDICAL CONDITION] and I8000 Other Dependence on [MEDICAL TREATMENT]. Section O0100 (Special treatments, Procedures, and Programs) the resident was coded as J indicating the resident received [MEDICAL TREATMENT] treatments. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's Care Plan showed a Focus Area of [MEDICAL CONDITION] related to End-Stage Disease. However, the Care Plan lacked documented evidence of the name, location, and contact personnel at the [MEDICAL TREATMENT] center. A face-to-face interview conducted on 02/13/20, at approximately 1:00 PM, Employee #8 stated, We did not include the [MEDICAL TREATMENT] Center information, but we will include the information immediately.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, residents preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, for three (3) of 75 sampled residents, the facility's staff failed to: (1) provide care per the person-centered Care Plan for one (1) resident; (2) provide medication per professional standards and as prescribed by the physician for one (1) resident; and (3) failed to obtain a physician's orders [REDACTED]. (Residents' #23, #295, and #TF) Findings included . (1) The facility's staff failed to provide Resident #23 with care per his person-centered Care Plan. During an interview on [DATE] at 11:00 AM, Resident #23 stated that the nursing staff failed to administer his hypertension medications for [DATE]. Continued interview revealed that the nurses take his blood pressure daily, and he always requests his readings. Resident #23 said that once his blood pressure reached ,[DATE], he asked to see the nurse practitioner, who informed him that his blood pressure medication had been left off the list. The resident also stated, The last time my blood pressure was that high (,[DATE]). I had a stroke. Review of Resident # 23's current medical record on [DATE] starting at 2:00 PM showed that the resident had an initial admission date of [DATE] with multiple [DIAGNOSES REDACTED]. Continued review of Resident # 23's medical record revealed a Quarterly Minimum Data Set ((MDS) dated [DATE]. The MDS data showed the following: Section C (Cognitive Pattern) the resident had a score of 15, which indicated that the resident's cognitive response was intact; and Section I (Active Diagnoses) - the resident had several active diagnoses, including Hypertension and [MEDICAL CONDITION]. Further review of Resident # 23's medical record showed a Care Plan with an initiation date of [DATE] with the following focus areas and interventions: Focus Area- Hypertension related to lifestyle, Intervention- give antihypertensive medications as ordered . [MEDICATION NAME] tablet 10 milligrams by mouth one time a day; and Focus Area- Acute [MEDICAL CONDITION] Superimposed on [MEDICAL CONDITION], Intervention - give medications as ordered by a physician. Further review of the resident's record revealed a [DATE] Medication Administration Record [REDACTED] (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[MEDICATION NAME] ([MEDICATION NAME]) Tablet 10 mg (milligrams) give one tablet by mouth one time a day [MEDICAL CONDITION](Hypertension) with a start date of [DATE] and a discontinue date of [DATE]. [MEDICATION NAME] ([MEDICATION NAME]) Tablet 40 mg (milligram) give one tablet by mouth one time a day for [MEDICAL CONDITION] with a start date of [DATE] and a discontinue date of [DATE]. Continued review of the [DATE] MAR indicated [REDACTED]. However, further review of Resident # 23's medical record showed that there was no documented evidence of a physician's orders [REDACTED]. Continued review of Resident # 23's medical record showed a nurse practitioner note dated [DATE] that documented Was asked to see pt (patient) for elevated BP (Blood pressure) . Meds (medications) reviewed. No antihypertensive noted on profile-pt (patient) was previously on [MEDICATION NAME]. During a face to face interview on [DATE] at 3:00 PM, Employee #2 (DON) and Employee #7 (Unit Manager) acknowledged the findings. The facility's nursing staff failed to implement the care plan for the administration of hypertensive and diuretic medications for Resident #23. 2. The facility's staff failed to ensure Resident #295 received medication per professional standards. The manufacture instructions stipulate, Once a bottle is opened for use, it may be stored at room temperature up to 25C (77F) for 6 weeks. https://www.accessdata.fda.gov/drugsatfda_docs/label/, [DATE]s044lbl.pdf Observation of Unit 2 North on [DATE] at 8:15 AM, showed a medication cart that contained one (1) bottle of Latanoprost 0.005% with an open date of [DATE] written on the bottle, which was a total of nine (9) weeks. Continued observation revealed that the facility's staff failed to follow the manufactures specified storage time of 6 weeks to store Latanoprost 0.005%. Resident #295 was admitted to the facility on [DATE] with multiple diagnoses, including Open-Angle [MEDICAL CONDITION]. Review of the current physician's orders [REDACTED]. During a face-to-face interview on [DATE] at 8:20 AM, Employee #31 (the charge nurse on duty) acknowledged the finding. 2B. The facility's staff failed to ensure Resident #295 received medication as ordered by the physician. Review of the resident's February 2020 Medication Administration Record [REDACTED]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A second observation of Unit 2 North on [DATE] at approximately 9:20 AM, revealed a medication cart that lacked evidence of Resident # 295's prescribed medication of Latanoprost 0.005%. However, continued observation showed that the previously mentioned medication was stored on the unit unopened in the medication room. During a face-to-face interview with Resident #295 on [DATE] at approximately 11:30 AM, she stated, I did not get my eye drops last night .I never refuse my eye drops. However, an interview with the staff nurse on [DATE] at approximately 9:30 AM revealed that the resident's Latanoprost 0.005% was not delivered by pharmacy until 3:00 AM on [DATE]. During a face-to-face interview on [DATE] at approximately 11:00 AM, Employee # 6, Unit Manager, acknowledged the findings. The facility staff failed to ensure that Resident # 295's Latanoprost 0.005% eye drops were available for administration on [DATE] at 8:00 PM. Also, the facility's staff inaccurately recorded that Resident #295 refused the previously mentioned medication on [DATE] at 8:00 PM. 3. The facility's staff failed to obtain a physician's orders [REDACTED]. Resident #TF was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The resident expired at the facility on [DATE]. Review of the nurse's notes dated [DATE] revealed, At about 9:20 AM . (Medical Director) was made aware . cause of death as ASCVD ([MEDICAL CONDITION] Cardiovascular Disease), [MEDICAL CONDITIONS], DM (Diabetes Mellitus),[MEDICAL CONDITION](Hypertension), [DIAGNOSES REDACTED] Left Foot .Medical Examiner was called by police .