STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215001	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ballenger Creek	347 Ballenger Drive Frederick, MD 21701

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based upon record review and pertinent staff interviews, it was determined that facility failed to ensure that incidents of alleged abuse were thoroughly investigated and reported to the state agency in a timely manner. This was evident for 1 (Resident #125) of 13 residents reviewed for abuse during the survey. The findings include: 1) Resident #125 was admitted into the facility in early 2022. A quick look into the resident's medical record indicated severely impaired mental cognition. A review of the intake information related to MD00192139 was conducted on 6/27/25 at 12:48 PM. The review indicated that Resident #125's family member alleged that another resident may have been inappropriately touching the resident. On 6/27/25 at 1:43 PM, a review of the investigation packet for MD00192139 revealed that the initial report was sent on 5/5/23 at 5:36 PM by the Director of Nursing (DON). The initial report noted the time and date of the incident as 5/5/23 at 4 PM. However, a statement by a nurse (Staff #20) reporting the allegation was signed and dated 5/3/23. The DON was interviewed about the allegation on 6/27/25 at 3:10 PM. During the interview, the DON reported that Resident #125's family member reported the allegation to Staff #20, who then reported it to her. The DON indicated that she investigated and reported the concern immediately. However, the date on the initial report was 2 days after Staff #20 made her statement. The DON acknowledged the concern.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility investigative material, medical record review and interview with resident representatives along with facility staff, it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 4 (Resident #17, 121, 125, 118) of 13 residents reviewed for abuse during a survey. The findings include: 1. On 6/24/25 at 7:05 AM review of intake #MD00218372 revealed concerns regarding the care of Resident #17, a long-term resident of the facility. The intake included concerns that a staff member stuck Resident #17. On 6/25/25 the facility provided a self-report investigation regarding the above concern. 6/25/25 at 9:30 AM review of the facility self-report revealed a statement from Resident #17 that was taken by the Unit Manager (Staff # 8) on 5/22/25. Review of Resident #17 statement revealed that s/he reported that the staff feeding her/him the previous night kept hitting her/his nose when the staff was pulling the spoon out of her/his mouth. The resident stated that s/he told her to stop but the Aide did not stop. The resident reported s/he spit out the food and the Aide smacked her upside the head. The resident motioned to the right temple area when asked where s/he was hit. On 6/25/25 The police were notified regarding the above allegation of abuse. Review of the police report, recorded on 5/21/2025 at 6 PM, revealed the following statement, It should be noted that (Resident #17) had visible redness at the corner of (her/his) right eye and complained of eye pain. I photographed the area to document the possible injury. On 6/25/25, the review of Resident #17's medical record (prior to the allegation of abuse) from 5/19/25 to 5/21/25 failed to reveal documentation regarding any discoloration to Resident #17s eye. On 6/25/25 Review of Resident #17's medical record revealed a late entry note dated 5/22/2025 at 9:00 AM titled Change in Condition Late Entry. Further review of this note revealed the change in condition included a small red discoloration noted to the right corner of the right eye. Further review of the medical record failed to reveal a follow-up change in condition form regarding the right eye discoloration. On 6/26/25 at 5:53 PM the Director of Nursing (DON) was interviewed. During the interview she reported that a follow-up change in condition should be completed within 72 hours of the initial change in condition documentation. She confirmed that residents medical record did not contain a follow up change in condition nor was the resident asked why she was rubbing her eye. On 6/26/25 at 5:56 PM The above concerns were discussed with the DON, that there was a lack of thorough investigation into the resident possible injury following an allegation of abuse. No additional information was provided prior to the end of the survey. 2. A review of the facility reported incident #MD00211311 revealed that a local hospital emergency department contacted the facility to report that Resident #121 had been pushed at the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's investigation file revealed that in addition to the self-report to the state agency, it contained 3 pages of documents that appeared to be medical records. These documents lacked the name of the patient or the healthcare facility. One of the pages contained a nurses note dated 10/28/24 17:00 [5:00 PM] which stated pt [patient] arrives to ED [emergency department] c/o [complaint of] 20/10 [pain score which rated patient said pain level 20 on scale of 0-20] R [right] leg pain. Pt. has significant bruising to the leg without any deformities. Pt also has bruising to the L [left] cheek and blood coming from her mouth. Pt stated she was pushed at [NAME] Lake. Pt is alert and oriented x 4 upon assessment