STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 14894 Based on a review of a facility reported investigation, clinical record review, and staff interview it was determined that the facility staff failed to prevent abuse of a resident. This was evident for 1 (#155) out of 67 residents in the resident sample. The findings include: An investigation of Facility Reported Incident MD00186212 was started on 6/25/24. On November 11, 2022, during the day shift Resident #155 had a bowel movement and needed assistance from the Geriatric Nursing Assistant (GNA). GNA #21 was assigned to the resident and went into the room to clean and change the resident. GNA #21 entered the room to assist. While changing the incontinence brief the resident grabbed GNA #21's hand and dug their nails into the GNA's skin causing it to bleed. GNA #38 alleged that GNA #21 then hit the resident's hand. GNA #38 then reported the incident to the charge nurse (Staff #39). A review of the facility investigation revealed that Staff #39 no longer works for the facility. The nurse reported the suspected abuse to the Director of Nursing (DON) on 11/29/22 and an investigation was initiated. Staff #39 was interviewed on 11/29/22. She stated that GNA #38 reported it to her on 11/29/22. She said GNA #38 saw GNA #21 hit the resident on the hand. GNA #38 gave a statement on 11/29/22: I was asked to assist with washing and cleaning the resident. The resident grabbed and slapped at myself and another GNA during care. The resident grabbed and scratched the GNA, and she removed the resident's hand from her arm, and I saw her hit the resident on the arm. The incident was reported to the charge nurse who came and placed a dressing on the resident's left arm open area. Resident was interviewed on 11/29/22 but unable to respond secondary to cognitive deficit. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GNA #38 was interviewed on 11/29/22. She said . when we got to [resident's room] was soiled with feces and we were trying to help [resident]. [He/She] was fighting and combating with us, throwing [his/her] hands up and everywhere trying to scratch us and [GNA #21] explained to [him/her] that we were trying to change and wash [him/her]. When [GNA #21] tried to transfer [him/her] to the toilet commode [he/she] grabbed [the GNA's] hand on her wrist and started digging into [GNA's] hand. I saw [GNA]'s hand bleeding. [GNA #21] then freed her hands away and then she hit the resident's hand. There was bleeding from the resident's hand when we finished transferring [him/her] and I went and reported to the nurse. GNA #38 then said she reported to Staff #27 who was the nurse. She also mentioned the incident to Staff #7 who was the Certified Medication Aide. (CMA). She did not report to anyone else because she thought Staff #27 would tell Staff #39. Staff #27 was interviewed on 11/29/22. She said a GNA mentioned it while walking past her. GNA said she saw another GNA hit [the resident]. She assessed the resident and did not see anything. She also asked the alleged perpetrator who denied hitting the resident. GNA #21 was interviewed on 11/29/22. She noticed the resident had a bowel movement. She asked GNA #38 to help her and a housekeeper who spoke Spanish to translate. Resident was fighting them which was normal. GNA #21 stated I tried to have [him/her] stand up so I could changed [him/her], this was when [he/she] grabbed into my arm tightly and scratched me. I removed [his/her] hand, changed [him/her], and then noticed that [his/her] left hand was bleeding. The skin on [his/her] left hand had peeled. I then informed the nurse, and she came and dressed it. Staff #7 was interviewed on 11/29/22. She was asked by GNA #38 if they report abuse and she told GNA #38 that they report to the Charge Nurse and if the Charge Nurse does not report then you tell the manager. GNA #38 did not say what happened. Staff #7 admitted that she did not report the abuse. Staff #40 was interviewed on 11/29/22. She denied being asked to interpret or explain what was going on for the resident. She said she did not witness anything. The DON was interviewed on 6/26/24 at 10:55 AM. He said he suspends his staff when there is an allegation of abuse but does not tell the nursing agency except that he does not want the person to return secondary to an accusation of abuse. The alleged perpetrator cannot return to the facility. Staff #7 was interviewed on 6/26/24 at 12:37 PM. She said she does not recall the incident. The DON was informed of the findings on 6/28/24 at 1:15 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 14894 Based on an investigation into a facility reported incident, clinical record review, and staff interview it was determined that the facility staff failed to ensure an incident of alleged abuse was reported immediately to the Administrator and to the state agency. This was evident for 1 (#155) out of 67 residents that were part of the survey sample. The findings include: An investigation of Facility Reported Incident MD00186212 was started on 6/25/24. On November 11, 2022, during the day shift Resident #155 had a bowel movement and needed assistance from the Geriatric Nursing Assistant (GNA). GNA #21 was assigned to the resident and went into the room to clean and change the resident. GNA #38 entered the room to assist. While changing the incontinence brief the resident grabbed GNA #21's hand and dug their nails into the GNA's skin causing it to bleed. GNA #38 alleged that GNA #21 then hit the resident's hand. GNA #38 then allegedly