(Family member) call back and stated that let the facility have the medical examiners office pick up the body and they will have (Funeral Home) pick up the body form the DC Medical Examiner's office . Review of Resident TF's medical record lacked evidence that the facility's staff obtained a physician's orders [REDACTED]. During a face-to-face interview with on [DATE] at 4:23 PM, Employee #2 acknowledged the findings.

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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 0689 Level of Harm - 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** Based on record review and interviews for five (5) of 75 sampled residents, the facility's staff failed to: (1) ensure 1 to 1 monitoring (supervision) was provided for one resident; (2) ensure two (2) residents, who were asssessed as fall risks, recieved adequate supervision; and (3) supervise two (2) residents when placing them in a ride share car (Uber). for two (2) of 75 sampled residents (Residents' #56, #187, #226, #235, and #305). Findings included . (1) The facility's staff failed to ensure Resident #235 recieved 1 to 1 monitoring (supervision), as perscibed. Review of Resident # 235's current medical record on 02/19/20, starting at 1:00 PM, showed that the resident was admitted on [DATE] with multiple diagnoses, including Alteration in Neurological Status related to Closed head Injury, [MEDICAL CONDITION], Muscle Weakness, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. Continued review of the record revealed a physician order [REDACTED]. Further review of Resident # 235's medical record revealed a nursing note dated 01/27/20 that documented, At about 6:05 PM, Resident was noted standing up in the lounge .bleeding from .left eyebrow measuring 0. 5cm (centimeter) X 0.5 cm. Resident stated .I was making a move forward when I fell and hit my left eye. The nursing note also documented that the resident was transferred by 911 to the nearest emergency room for further evaluation on that same day at 7:18 PM. However, the nursing note lacked documented evidence that the staff was provided 1:1 monitoring for safety prior to Resident # 235's fall on 01/27/20. Further review of the medical record showed a discharge instruction from a local hospital dated 01/27/20 that documented the resident was seen for Facial laceration (and) Fall. The discharge instructions indicated that the resident's laceration was at the left lateral near temple. Continued review of the discharge instructions revealed that Resident # 235's wound was closed with 4 sutures. Review of the Care Plan dated 12/24/19 lacked documented evidence of the staff's responsibility when providing 1:1 monitoring for the safety of Resident #235. During an interview on 02/19/20 at 3:00 PM, Employee #2 (DON) and Employee # 7 (Unit Manager) acknowledged the finding. Employee #2 then stated that Employee #18 Cetified Nursing Assistant (CNA) left the resident without waiting for her relief. When asked if Employee #18 received training on 1:1 monitoring for safety, Employee #2 and Employee #7 stated, Yes However, the facility had no documented evidence of Employee # 18's training or competency on 1:1 monitoring for safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further interview with Employee #2 and Employee #7 revealed that the facility did not have a policy on 1:1 Monitoring for Safety. The facility's staff failed to provide 1 to 1 monitoring (supervision)for Resident #235 on 01/27/20. (2). The facility staff failed to ensure Resident #56 and Resident #305, who were asssessed as fall risk(s), recieved adequate supervision. A. Resident #56 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident's #56's medical record showed that on 02/07/20 at 9: 00 AM, the resident was found in front of the nursing station lying face down bedside her wheelchair. Review of the resident's Quarterly Minimum Data Set ((MDS) dated [DATE], showed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) with a score of 13 which indicated that the resident had moderate cognitive impairment. Section G (Functional Status) resident is coded as 3 extensive assistance with two (2) persons physical assist for bed mobility and transfer and coded 7 activity occurred only once or twice for locomotion on the unit and locomotion off the unit. Section G 0400 Functional Limitation in Range of motion code 0 indicates No impairment. Section J I700 Fall History on Admission/entry was coded as0 to indicate that the resident had no fall 2 - 6 months prior to his admission to the facility. Review of the Care Plan initiated on 12/01/16 showed Resident at risk for falling r/t (related to) dx (diagnoses) of Catatonia and Epileptic [MEDICAL CONDITION] Disorder. However, the Care Plan lacked documented evidence that the staff was to monitor Resident #56 while in her wheelchair. Continued review of Resident #56's medical record revealed a nursing note dated 02/07/20 at 13:42 that showed Resident was noted lying face down by her wheelchair in front of the nursing station. On assessment resident was noted with a swelling to the right frontal part of head active ROM (range of motion) to both upper and lower extremities done, resident obeys commands, and respond to question spontaneously. LOC (level of conciousness) was within normal, alert verbal responsive. neuro check initiated, ice pack applied to swelling on the frontal part of the head (doctor name) . gave order to transfer resident to hospital ER (emergency room) for evaluation of swelling to the head post fall . During a face to face interview on 2/13/20 at 2:55 PM, Employee #21 stated, Resident was at the nursing station waiting to be picked up for an appointment to the urologist doctor, I placed her there and then went to attend to another resident. During a face-to-face interview on 02/13/20 at 1:44 PM, Employee #8, Unit Manager acknowledged the findings and stated, No one witnessed the resident's fall. The staff assigned to the resident left the resident at the nursing station and went to attend to another resident. The facility's staff failed to supervise Resident #56 on 02/07/20 while she was sitting in her wheelchair at the nursing station. B. Resident #305 was admitted to the facility on [DATE], with several [DIAGNOSES REDACTED]. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #305's medical records revealed a nursing note dated 02/08/20 at 9: 00 AM that showed The resident was found on the floor, beside his bed and sitting on his buttocks Review of Resident #305's Quarterly Minimum Data Set ((MDS) dated [DATE] showed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) with a score of 13 which indicates the resident had moderate cognitive impairment. Section G (Functional Status) resident is coded as 3 extensive assistance with one (1) person physical assist for bed mobility, transfer, locomotion on the unit, and is coded 1 supervision, oversight, encouragement or cueing for locomotion off the unit. Section G 0400 Functional Limitation in Range of motion code 0 indicates No impairment. Section J I700 Fall History on Admission/entry was coded as0 to indicate that the resident had no fall 2 - 6 months prior to his admission to the facility. Review of the Care Plan initiated on 01/20/15 showed Resident at risk for falls r/t (related) gait/balance problems, non-adherence to calling for assistance. The Care Plan lacked documented evidence how staff supervise resident while he was in his room unattended. Continued review of Resident #305's medical record showed a nursing note dated 2/8/20 at 21:20 that showed, Around 3:10 PM resident was noted sitting on his buttock on floor. Beside his bed in his room. The resident stated he was trying to sit in his w/c (wheelchair). Upon assessment .denied hitting his head. No bruise or injury noted this time. Neuro check initiated. The resident was educated to use the call light for assistance. During a face-to-face on 2/18/20 at 12:24 PM, Employee #9, Unit Manager, acknowledged the finding. Employee #9 then stated Resident has consistent falls. He is non-adherent to the education staff gives him. We ask him to call for help, but he still tries to walk and transfer by himself. The facility's staff failed to provide supervision for Resident #305. (3). The facility's staff failed to supervise Resident #187 and Resident #226 after placing them in a ride share car (Uber). A. Review of Resident #187's medical record showed that she was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE], showed Section C (Cognition Patterns) C1000 Cognitive Skills for daily decision making was scored as 15 which indicated that the resident was cognitively intact. Under Section G0300 the resident was coded as not steady, but able to stabilize without human assistance, and requires supervision with transfers, locomotion off the unit with one person physical assistance. During a face-to-face interview with Resident #187, on 02/10/20 at approximately 11:00 AM, she stated, I went out with another resident, far out in Maryland to look at an Assisted Living Facility about 3-4 weeks ago. I only went because I was told that if I didn't pick a place I would be discharged to a shelter. Resident #187 then said, I chose not to rent a room at the Assisted Living facility because my [MEDICAL TREATMENT] center is far from the facility, and I have limited income. B. Review of Resident # 226's medical record showed that he was admitted to the facility on [DATE], with several [DIAGNOSES REDACTED]. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Admission Minimum Data Set ((MDS) dated [DATE], showed Section C (Cognition Patterns) C1000 Cognitive skills for daily decision making wAS recorded as 13, which indicated that the resident was cognitively intact. Under Section G the resident was coded as requiring supervision to transfers, locomotion off the unit with one person physical assistance, not steady, but able to stabilize without human assistance; Additionally, the resident was coded as having impairment on one side of his upper extremities and using a wheel chair. Through observation on 02/19/20 at 5:35 PM, the resident was observed using a rollator walker to assisst with ambulation. During a face-to-face interview on 02/19/20 at 5:35 PM, Resident #226 explained that on 01/24/20 (Friday), Employee #29, Social Worker, called an Uber to drive him along with another resident (Resident #187) to look at some rooms that were available for rent in Clinton, Maryland, approximately 15 miles away. Continued interview the resident stated, It felt scary for me to be in a car and have no idea where I was going. The resident then stated that the Uber driver dropped him and other resident (Resident #187) off in front of a private home where he met a male (the renter) and a female. Further interview with Resident #226, revealed that the home had available rooms for rent upstairs and downstairs (basement). The resident stated, I was unable to observe the rooms upstairs because I could not go up the steps with my walker and the stairs did not have (hand) rails. Continued interview with Resident #226 revealed that when he made the renter aware he was unable to safely navigate the stairs, the renter told him to go outside to the back of the house, so that he could access the basement from an outside door. The resident indicated that he refused to go to the back of the house because he was not interested in moving so far away from DC. Resident #226 then said, I called the nursing home and informed the social worker (Employee #29) that I did not like the room and needed someone to pick us up. During a face to face interview on 02/19/20 at 5:30 PM, Employee #29, Social Worker, acknowledged the finding. Employee #29 then stated The two residents (Residents #187 and #226) went together in an Uber to Clinton, Maryland. We (the facility) paid for the Uber. It was early in the day. Employee #29 was asked, is this your practice? She replied, I didn't think this was an issue because the gentlemen that owns the Assisted Living is familiar with us (the facility). During a face-to-face interview on 02/19/20 at 5:32 PM, Employee #1, Adminstrator, stated We have a transportation system that has 10 escorts to take residents back and forth to appointments. The facility's staff failed to provide adequate supervision to Residents' #187 and #226 when they sent them without a facility escort to visit an Assisted Living facility in Clinton Maryland, approximately 15 miles away from the nursing home. Through interview with one resident he stated, It felt scary for me to be in a car and have no idea where I was going. and once the resident entered the Assissted Living facility, they did not have hand rails to aid in the resident's safe navigation of the stairs within the home.