repeatedly asking for a pain shot. Further review of the facility's investigation file revealed a typed statement with the Nursing Home Administrator's handwritten name and signature, that was dated 10/28/24. The paragraph stated that she received a call from [police officer name] stating he had met with the resident and spouse at the emergency room. The spouse told the police officer that Resident #121 was allegedly pushed by someone about 2 months prior at another facility, and they felt that the resident's bruises were from that alleged incident. Further review of the facility's investigation file failed to reveal any investigation of Resident #121's care at the facility or investigation notes. There were no witness statements, no staff or resident interviews, and no evidence that the resident facility medical records were reviewed. Although the facility's self-report contained a police report number, no report was found in the file. On 6/27/25 at approximately 4:10 PM an interview was conducted with the Nursing Home Administrator (NHA) to review the lack of evidence that the facility investigated the resident's allegation that he/she was pushed. The NHA acknowledged that she heard the surveyor's concern but had no response. No further evidence was provided by the end of the survey. 3) Resident #125 was admitted into the facility in early 2022. A quick look into the resident's medical record indicated severely impaired mental cognition. A facility reported incident (FRI) related to MD00192139 alleged that Resident #125 was inappropriately touched by another resident of the facility. The facility's investigation for the FRI mentioned above was reviewed on 6/27/25 at 1:43 PM. The review revealed the final report submitted by the Director of Nursing (DON) on 5/9/23. The final report noted that the allegation of sexual abuse was unsubstantiated because Resident #125 had no injuries based on the provider assessment and staff that were interviewed had not observed any inappropriate touching. Further review of the investigation revealed the social services director interviewed 3 residents and had no concerns. However, the interview documentation was not dated, 4 other residents were also interviewed but the documentation failed to reveal who conducted the interview and was not dated as well. One documentation for staff interview was filed with the investigation that indicated the staff (Staff #21) had not witnessed anything. This document was dated 5/12/23. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 6/27/25 at 3:10 PM. During the interview, the concern was discussed that resident interviews were not dated, 4 of the 7 residents interviewed failed to indicate who conducted the interview, and the 1 staff interview documented was dated 3 days after the final report was submitted. The DON confirmed that the resident interviews were not dated and 4/7 did not indicate who conducted the interviews. Furthermore, the DON indicated that she must have interviewed Staff #21 over the phone, and she may have written her statement when she came back to work. However, there was no other documentation to indicate that Staff #21 was interviewed prior to the completion of the facility's investigation or other staff interviews conducted. The DON verbalized understanding and acknowledged the concern. 4. Resident #118 has a medical history of cerebral infarction (stroke), resulting in hemiplegia and paralysis on the right side, along with polyneuropathy, which causes numbness, pain, and muscle weakness. The resident has a BIMS (Brief Interview for Mental Status) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/27/25 at 3:26 PM, the surveyor reviewed a facility-reported incident (MD00190346), which read as follows: The resident [Resident #118] stated that a staff member came in to provide care and was rough and appeared to be rushing. The resident reported that when the staff member turned them, they placed all their weight on the resident's leg/knee area. The resident's BIMS score is 15. A head-to-toe assessment was completed, with no bruising, swelling, or redness noted. The staff member was suspended pending investigation. Investigation is pending. On 6/29/25 at 7:30 PM, the surveyor reviewed the resident's progress notes, which documented the following: * 3/19/23 at 1:20 PM, Change in Condition Note: Right knee swollen, bruise to right outer knee, unable to bend knee without difficulty. * 3/19/23 at 1:53 PM, General Nurse's Note: Physician notified for x-ray; change in condition noted to have occurred during the 11-7 shift. * 3/19/23 at 9:53 PM, Change in Condition: Ongoing swelling and bruising of the right knee. * 3/21/23 at 10:36 PM, Change in Condition: Bruising continues with less swelling. * 3/23/23 at 2:18 PM, Care Plan Progress Note: New order for Tylenol for five days due to increased leg pain. The facility's investigation packet related to this allegation contained the following: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* A self-report form completed by former Licensed Nursing Home Administrator (LNHA #32). The form inconsistently listed the time of the allegation as both 11-7a and 11-7p and left the alleged perpetrator section blank. It also indicated law enforcement was contacted but omitted the date, time, case number, and officer's name. * A statement from GNA #33, which read in part (quoted exactly): At 5:45 AM I immediately went to his room to answer