reported the incident to the charge nurse (Staff #39). There was no evidence that Staff #39 reported the incident to the Administrator nor was there evidence that GNA #38 reported the incident herself. The incident was not reported until 11/29/22. The Director of Nursing (DON) was informed of the findings on 6/28/24 at 1:15 PM. The facility took corrective action as of 2/28/23. The nurse (Staff #39) was educated, and disciplinary action was taken. A 100% education of all staff to ensure all incidences of abuse is reported immediately to immediate supervisor, manager, the assistant director of nursing, and Director of Nursing. Facility staff will review all incidents of alleged abuse during quality assurance meetings to ensure the timely reporting of allegations of abuse. Past Non-compliant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 50504 Based on interviews and medical record review it was determined that the facility failed to: 1) revise a Resident's care plan and 2) provide an invitation and/or invite a resident for a care plan meeting . This was evident in 4 Residents (#65, #36 #143, & #57) and 2 Residents (#63 and #38) out of 10 residents reviewed for care planning. The findings include: 1a) On 6/13/24 at 12:40 PM a review of Resident's #65 medical record revealed that the resident was admitted to the facility on [DATE] with multiple diagnoses which included Dementia, ETOH (alcohol) abuse and Hypertension (high blood pressure). On 4/16/24 Resident #65 sustained a fall and was hospitalized for Hip Fracture. Resident #65 was readmitted to the facility on [DATE]. A review of Resident #65 medical record on 6/14/24 01:06 PM revealed that the resident was administered Lovenox (Enoxaparin) injections for the period 4/22/24 to 5/5/24 for Deep Vein Thrombosis prophylaxis and a care plan was initiated on 4/22/24. The resident's care plan for Lovenox remained active even though the medication was discontinued on 5/5/24. On 6/17/24 at 09:05 AM the surveyor informed Unit Manager, Staff #5 of the care plans findings for Resident # 65. Staff #5 confirmed the findings and stated that they would take care of them. Further review of the residents' medical record on 6/28/24 at 12:55 PM revealed that the care plans for Resident #65 for Lovenox discontinued on 6/17/24. On 6/20/24 10:30 AM The Assistant Director of Nursing (ADON) was made aware of the findings. 1b) A review on 6/17/24 at 8:12 AM of Resident #36's medical record revealed the following. The resident was admitted to the facility on [DATE] with multiple diagnoses including Hypertension (high blood pressure), Atrial Fibrillation (irregular heart rhythm), Diabetes Mellitus. Resident #36 was administered Vancomycin (an antibiotic) for the period 5/9/24 -5/19/24 for C-diff (a bacteria that causes infection in the colon). The resident's care plan for Vancomycin remained active even though the medication was discontinued on 5/19/24. On 6/17/24 at 9:05 AM the surveyor informed Unit Manager, Staff #5 of the care plans findings for Resident #36. Staff #5 confirmed the findings and stated that they would take care of them. Further review of the residents' medical record on 6/28/24 at 12:55 PM revealed that the care plans for Resident #36 for Vancomycin were discontinued on 6/17/24. On 6/20/24 10:30 AM the Assistant Director of Nursing (ADON) was made aware of the findings. 44440 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c) On 6/25/24 at 12:02 PM, the surveyor reviewed Resident #143's medical record. The review revealed that Resident #143 was first admitted to the facility in early 2018 and had a past medical history, which included but not limited to, bipolar disorder, dementia with behavioral disturbances and schizoaffective disorder. On further review the surveyor noted a care plan for Resident #143 initiated on 8/26/20 that stated, Resident #143 is to be on one-on-one monitoring. The goal stated Resident #143 will remain calm without hurting someone through the next review date. This goal was revised on 6/3/21 however, the intervention of, to monitor the resident as ordered that were initiated on 8/26/20 were not revised. An additional care plan stated, Resident #143 has the potential to be physically aggressive related to dementia and was initiated on 10/21/20. The goal for this care plan stated Resident #143 will not harm self or others through the review date and was last revised on 6/3/21. One intervention listed was for one on one and supervision ongoing for the resident's safety and the safety of others. This intervention was initiated on 8/25/20. This intervention was initiated before the care plan date and both the care plans and intervention were not revised and not updated when the goals were reviewed on 6/3/21. The surveyor noted a psychiatric progress note written on 9/10/20 that stated that Resident #143 was seen, and no behavior disturbance was reported or noted. If further recommended, discontinuing the one to one monitoring. Additionally, a progress note written by the Director of Nursing (DON) on 9/11/20 that stated, the Facility will continue One on One at this time as a plan of care not physician orders. On 7/2/24 at 12:16 PM, the surveyor conducted an interview with the DON and Nursing Home Administrator. During this interview the DON confirmed that the care plan was not up to date, that the resident did not need one to one monitoring, and the care plan was inaccurate. 