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility's staff failed to provide incontinent care in a timely manner for one (1) of 75 sampled residents (Resident #23). Findings included . During an interview with Resident #23 on 02/14/20 at 10:00 AM, the resident stated that the dayshift staff did not provide incontinent care for him on 02/12/20 at 2:00 PM when he returned from his doctor's appointment. The resident then said, I was sitting in my wheelchair, wet all the way down to my feet. Continued interview revealed that staff answered his call light several times but did not provide the care until 4:00 PM when the next shift (evening shift) came to work. When queried, why staff didn't provide incontinent care? Resident #23 stated that he was told his assigned certified nursing assistant was providing one to one care for another resident. During an interview on 02/14/20 at 11:00 AM, Employee #22, the person who arranges residents' appointments, stated that Resident #23 returned from his appointment on 02/12/20 at 1:45 PM. Review of the Resident # 23's current medical record on 02/14/20 at 2:00 PM showed that the resident was initially admitted on [DATE] with several [DIAGNOSES REDACTED]. Continued review of the resident's medical record revealed [REDACTED]. The MDS data showed the following: Section G0110 (1A) Toilet Use - the resident, was coded as 3 indicating that the resident needed extensive assistance from two (2) staff members with this activity of daily living; Section G0300 (E) Surface to Surface Transfers - the resident was coded as 2, indicating that the resident was not steady and needed staff assistance with stabilizing when transferring from one to surface to another; and Section G0600 (C) Mobility Devices - the resident was coded as wheelchair, indicating that the resident normally used a wheelchair. Further review of Resident # 23's medical record showed a Care Plan with an initiation date of 07/30/19 that revealed a Focus area of Incontinent Bladder with an Intervention that instructed the staff to Check (resident's name) every 2 hrs (hours) and as required for incontinence. During an interview on 02/15/20 at 3:00 PM, Employee #2 (DON) and Employee #7 acknowledged the finding. The facility's staff failed to provide Resident #23 with incontinent care, although he asked for help several times on 02/12/20.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview for one (1) of 75 sampled residents, facility staff failed to administer Resident #148's enteral feeding as directed by the physician. Findings included . Review of physician's orders [REDACTED]. x 18 hours. Feeding to be hung at 12:00 PM and to run until 6:00 AM; plus water flushes of 200ml every 6 hours. During an observation of Resident #148's room at 1:20 PM on February 11, 2020 the resident was observed lying in bed on his right side. A pole was on the right side of the bed but no enteral feeding was noted hanging on the pole or in the room. Employee #5 was taken to the room and asked to verify the time that the feeding should be hung. The employee checked the order and acknowledged that the feeding was scheduled to be hung at 12:00 PM one hour and twenty minutes earlier. Employee #5 acknowledged the finding; that the facility staff failed to administer Resident #148's enteral feeding as directed by the physician.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview for one (1) of 75 sampled residents, the facility's staff failed to provide appropriate care to the Percutaneous Endoscopic Gastrostomy tube (PE[DEVICE]) site for one (1) resident. (Resident #233). Findings included . According to the Nursing Times Journal, It is vital that nurses are aware of the complications that may arise when caring for a patient with a PEG (percutaneous endoscopic gastronomy) tube ([DEVICE]) .The most common complication is an infection at and around the insertion site . Infection can present as inflammation around the site, coupled with discharge and pain or discomfort . Nurses should follow their local dressing policy for cleaning wounds . The number of times per day that sites need to be cleaned will depend on the amount of leakage; a dressing may be required to absorb any moisture from the wound. https://www.nursingtimes.net/clinical-archive/nutrition/pe[DEVICE]s-dealing-with-complications-31-10-2014/ Review of the facility's policy Enteral Feedings - Safety Precautions Level 111 (revised November 2018), Title: Preventing Skin Breakdown. Instructed the staff to: Keep the skin around the exit site clean, dry, and lubricated (as necessary). Assess for leaking around the gastrostomy with each feeding or medication administration . Observe for signs of skin break down. Observation of Resident #233's PE[DEVICE] site on 02/13/20 at approximately 1:30 PM showed that the insertion site was covered with a white gauze dated and time 02/13/20 6 AM. Further observation of the gauze revealed that the gauze appeared to have a moderate amount of brownish colored drainage. After Employee #8, staff nurse, was queried about the brownish colored drainage on the dressing, he changed the dressing. A review of the physician order [REDACTED]. If drainage noted, may cover with aviant (avant) drain sponge or similar every night shift for [DEVICE] site care. The evidence showed facility staff failed to ensure Resident#233's [DEVICE] site was examine and cleaned at the insertion site to identify, lessen or resolve possible skin irritation and local infection as evidence by the gauze dressing removed from around the [DEVICE] insertion site was observed to be saturated with brownish drainage. During a face-to-face interview on 02/13.20, at approximately1:35 PM, Employee #8 acknowledged the finding.