the call light and ask to be change, [their] bed was very wet so I told [them] I'm going to bed sheet to change the whole bed why changing [them]. All I did was to ask [them] to move side to side and fasting pad because patient move in bed. S/He always ask you to roll [him/her] that is in so much pain. Only time I touch the patient was to ask [them] to roll so I cloud [NAME] the sheet under [them] and fasting [their] pad. There was no documentation indicating whether GNA #33 was the staff member against whom the allegation was made, nor was there evidence of follow-up to clarify her involvement. The statement she provided contained multiple grammatical and spelling errors, which made it challenging to clearly interpret her account of the events. * Resident #118 statement dated 3/19/23 at 6:00 PM was taken by an unidentified staff member (#34), listed only by first name and last initial, with no title included. The resident reported that the nursing assistant was rough and rushed, resulting in injury to his right knee. There was no evidence of follow-up questions to determine the identity of the alleged perpetrator or whether other witnesses were interviewed. On 3/23/23 at 4:46 PM, the final investigation was submitted to the Office of Health Care Quality by LNHA #32. It failed to identify the alleged perpetrator or include a police report case number, date, time, or officer name. The conclusion read: The GNA (Geriatric Nursing Assistant) involved stated that the resident needed changed due to him being incontinent. She was assisting [them] in turning but never touched [their] knee, nor did she lean on the resident to turn [them]. Head to toe assessment was completed, no bruising, swelling, or redness was noted. X-ray was done as resident complained of pain to right knee. X-ray showed no fracture or any abnormalities to the right knee. Staff interviewed and other residents in GNA's group. No other residents stated they felt rushed by GNA or that GNA was rough with them. Unable to substantiate. On 6/30/25 at 8:31 AM, the surveyor interviewed the current Nursing Home Administrator (NHA) regarding the self-reported incident. After reviewing the facility's investigation, the NHA agreed that: * The identity of the accused staff member was unclear. * No evidence of police report or other staff/resident interviews was included in the investigation packet. * While the skin assessment showed no bruising, multiple clinical notes confirmed swelling and bruising to the resident's knee. The NHA acknowledged that the allegation was not thoroughly investigated.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record review it was determined that the facility failed to provide activities of daily living (ADL) care to dependent residents. This was evident for five (Resident #83, #25, #112, #15 and Resident #62) out of ten residents reviewed for ADL care. The findings include: 1.On 06/23/25 at 8:44 AM Resident # 83, a long-term resident of the facility, and their family members were interviewed. During the interview they reported that the resident goes a long time without receiving incontinent care from the staff. On 6/25/25 at 7:39 AM an observation in Resident #83 room was made. A family member and a resident were in the room. Observation revealed that the resident's top bedsheet was soaked with liquid, which had a slight smell of urine. The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected on the MDS drives Resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need. On 6/26/25 review of the quarterly MDS dated [DATE] revealed that Resident #83 was always incontinent of bowel and bladder, indicating that the resident was dependent on the staff for incontinent care. On 6/26/25 at 12:25 PM the Director of Nursing (DON) was interviewed regarding the incontinent care provided to the residents at the facility. She reported that the staff were to check residents every 2 hours and provide incontinent care when needed. In addition, the staff were to document, in the medical record (under TASKS), once a shift that incontinent care was provided during each shift. On 6/26/25 at 12:37 PM the geriatric nursing assistant documentation (TASKS) for incontinent care was reviewed for the time frame 5/28/25 through 6/26/25. The review revealed 15 of the 29 days of that period, failed to record all three shifts documenting that incontinent care was completed. On 06/26/25 at 01:01 PM during an interview the DON confirmed the lack of documentation for Resident #83's incontinent care. No additional documentation was provided prior to the end of the survey. 2.An interview with Resident #25 on 6/23/25 at 9:07 AM, showed that s/he only received one shower a week sometimes. Record review on 6/25/25 at 1:17 PM, showed that Resident #25 had been in the facility since May 2025. A continued review included a care plan for Resident #25. The care plan noted that the Resident was to have showers on Wednesdays and Saturday mornings,, meaning eight showers in a month and required staff assistance with the showers. The review also showed that Resident #25 also went for dialysis on Wednesday mornings. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent review of the GNA (Geriatric Nurse Aid) shower documentation for Resident #25 from 5/22/25-6/25/25 was completed. The review showed one shower in May and two showers in June. The review also recorded that Resident #25 refused showers one time in May and twice in June, one of the days being a dialysis day. In an interview on 6/26/25 at 7:19 AM, staff #15, unit manager for the TCU unit, stated that whenever residents refused showers, it was documented which helped flag it so that staff would re-offer the shower to the residents the following day. However, the interview failed to show that Resident #25 was re-offered a shower the next day following a refusal especially when s/he refused shower on a dialysis day. Staff verbalized understanding of concern and added that one of Resident #25's shower days was also a dialysis day so she would talk to the resident to find out if s/he preferred to change it to another day. 3. Resident #112 was admitted into the facility in early 2022. A review of the intake information related to MD00199099 revealed concerns with nursing services that include not feeding the resident. A review of Resident #122's medical record was conducted on 6/23/25 at 10:33 AM. The review revealed a nutrition evaluation by the dietitian (Staff #22) with a service date of 9/27/23 that stated, resident is now fully dependent on staff for meals. Dietitian #22 again indicated in a progress note with an effective date of 10/6/23 that Resident #122 was fully dependent on staff for meals. Further review of the resident's medical record indicated that the resident was placed on hospice care effective 10/16/23. Hospice is a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease. Hospice offers physical, emotional, social, and spiritual support for patients and their families. The main goal of hospice care is to control pain and other symptoms of illness so patients can be as comfortable as possible A review of the task documentation for eating was conducted on 6/23/25 at 11:27 AM. The review conducted was for the dates between 9/27/23 (when Dietician #22 indicated that Resident #122 was dependent on staff for eating) and 10/16/23 (when the resident was placed on hospice care). The review revealed 15 shifts where the nursing staff had not documented any assistance and 3 shifts with set up only. The Director of Nursing (DON) was interviewed on 6/23/25 at 2:07 PM. During the interview, the findings were discussed and the DON reported that during the last couple of weeks before Resident #122 passed, family members were coming in and were feeding the resident and indicated that the holes/absence in the task documentation was because of this reason. The instructions for the task documentation on SUPPORT PROVIDED for eating was reviewed with the DON. Option 8 read, ADL activity did not occur or family and/or non-facility staff provided care 100% of the time. The DON indicated that option 8 was what the staff should have documented on the medical record and that she would continue to review to find out more information and report back to the surveyor. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Later, on a subsequent interview with the DON at 2:56 PM, the DON reported that she found a progress note from the provider with an effective date of 10/11/23 that indicated the resident's family came in and fed the resident. However, no other documentation was found to indicate that adequate assistance was provided to Resident #122 to complete the eating task for 15 shifts out of the 18 days reviewed. the DON verbalized understanding and acknowledged the concern. 4) Resident #15 has a medical history of stroke and hemiplegia (complete loss of strength on one side of the body) which requires that s/he has total assistance for activities of daily living. S/He has a Brief Interview Mental Status (BIMS) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/25/25 at 1:40 PM, Resident #15 informed the surveyor that they had not received a bed bath or been changed since sometime during the night shift and stated that they are incontinent. The surveyor observed that the resident was still in bed and wearing a gown. The surveyor located Geriatric Nursing Assistant (GNA #17) and asked whether she had attended to Resident #15 during the current shift. She stated that she had not yet been in the room to turn, bathe, or change them, adding that they sometimes refuse care and prefers to sleep in. When asked if she documents such refusals, she stated that she does so occasionally but had not documented anything for today. The surveyor then asked whether she had offered to change the resident that day, and GNA #17 admitted she had not, explaining that she waits for them to call if they want assistance. When asked about the facility's expectations for turning and changing dependent residents, she stated that she understands residents should be turned and changed every two hours. The surveyor informed the GNA that the resident is requesting that she attend to their care and subsequently observed GNA #17 entering Resident #15's room. On 6/26/25 at 7:55 AM, the surveyor spoke with Resident #15, who confirmed that GNA #17 had cleaned and changed them the previous day but stated they had not yet been attended to that morning. Later, at approximately 9:01 AM, the surveyor asked if they had received a shower on 6/25/25. The resident stated that a shower had not been offered. When asked if they ever refuse showers, they responded that they do on occasion but generally enjoy them. At 9:04 AM, the surveyor reviewed the medical record, which indicated that the resident had received a shower on 6/25/25. However, the resident and his roommate, Resident #62, stated that Resident #15 had not received, nor had s/he been offered, a shower on 6/25/25. Both residents have a BIMS score of 15 and have been articulate when interviewed by the surveyor. On 6/26/25 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator (NHA) to express concerns that Resident #15 was documented as having received a shower, despite the resident denying that a shower was provided. The DON stated she would look for a corresponding shower sheet, which is required for all residents who receive showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/25 at 1:27 PM, the surveyor followed up with the DON, who confirmed that there was no shower sheet on file for Resident #15 for 6/25/25 to support the documentation that a shower was provided. 