49815 1d) On 6/21/2024 at 8:36 AM the surveyor reviewed Resident #57's medical record. There was a current care plan for Seroquel which is an antipsychotic medication. Further review of the medical record revealed that there was not a current physician order for the medication and that the Seroquel was discontinued by the physician on 5/23/2024. The surveyor interviewed the Director of Nursing on 6/24/2024 at 12:25 PM and reviewed Resident #57's current care plan for Seroquel and the physician orders for the discontinuation of Seroquel on 5/23/2024. The Director of Nursing stated that he would have to investigate this. No additional information was provided to the surveyor by the Director of Nursing at the time of exit. 2a) During an interview on 6/12/2024 at 9:14 AM Resident #63 stated to the surveyor that he/she does not get invited to care plan meetings. The surveyor reviewed Resident #63's medical record on 6/17/2024 at 8:00 AM. There was no documentation that a care plan invitation was provided to Resident #63 for the December 2023 care plan meeting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on 6/17/24 at 1:30 PM, the Social Services Director #15 conveyed that the facility was unable to locate the care plan invitation letter for Resident #63 for the December 2023 care plan meeting. The Social Services Director #15 was able to provide to the surveyor a copy of the September 2023 Care Conference Invitation letter that was provided to Resident #63 and the Responsible Party which is the expectation of the facility. 45733 2b) During a floor rounding, on 6/12/24 at 2:43 PM, Resident #38 stated, No one had talked to me about what program that I was in since I got here. Record review, on 6/13/24 at 1:28 PM, revealed that Resident #38 was admitted to the facility, on 2/21/24, with diagnoses of percutaneous pinning of pelvis on 2/12/24, impaired vision, cardiac arrhythmia and dementia. The resident was authorized for skilled level nursing care upon admission. The resident was able to answer questions appropriately, making his/her own decisions about his/her care and making his/her needs known. Further review of the Social Worker Staff #16's notes, dated 2/28/24 at 16:18 PM and 5/24/24 at 9:40 AM, revealed that the interdisciplinary team had conducted care plan meetings telephonically with this resident's surrogate without inviting the resident. During the second care plan meeting on 5/24/24, the discharge plan was changed from going home to becoming a long-term care resident. Per facility staff that the surrogate had not visited this resident since 2/21/24 nor to explain the long-term care's decision. During interview, on 6/14/24 at 10:09 AM, Social Worker Staff #15 stated that the care plan meetings were conducted telephonically and because the surrogate had only very limited for each care plan meeting, Staff #16 excluded Resident #38 from the meeting. During interview, on 6/14/24 at 11:50 AM, the Director of Nursing (DON) stated he could not remember why this resident was not in his/hers care plan meetings. The surveyor informed the DON that this resident was excluded from his/her own care plan meetings which it was a concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 44440 Based on interviews, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by keeping complete and accurate documentation. This was found evident in 5 (Resident #154, #143 #121 #26 and #158) of 67 residents reviewed during the survey. The findings include: 1a) On 6/12/24 at 10:55 AM, the surveyor reviewed Resident #154's medical record. The review revealed that Resident #154 had a past medical history that included, but was not limited to, below the knee amputation, and osteomyelitis (infection of the bone). On further review Resident #154 had a Peripherally Inserted Central Catheter (PICC) (a catheter inserted into a vein in the upper arm and guided into a large vein above the right side of the heart, used to give intravenous fluid, medications and blood products) on 10/11/22. Orders were also written on the same day for measuring external length of catheter each week, changing dressing every Friday, and measuring arm circumference every Friday. On 6/13/24 at 11:15 AM, the surveyor reviewed the October 2022 Treatment Administration Record (TAR). On 10/14/22, 10/21/22 and 10/29/22 the dressing changes for the PICC were documented as completed. On further review, on the same days of the dressing changes, the external length of the catheter was documented at 5 cm and the arm circumference was documented as 6 cm. On 6/13/24 at 11:15 AM, the surveyor conducted an interview with the Regional Nurse. During the interview the Regional Nurse stated the facility uses an outside agency to place PICC lines. The surveyor asked for documentation from the PICC line placement. On 6/17/24 at 8:05 AM, the surveyor reviewed the documentation from the company that placed Resident #154's PICC line. The review revealed that the PICC was placed on 10/11/22 and the arm circumference was documented at 28 cm on the day of insertion. On 6/17/24 at 9:37 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the surveyor asked why there was a 22 cm discrepancy from the placement of the PICC to the facility's documentation. The DON stated he would look into the concern and follow up. On 6/17/24 at 1:27 PM, the surveyor conducted a follow up interview with the DON. He further stated that the documentation was done in error and an in-service education was started on appropriate PICC line documentation. 