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility staff failed to ensure that they followed a physician order [REDACTED]. Finding included . Observation on 02/09/20 at 8:00 AM of Resident #215's room showed the resident sitting in bed receiving oxygen at a flow rate of 7 liters per nasal cannula by way of an oxygen concentrator. Review of the resident's current medical record on 02/09/20 at 8:15 AM showed that Resident #215 was admitted on [DATE] with several [DIAGNOSES REDACTED]. Further review of the record revealed a physician order [REDACTED].@ (at) 6L (liter) via nasal cannula r/t (related to) history of [MEDICAL CONDITION]. During a face to face interview at the resident's bedside on 02/09/20 at 8:20 AM, Employee #17 (RN) observed Resident #215's oxygen concentrator and acknowledged the finding. Employee #17(RN) stated that the resident was ordered 6 liters of oxygen and not 7 liters, as set on the concentrator. Employee #17 (RN) then decreased the oxygen flow rate from 7 liters to 6 liters. The facility's staff failed to ensure Resident #215 received oxygen therapy as ordered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview for one (1) of 75 sampled residents, facility staff failed to ensure the [MEDICAL TREATMENT] communication form used to reflect ongoing collaboration between the facility and [MEDICAL TREATMENT] staff was included in the medical record for Resident #322. Findings included . Facility staff failed to ensure the [MEDICAL TREATMENT] communication form used to reflect ongoing collaboration between the facility staff and [MEDICAL TREATMENT] staff was included in Resident #322's medical record. Resident #322 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of Resident #322's medical records from 1/25/20 to 2/3/20, showed that the resident goes to [MEDICAL TREATMENT] on Tuesdays, Thursdays, and Saturdays. The resident's [MEDICAL TREATMENT] record for communication between the [MEDICAL TREATMENT] center and the facility was not included as part of the resident's medical record. Observation made on 2/13/20, at approximately 4:14 PM of the resident's [MEDICAL TREATMENT] communication record and the medical record showed that they were maintained in a separate binder and not as a part of the resident's active clinical record. A face-to-face interview was conducted with Employee #8 on 2/13/20, at approximately 4:16 PM. He acknowledged the finding.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a nursing assistant had the skill to safely provide 1:1 care for one (1) of 75 residents in the sample (Resident #235). Findings included . Review of Resident # 235's current medical record on 02/19/20, starting at 1:00 PM, showed that the resident was admitted on [DATE] with multiple diagnoses, including Alteration in Neurological Status related to Closed head Injury, [MEDICAL CONDITION], Muscle Weakness, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. Continued review of the record revealed a physician order [REDACTED]. Further review of Resident # 235's medical record revealed a nursing note dated 01/27/20 that documented, At about 6:05 PM, Resident was noted standing up in the lounge .bleeding from .left eyebrow measuring 0. 5cm (centimeter) X 0.5 cm. Resident stated .I was making a move forward when I fell and hit my left eye. The nursing note also documented that the resident was transferred by 911 to the nearest emergency room for further evaluation on that same day at 7:18 PM. However, the nursing note lacked documented evidence that the staff was providing 1 to 1 monitoring for safety before Resident # 235's fall. Further review of the medical record showed a discharge instruction from a local hospital dated 01/27/20 that documented the resident was seen for Facial laceration (and) Fall. The discharge instructions indicated that the resident's laceration was at the left lateral near temple. Continued review of the discharge instructions revealed that Resident # 235's wound was closed with 4 sutures. Review of the Care Plan dated 12/24/19 lacked documented evidence of the staff's responsibility when providing 1 to 1 monitoring for the safety of Resident #235. During an interview on 02/19/20 at 3:00 PM, Employee #2 (DON) and Employee # 7 (Unit Manager) acknowledged the finding and stated that Employee #18 Cetified Nursing Assistant (CNA) left the resident without waiting for her relief. When asked if Employee #18 received training on 1 to 1 monitoring for safety, Employee #2 and Employee #7 stated, Yes. However, the facility had no documented evidence of Employee # 18's training or competency on 1 to 1 monitoring for safety. Further interview with Employee #2 and Employee #7 revealed that the facility did not have a policy on 1 to 1 Monitoring for Safety. The facility failed to ensure that Employee #18 (CNA) was competent to provide 1 to 1 monitoring for the safety of Resident #235.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and staff interview, facility staff failed to post daily nurse staffing information in a readily accessible location. The resident census on the first day of the survey was 346. Findings included . On February 9, 2020 at approximately 7:10 AM there was no posting of the staff information on Units One (1) North, One (1) South, Two (2) North, Two (2) South, Three (3) North and Three (3) South. Upon arrival on the units between 7:00 AM and 7:10 AM Surveyors observed staff erasing information from all of the grease boards directly across from the nurses' stations. It was later determined that they were erasing the staffing information from the prior shift (11 PM on 11/8 through 7 AM on 11/9/2020.) In addition, facility staffing information was not observed in readily accessible locations within the facility. During a face-to-face interview on February 14, 2020, at approximately 10:00 AM Employee #2 stated, the daily staffing is posted on the door in the supervisors' office. The writer stated, that this is not a location where residents and visitors can view the form as they would have to enter the supervisors' office because the door is always open. The door has been observed open during our visit (2/9/2020 - 2/14/2020) not allowing me to see the form without first entering the supervisors' office. Therefore, the form has not been readily available for residents and visitors to review at any given time. Employee #2 acknowledged the finding.