5) Resident #62 has a history of stroke, which requires him/her to depend on staff for total care. They have a Brief Interview Mental Status (BIMS) score of 15. A BIMS score is a short test used to check a person's thinking and memory skills. It helps doctors see if someone has trouble with their mental abilities. The score ranges from 0 to 15, with higher scores meaning better brain function. On 6/23/25 at 7:55 AM, the surveyor interviewed Resident #62, who reported that they had not received a shower in at least two weeks. The resident stated that they require the use of a Hoyer lift to get out of bed and that the facility does not have enough staff to operate the lift with only one aide. As a result, the resident reported that they often remain in bed and do not receive showers. The surveyor observed that the resident had greasy hair and face, an untrimmed beard and hair, extremely dry skin on the legs and feet, and an odor of sweat and urine. On 6/25/25 at 12:30 PM, the surveyor spoke with Resident #62, who reported that they still had not received a bed bath or shower. The surveyor observed the same dried skin flaking from the resident's feet onto the linens, as well as greasy hair, unshaven facial hair, and body odor. The surveyor had not observed the resident out of bed or cleaned since arriving at the facility on 6/23/25. On 6/25/25 at 12:42 PM, the surveyor reviewed Resident #62's medical record, which documented that the resident received a shower at 2:50 AM on 6/25/25. Further review confirmed that the resident is fully dependent on staff for ADL care, including personal grooming, bathing, and showering. The record also included an order dated 12/27/22 for the use of a Hoyer lift to assist with transfers. On 6/25/25 at 1:31 PM, the surveyor conducted an interview with Geriatric Nursing Assistant (GNA #17), who stated that Resident #62 is scheduled for nightly showers twice weekly and bed baths during the day shift. When asked if the resident ever gets out of bed, GNA #17 responded, We will get [her/him] up if we can, and explained that the resident uses a Hoyer lift and requires more staff to assist with transfers. When asked if the resident had received a bed bath that day, she replied, I haven't had time to get to [her/him], and added that because the resident often refuses care, I just leave [her/him] because [s/he] will call if [s/he] needs me. On 6/26/25 at 7:55 AM, the surveyor spoke with Resident #62, who reported that they still had not received a bath or shower. The surveyor observed that the resident continued to have extremely greasy hair, oily facial skin, debris in an untrimmed beard, body odor, and flaky dry skin on the legs, which had shed onto the bed linens. When asked if they ever refuse showers, the resident replied, No, I would love to get cleaned up. The surveyor then asked if they had been out of bed recently, and the resident stated that the last time they were out of bed was when they attended a baseball game with the activities department, which occurred about two or three weeks ago. When asked if they would get out of bed if offered, the resident responded that they want to get up daily but are not asked. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/25 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator (NHA) to express concerns that Resident #64 was documented as having received a shower, despite the resident denying that a shower was provided. The DON stated she would look for a corresponding shower sheet, which is required for all residents who receive showers. On 6/26/25 at 1:27 PM, the surveyor followed up with the DON, who confirmed that there was no shower sheet on file for Resident #62 for 6/25/25 to support the documentation that a shower was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215001	A. Building B. Wing	06/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ballenger Creek	347 Ballenger Drive Frederick, MD 21701