1b) On 6/25/24 at 12:02 PM the surveyor reviewed Resident #143's medical record. The review revealed that Resident #143 was first admitted to the facility in early 2018 and had a past medical history, which included but not limited to, bipolar disorder, dementia with behavioral disturbances and schizoaffective disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24 at 11:02 AM, the surveyor reviewed the Task flow documentation that the Geriatric Nursing Assistance (GNA) used to document interventions/cares. Review of the May 2021 behavior monitoring for Resident #143 had no documentation on; 5/3/21 11PM-7AM shift, 5/8/21 7AM-3PM shift, 5/9/21 on 7AM-3PM shift 5/10/21 11PM-7AM shift, 5/14/21 7AM-3PM shift, 5/15/21 11PM-7AM shift, 5/21/21 11PM-7AM shift, 5/22/21 11PM-7AM shift, and 5/29/21 11PM-7AM shift. Further review revealed behaviors documented on 5/22/21 at rejecting care, push/grabbing/kicking hitting, on 5/23/21 rejecting cares, pushing/grabbing, kicking hitting, and biting and on 5/31/23 behaviors noted of pinching scratching and kicking hitting. On 7/2/24 the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON confirmed that documentation of behaviors was missing on the May 2021 GNA Task form. He further stated it is the expectation the behaviors be monitored and documented by the GNAs. He further stated that the nurses also monitor and document behaviors. The DON provided the May 2021 Treatment Administration Record (TAR) for Resident #143 to the surveyor. The monitoring stated, nursing to monitor behavior and mood and redirect patient every shift for being combative. On 5/4/21 there was no documentation that the behavior was monitored on the 11PM-7AM shift. 49815 1c) During medical record review by the surveyor on 6/17/2024 at 8:15 AM it was revealed that there were multiple dates that initials were not documented on the enteral orders - medication and treatment administration record that Resident #121 had received prescribed enteral tube feedings. The following dates did not have documented initials that the prescribed enteral tube feedings were administered: January 6, 8 and 30; February 5, 8, 9, 13, 21, 22, and 23; March 6, 18, 25 and 31; April 23; May 14, 24 and 27; and June 15, 2024. During review of the nursing progress notes on these dates there was no documentation that the enteral tube feedings were held or any adverse effects on Resident #121. At 10:25 AM on 6/17/2024 the surveyor reviewed the facility's enteral tube feeding policy and procedure dated 12/12/2022. The policy on page 2 - #9 stated that Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders. The surveyor conducted an interview with the Director of Nursing at 11:25 AM on 6/20/2024 and reviewed the enteral orders - medication and treatment administration record for January through June 2024 for Resident #121. The surveyor informed the Director of Nursing of the missing initials of the nursing staff for those dates. The Director of Nursing stated to the surveyor, I will look into that, there must be a reason. During follow-up interview with the Director of Nursing on 6/21/2024 at 1:07 PM the Director of Nursing confirmed with the surveyor that there were missing initials of the nursing staff on the enteral orders - medication and treatment administration records for Resident #121 for these dates. In addition, there was no documentation in the progress notes as to why the enteral tube feedings were not administered by the nursing staff as ordered by the physician for Resident #121. The Director of Nursing conveyed to the surveyor that the nursing staff was already being in-serviced on the enteral orders - medication and treatment administration record documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215014	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Arcola	901 Arcola Avenue Silver Spring, MD 20902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50503 1d) During an interview with Resident #26 on 6/12/24 at 8:34 AM, he/she was asked about whether he/she received showers since admission to the facility. He/she stated they tried to get a shower but staff told him/her to ask the next AM or PM shift and they wouldn't give them to him/her and knew nothing about shower preferences. During record review on 6/25/24 at 11:07 AM, the surveyor received hard copy shower records from Staff #2 for Resident #26. The hardcopy shower record was documented that a shower was given to the resident on 6/12/24 and 6/19/24. Under the tasks section in the electronic health record on 6/12/24 and 6/19/24 it was documented that a bath was given to the resident. Both methods used for the documented care specifically require a selection of whether a bath or shower was given. The records revealed the indicated dates of care did not accurately depict what type of care had been provided for the resident. During an interview with Staff #2 on 6/28/24 at 2:04 PM he was asked about the inaccuracy of documentation for resident records pertaining to baths and showers. He stated that this may be a Point Click Care system error and would have to check into that issue. He also mentioned that perhaps the staff who documented the resident records may have thought that both baths and showers coincided with one another. 1e) During record review on 7/01/24 at 11:30 AM, it was revealed the Notification of Change for Resident #158 by the facility on 9/23/23 was incomplete. The hospital information, to include phone number, was left blank. During record review on 7/01/24 at 11:30 AM, it was revealed the Bed Hold authorization for Resident #158 by the facility on 9/24/23 was incomplete. The resident signature or responsible party signature was left blank.