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, for two (2) of 75 sampled residents, the facility's pharmacist failed to identify a medication error (Omission of Antihypertensive medications) during the January 2020's Drug Regimen Review for one (1 resident; and to ensure the pharmacist completed The Pharmacist's Chronological Record of Medication Regimen Review for 2 months (August 2019 and Jaqnuary 2020) for one (1) resident. (Residents #23 and #220). Findings include . 1. During an interview on 02/10/20 at 11:00 AM, Resident #23 stated that the nursing staff failed to administer his hypertension medications for January 2020. Review of Resident #23's current medical record on 02/13/20 starting at 2:00 PM showed that the resident had an initial admission date of [DATE] with multiple [DIAGNOSES REDACTED]. Further review of the resident's record revealed a January 2020 Medication Administration Record [REDACTED] [MEDICATION NAME] ([MEDICATION NAME]) Tablet 10 mg (milligrams) give 1 tablet by mouth one time a day [MEDICAL CONDITION](Hypertension) with a start date of 08/20/19 and a discontinued date of 01/01/20. [MEDICATION NAME] ([MEDICATION NAME]) Tablet 40 mg (milligram) give 1 tablet by mouth one time a day for [MEDICAL CONDITION] with a start date of 08/20/19 and a discontinue date of 01/01/20. Continued review of the January 2020 MAR indicated [REDACTED]. Further review of Resident #23's medical record showed no evidence of a physician's orders [REDACTED]. Continued review of Resident #23's medical record showed a document entitled, Pharmacist's Chronological Record of Medication Regimen Review dated 01/27/20. The review lacked documented evidence that the pharmacist captured the medication error that the facility's staff did not administer Resident #23's physician ordered [MEDICATION NAME] or [MEDICATION NAME] for 19 days from 01/02/20 to 01/20/20. However, the pharmacist documented NI (indicating no irregularities). During a face-to-face interview with Employee #4 at approximately 9:00 AM on February 20, 2020, the employee acknowledged that the pharmacist failed to identfy a medication error (Omission of Antihypertensive medications) during the January 2020's Drug Regimen Review. 2.The facility staff failed to ensure the pharmacist completed The Pharmacist's Chronological Record of Medication Regimen Review for 2 months (8/2019 and 1/2020) for Resident #220. Resident #220 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Section C400 of the Quarterly Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 15 which is an indication that the resident is cognitively intact and able to make decisions. A review of the medical record showed The Pharmacist's Chronological Record of Medication Regimen Review was available on the record. The Medication Regimen Review was documented on the record from February 2019 through February of 2020. However, there was no documentation to show that the review was completed for August of 2019 and January 2020. A face-to-face interview was conducted with Employee #4 on 2/18/20 at approximately 1:00 PM concerning omission of the the two-months Medication Regimen Review by the Pharmacist without a reason as to why the review was not available in the resident's record. Employee #4 stated, I will check to see if the resident was hospitalized . The employee later reported, The resident was in the facility. I do not know what happened. will check and let you know Employee #4 acknowledged the finding, during the aforementioned interview.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview for one (1) of 75 sampled residents, the facility's staff failed to respond to the pharmacist's recommendation for dosage reduction for one resident who receives [MEDICATION NAME]. (Antidepressant). Resident #56 Findings included . Resident #56 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of the Pharmacist's Medication Regimen Review showed that on 08/15/19 the Pharmacist documented, RMP (Recommendation made to Physician) decrease [MEDICATION NAME]. Continue review of Resident #56's medical record lacked documented evidence the physician responded in writing to the Pharmacist reccommendations. A face-to-face interview was conducted on 02/14/20 at 2:00 PM with Employee#4 concerning the physician response to the Pharmacist Recommendation dated 08/15/19. She stated,I will look for it. A face-to-face interview was conducted on 02/18/20, at approximately 1:00 PM with Employee #4, she acknowledged the findings. The phyisican failed to responded to the pharmacist's recommendation for a dosage reduction of [MEDICATION NAME] (Antidepressant) on 08/15/19 for Resident #56.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility staff failed to ensure a resident was free from a significant medication error for one (1) of 75 sampled residents (Resident #23). Findings included . During an interview on 02/10/20 at 11:00 AM, Resident #23 stated that the nursing staff failed to administer his antihypertensive medications for January 2020. Continued interview revealed that the nurses take his blood pressure daily, and he always requests his readings. Resident #23 said once his blood pressure reached 189/111, he asked to see the nurse practitioner, who informed him that his blood pressure medication had been left off the list. The resident also stated, The last time my blood pressure was that high (189/111). I had a stroke. Review of Resident #23's current medical record on 02/13/20 starting at 2:00 PM showed that the resident had an initial admission date of [DATE] with multiple [DIAGNOSES REDACTED]. Continued review of Resident #23's medical record revealed a Quarterly Minimum Data Set ((MDS) dated [DATE]. The MDS data showed the following: Section C (Cognitive Pattern) the resident had a score of 15 (cognitive response intact); and Section I (Active Diagnoses) - the resident had several active diagnoses, including Hypertension and [MEDICAL CONDITION]. Further review of Resident #23's medical record showed a Care Plan with an initiation date of 07/31/19 with the following focus area and interventions: Focus area- Hypertension related to lifestyle, Intervention- antihypertensive medications