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and relevant interviews it was determined that the facility failed to provide care consistent with professional standards of practice to promote healing of an existing diabetic foot wound. This was evident for one (Resident #116) of two residents reviewed for pressure injuries during the survey process. The findings include: Negative Pressure Therapy is a vacuum assisted closure (VAC) therapy that uses suction and a dressing to remove excess wound drainage and to promote wound healing. Nursing responsibility for proper VAC functioning and care includes assessing and monitoring that the vacuum device is properly calibrated and functioning and to document the findings. On 6/24/25 at 12:39 PM a record review of the admission face sheet revealed Resident #116's diagnosis was Type 2 Diabetes Mellitus with foot ulcer, Encounter for orthopedic aftercare following surgical amputation, Bipolar Disorder, Post-Traumatic Stress Disorder and Cerebral Infarction, also known as a Stroke. On 6/24/25 at 1:13 PM a review of Resident #116's Care Plan revealed a risk for skin breakdown related to amputation; wound VAC per orders. The Treatment Administration Record (TAR) dated August 2024 revealed a lack of documentation for Negative Pressure Therapy on August 2, 3, 4, 5, and 6. On 6/24/25 a record review of Resident #116's closed medical record including the electronic health record, PointClickCare (PCC) revealed the following: A long-standing Physician order for Negative Pressure Therapy to Right foot SET Unit to 125 mmHg continuously every shift for right great toe. On 8/1/24 Licensed Practical Nurse (LPN #29) wrote a Progress Note, VAC to the right great toe in working order. On 8/2 and 8/3/24 a review of Nurse Progress Notes lacked PCC documentation that the VAC was assessed. On 8/4/24 LPN #29 entered a Nurse Progress Note, patient has wound VAC to the right foot for the right great toe amputee working well. On 8/5/24 a review of Nurse Progress Note lacked PCC documentation that the VAC was assessed. On 8/6/24 Nurse Practitioner (NP #30) wrote a Progress Note that resident was seen as follow up for diabetic right foot abscess. Collaborated with NP wound specialist today regarding worsening of right foot wound now with cellulitis. Assessment and Plan indicated continue negative pressure therapy to right foot. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 Wound Specialist (NP #31) wrote a General Nurse Note late entry that indicated Wound VAC therapy is in progress; however, it apparently stopped working. Right surgical site deteriorated today. On 8/7/24 at 5:00 PM a General Nurse Note revealed Resident #116 attended the podiatry appointment and was later sent to [NAME] Memorial Hospital for further evaluation. Review of the closed records indicated Resident #116 was hospitalized on [DATE] for right foot wound. On 6/25/25 at 11:55 AM an interview with Registered Nurse (RN #35) revealed that any resident with a pressure ulcer, stage 2 and higher, non-healing surgical sites, and vascular concerns were seen every Tuesday by the wound specialist, Nurse Practitioner (NP #31). Her role was to assist NP #31 with assessments, measurements, treatments and to enter orders into the electronic health record, (PCC). She acknowledged it was nursing responsibility and her expectation that nursing staff would give VAC care in her absence. She also acknowledged that if it's not documented, then it wasn't done. On 6/25/25 at 1:04 PM during an interview with NP #31 it was acknowledged that residents with non-healing surgical sites and a VAC are seen every Tuesday. She indicated that the wound care on the weekends was sub-par. It was also acknowledged that the wound VAC appeared to have not been working over a couple of days prior to her documented assessment on 8/6/24. She acknowledged that it was her expectation that the floor nurses should have known that the VAC was not functioning properly and should have applied the rescue dressing per the order. On 6/25/25 at 2:12 PM in an interview, the Director of Nursing (DON) agreed in principle, if it's not documented, it's not done. She stated that nursing care should be documented on the resident's TAR and/or in the Nurse Progress Notes in PCC. The DON reviewed Resident #116's August 2024 TAR and confirmed it appeared that the VAC was not assessed on August 2, 3, 4, 5 or 6th and that there was a lack of Nursing Progress documentation in PCC on August 2, 3 and 5th. The DON acknowledged that based on documentation and/or the lack thereof, it looks like nursing failed to provide care consistent with professional standards of practice to promote healing.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and pertinent interviews, it was determined that the facility failed to maintain safe operating condition of patient care equipment. This was evident for 1 resident complaint (Resident #115) of 20 resident complaints reviewed during this survey. The findings include: A Hoyer Lift is a mobility device to support residents who require mobility assistance to safely transfer to/from bed to a wheelchair or chair. On 6/24/25 at 10:33 AM a record review of the grievance log dated April 2023 revealed that a grievance form was filed on 4/18/23. A review of this grievance revealed that Social Service Designee (Staff #23) completed and submitted the form. The investigative process conducted by Registered Nurse (RN #26) confirmed the validity of the grievance and concluded that one of two facility Hoyer lifts was not in safe operating condition due to dead batteries. On 6/24/25 at 9:00 AM in an interview with the Complainant regarding Resident #115's care, it was confirmed that a grievance was filed with Staff #23 on April 18, 2023 and that the Director of Nursing and the Nursing Home Administrator (NHA) were aware of the concerns. It was also stated that [NAME] County Ombudsman was notified. The Complainant verified that a facility issued written decision was received and that no harm resulted to Resident #115. On 6/24/25 at 10:00 AM in an interview, the [NAME] County Ombudsman validated the grievance. On 6/30/25 the NHA acknowledged the concern.