as ordered . [MEDICATION NAME] tablet 10 milligrams by mouth one time a day; and Focus area- Acute [MEDICAL CONDITION] superimposed on [MEDICAL CONDITION], Intervention - give medications as ordered by a physician. Further review of the resident's record revealed a January 2020 Medication Administration Record [REDACTED] [MEDICATION NAME] ([MEDICATION NAME]) Tablet 10 mg (milligrams) give 1 tablet by mouth one time a day [MEDICAL CONDITION](Hypertension) with a start date of 08/20/19 and a discontinue date of 01/01/20. [MEDICATION NAME] ([MEDICATION NAME]) Tablet 40 mg (milligram) give 1 tablet by mouth one time a day for [MEDICAL CONDITION] with a start date of 08/20/19 and a discontinue date of 01/01/20. Continued review of the January 2020 MAR indicated [REDACTED]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #23's medical record showed that there was no evidence of a physician's orders [REDACTED]. Continued review of Resident #23's medical record showed a nurse practitioner's note dated 01/20/20 that documented Was asked to see pt (patient) for elevated BP (Blood pressure) . Meds (medications) reviewed. No antihypertensive noted on profile-pt (patient) was previously on [MEDICATION NAME]. During a face to face interview on 02/13/20 at 3:00 PM, Employee #2 (DON) and Employee #7 (Unit Manager) acknowledged the findings. The facility's nursing staff failed to administer Resident #23's ordered medications [MEDICATION NAME] and [MEDICATION NAME] for 19 days from 01/02/20 to 01/20/20.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation resident and staff interview for one (1) of 75 sampled residents, the facility's staff failed to ensure the food prepared for the resident was attractive refers to the appearance of the food when served to residents. (Resident #246). Findings included . During a face-to-face interview with Resident #246 on 02/12/20 at 10:38 AM, she stated, I don't like the food here . I get food from the grocery store .I need food to take my meds (medication). During dining on 02/12/20 at approximately 1:30 PM (the lunch meal), the resident came to the writer upset about the salad that was served for her to eat. Resident #246 stated, I can't eat this food, look at it (pointing to the plate of food). The writer observed the resident with a plate of salad that appeared to have withered lettuce. The resident stated, She asked for an alternate meal a half smoke, and was told she could only have chicken or a cold cut sandwich. The resident siad, I'm tired of eating chicken and cold cuts. I asked for a half smoke The resident became tearful and said she could not eat the food. The writer informed Employee #1, Administrator, of the concern at the time of the occurrence, and he acknowledged the findings on 02/12/20 at 1:45 PM.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, facility staff failed to store and prepare foods under sanitary conditions as evidenced by inadequate internal temperatures in one (1) of one (1) walk-in freezer, four (4) of four (4) soiled convection ovens, one (1) of five (5) missing slat in one (1) of one (1) walk-in refrigerator and a broken outer temperature gauge in one (1) of three (3) reach-in refrigerator. Findings included . During a walkthrough of dietary services on February 9, 2020, at approximately 7:20 AM, the following were observed: 1. Internal temperatures in one (1) of one (1) walk-in freezer fluctuated between 30 degrees Fahrenheit (F) and 38 degrees F between 7:22 AM and 9:30 AM. Food items such as mixed vegetables and French fries were still frozen but approximately 15 of 15 one-serving containers of ice cream were melted and discarded. No other foods were affected as the walk-in freezer was repaired soon thereafter. 2. Four (4) of four (4) convection ovens were soiled throughout with burnt food deposits. 3. One (1) of five (5) slats was torn off in one (1) of one (1) walk-in refrigerator. 4. The outer temperature gauge to reach-in refrigerator #5 was broken, one (1) of three (3) reach-in refrigerators in the kitchen. These observations were acknowledged by Employee #13 during a face-to-face interview on February 9, 2020, at approximately 9:30 AM.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observations, record review, resident and staff interview, the facility failed to maintain and implement an effective, comprehensive quality assurance and performance improvement (QAPI) program inclusive of all systems; as evidenced by failing to ensure that they developed plans of action to identify quality deficiencies. The resident census during the survey was 346. Findings included . A review of the facility's previous survey dated December 18, 2018 showed that the facility was cited for the following deficiencies: F558 Reasonable Accommodations Needs/Preferences F584 Safe/Clean/Comfortable/Homelike Environment F656 Develop/Implement Comprehensive Care Plan F600 Free from Abuse and Neglect F607 Develop/Implement Abuse/Neglect Policies F610 Investigate/Prevent/Correct Alleged Violation F656 Develop/Implement Comprehensive Care Plan F657 Care Plan Timing and Revision F684 Quality of Care F689 Free of Accident Hazards/Supervisions/Devices F812 Food Procurement, Store/Prepare/Serve-Sanitary F865 QAPI/QAA Improvement Activities F880 Infection Control Program F908 Essential Equipment, Safe Operating Condition F919 Resident Call System The aforementioned deficiencies were again cited in this current survey of February 20, 2020. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on the repeated deficiencies, there is no evidence that the facility staff continuously monitored their deficient practices from the prior survey and implemented the corrective actions as they indicated in their Plan of Correction from the recertification survey of 12/14/2018 with a compliance date of 2/7/2019. In addition, the facility failed to: Develop and implement appropriate plans of action to correct identified quality deficiencies Failed to develop and implement a policy for providing 1:1 care to residents and Failed to thoroughly investigate and provide corrective action for one male resident who was accused of abusing several female residents. A face-to-face interview was conducted with Employee #1 at approximately 2/20/2020 at 4:20 PM. The employee acknowledged the findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, facility staff failed to provide a safe, sanitary environment to help prevent the expansion and transmission of communicable diseases and infections as evidenced by one (1) of one (1) heater blower in use, that was soiled with dust in the laundry room and the lack of a water management program with a risk assessment to identify where Legionella and other waterborne pathogens could grow in the facility's water system. Findings included . 1. During a walkthrough of the facility's laundry area on February 19, 2020, at approximately 11:07 AM, one (1) of one (1) heater blower, hanging down from the ceiling in the washing machine room, was soiled with dust. This deficient practice consistently exposes resident clean, personal clothing and linen to dust contamination. 2. A comprehensive water management plan to include a complete description of all potable and non-potable water systems in the building and a facility risk assessment to identify where Legionella and other water borne pathogens could grow and spread in the facility's water system was not available for review on February 14, 2020, at approximately 9:15 A.M. These findings were acknowledged by Employee #15 on February 18, 2020, at approximately 1:00 PM.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, record review and staff interview, facility staff failed to: (I) maintain essential equipment in a safe condition as evidenced by a high internal temperature in one (1) of one (1) walk-in freezer, a broken temperature gauge in one (1) of five (5) reach-in refrigerators and one (1) of five (5) slats from one (1) of one (1) walk-in refrigerator that was completely torn off; and (II) ensure a New Life Intensity Oxygen Concentrator was operating in a safe condition for one (1) of 75 sampled residents (Resident #215). Findings included . (I). The facility's staff failed to maintain essential equipment in a safe condition as evidenced by a high internal temperature in one (1) of one (1) walk-in freezer, a broken temperature gauge in one (1) of five (5) reach-in refrigerators and one (1) of five (5) slats from one (1) of one (1) walk-in refrigerator that was completely torn off. a. Internal temperatures in one (1) of one (1) walk-in freezer fluctuated between 30 degrees Fahrenheit (F) and 38 degrees F between 7:22 AM and 9:30 AM and food items were not frozen solid as required. b. The outer temperature gauge to reach-in refrigerator #5 was broken, one (1) of five (5) reach-in refrigerators. c. One (1) of five (5) slats was torn off in one (1) of one (1) walk-in refrigerator. d. The top, protective plastic cover to remote bed controller cords were torn throughout in resident's rooms #104, #141 and #325, three (3) of 60 resident's rooms. These observations were acknowledged by Employee #13 during a face-to-face interview on February 9, 2020, at approximately 9:30 AM. (II). The facility's staff failed to ensure a New Life Intensity Oxygen Concentrator was operating in a safe condition for one (1) of 67 sampled residents (Resident #215). According to the New Life Intensity Oxygen Concentrator Service Manual under Section 4.1.1 Air Intake Gross Particle Filter/GPF - The external air intake gross particle filter is located on the back of the unit. You can easily remove it by hand. Instruct the patient to clean this filter weekly. Observation on 02/09/20 at 8:00 AM of Resident #215's room showed that the resident was sitting in bed, receiving oxygen at a flow rate of 7 liters per nasal cannula being delivered by an oxygen concentrator. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued observation of the back of the oxygen concentrator revealed that the concentrator had a serial number of CBB and an inspection sticker dated 06/17/17. Further observation showed that the concentrator did not have an Air Intake Gross Particle Filter, and dust particles were collected in the filter area. It should be noted that Resident #215 did not appear to have any respiratory distress, and her oxygen saturation was 95% on oxygen at 7 liters per nasal cannula. Review of the facility's Preventive Maintenance Log revealed preventive maintenance service for equipment was conducted on 08/07/19. Continued review of the log lacked documented evidence that Resident #215 oxygen concentrator #CBB was inspected on 08/07/19. During a face to face interview on 02/10/20 at 10:00 AM, Employee #16, Director of Environmental Services and Supplies, acknowledged the finding. Employee #16 stated that he was not aware that Resident #215's oxygen concentrator #CBB had not been inspected during the preventive maintenance services on 08/07/19. He also said that he was not aware that oxygen concentrator #CBB did not have a filter. Continued interview with Employee #16 revealed that oxygen concentrators are inspected by a company every six (6) months. However, he did not have documented evidence on when oxygen concentrators were inspected before 08/07/19. When asked if he knew what residents were assigned to each oxygen concentrator, Employee #16 stated, No, I'm new to the job. I would have to go to the floors and look at the serial numbers on each resident's concentrator. The facility failed to ensure Resident #215's oxygen concentrator was maintained in a safe operating condition.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, facility staff failed to maintain the call bell system in good working condition as evidenced by call bells in two (2) of 60 resident's rooms that failed to alarm when tested , torn protective call bells cord cover in five (5) of 60 observations and a broken reset button from one (1) of 60 resident call bell housing. Findings included . During an environmental walkthrough of the facility on February 10, 2020, between 10:35 AM and 3:30 PM: 1. Call bells in resident's rooms #332 and #355 did not alarm when tested , two (2) of 60 resident's rooms. This breakdown could prevent or delay care to residents in an emergency. 2. The top, protective plastic cover to call bell cords in resident's room's #124A, #205A, #214A, #235 and #332 was torn, five (5) of 60 resident's rooms. 3. The reset push-button to the call bell housing, attached to the wall in resident room [ROOM NUMBER] was broken, one (1) of 60 resident's rooms. These findings were acknowledged by Employee #14 on February 10, 2020, at approximately 3:30 PM.