

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Chevy Chase		STREET ADDRESS, CITY, STATE, ZIP CODE 8700 Jones Mill Road Chevy Chase, MD 20815	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>30440</p> <p>Based on observations, resident and staff interviews, it was determined that the facility failed to ensure the residents were treated with dignity. This was evident for 2 residents (#109 and #121) out of 54 residents during this recertification survey.</p> <p>The findings include:</p> <p>1) While making observations on the Chesapeake Unit on 4/16/25 at 8:44 AM Staff # 17 a Certified Nurse Assistant (CNA) was observed feeding the resident in their room. The CNA was observed standing at the bedside above the resident's right side feeding the resident forkfuls of food and a substance that was in the resident bowl. There was a chair in the room on the left side of the resident bed. The CNA was asked at this time is there any reason why she is standing above the resident assisting with feeding. She stated that the resident had psychological issues and that the chair is too wide to fit in the area where she was standing. The GNA was made aware that standing over the resident to assist with feeding and not sitting in a chair at the level of the resident is a dignity issue. She said she was not aware. She continued to stand and feed the resident.</p> <p>The unit nurse supervisor (Staff # 16) who was in the hallway at this time, was made aware of the concern. He stated that all staff are to sit down with the residents when providing feeding assistance. The Nurse immediately went to the resident room and provided education to the CNA.</p> <p>The Administration team was made aware of all concerns at the exit conference on 4/28/25 at 2:45 PM.</p> <p>51712</p> <p>2) Medical record review revealed Resident #109 had the following but limited medical history of muscle spasm, congestive heart failure, fluid overload, and left leg below the knee amputation. Resident #109 was assisted with ADLs, and could transfer self in and out of bed with 1-person physical assist; toileting required extensive assistance, and the resident was wheelchair ambulatory.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/25 at 9:08 AM, Resident #109 was observed in his/her room sitting on the bedside commode next to his/her bed. Resident #109 asked the surveyor to come back in a few minutes when s/he was finished. At 9:35 AM, the surveyor returned to speak with the resident. Resident #109 stated that there was a lack of respect in this facility, and that s/he was left on the bedside commode for 2 hours before s/he got assistance back to bed one night. Resident #109 also stated that s/he felt like they treat him/her inhuman.</p> <p>On 4/22/25 at 9:05 AM, the Administrator and Director of Nursing (DON) were interviewed about Resident #109's care. The surveyor asked if they knew Resident #109 and if they were aware of the resident being left on the bedside commode for 2 hours one night. The Administrator and DON stated that they were not aware of this and would have a discussion with the resident.</p> <p>On 4/22/25 at 11:28 AM, the DON came back to the surveyor to inform the surveyor that the resident stated that the event did occur, however, s/he did not know the exact date that it occurred, only that it was 2 o'clock in the morning. Resident #109 stated that s/he had told their nurse. The DON stated that she would speak with the evening manager about educating the staff on leaving residents on the bedside commode too long and the rights of the residents.</p>

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>30428</p> <p>Based on the review of complaints, interview with complainants, review of facility policy and interview with facility staff, it was determined that the facility failed to provide a resident's medical records to the identified and established representative in a timely manner. This was evident during the review of 1 of the 2 complaints regarding access to medical records (Resident #162).</p> <p>The findings include:</p> <p>Interview with a complainant on 4/23/25 at 8:53 AM regarding the complaint MD00206860 revealed concerns that upon the request for their loved one's medical records it took over 40 days.</p> <p>On 4/23/25 at 9:50 AM staff # 24, the Business office manager was interviewed. She reported to this surveyor at that time that requests for records would go through her. The process includes the requestor would need to fill out the appropriate paperwork, the paperwork goes to the legal department so they can determine if that individual has authorization to the records, then the legal department will let the facility know if the records can be released. The records can then be gathered for the requester. Staff #24 further reported that depending on the volume she will mail or email the information to the requester.</p> <p>This surveyor asked if there is certified paperwork on the chart that the facility accepted and acknowledged as Power of Attorney (POA) paperwork to make healthcare decisions for a resident, why is that not sufficient to release medical records? Staff #24 stated that that was just the facility process. This surveyor asked what the turnaround time was and if that could cause a delay in the presentation of the records, staff # 24 was unable to provide an answer. The facility policy on record requests was requested at that time.</p> <p>At 11:53 AM on 4/23/25, staff #24 provided this surveyor with a request for medical records for Resident #162 that was completed and requested on 6/11/24. Staff#24 was asked if she had documentation of when the requested records were provided to Resident #162's POA. She stated that it was around the beginning to the middle of July 2024. According to an interview held with the resident representative earlier this morning, it took around 40 days to acquire these records.</p> <p>According to the facility policy provided on 4/24/25 at 1:17 PM Release of Medical Records implemented 2/3/23, 3. Upon request to access or obtain copies of the medical record, the facility should review the authorization to ascertain access rights of that person. Authority to assess or release records is only granted by the residents or the residents legal representative. The facility should request copies of any legal papers necessary to authenticate authority. #6. Upon receipt of request for medical record copies, the facility should notify the requesting party, in writing about the cost for obtaining the records and that records are available 2 days after receipt of payment for the copies.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>For Resident #162, the POA paperwork was reviewed by this surveyor and identified as in place at the time of the initial request. The medical record request form provided to the POA of Resident #162 had no financial liability attached. The form that was provided on 6/11/24 was an Authorization for the release of health information records. Therefore, there should have been no delay in providing Resident #162's medical records to this POA as it was the POA signing for the release of the records.</p> <p>As of exit on 4/28/25 no further documentation was provided to the survey team as far as when the records were delivered and provided to the POA, however, it was established from interview with Staff #24 and the complainant that it was over the regulatory 2 days of the initial request on 6/11/24 and the POA did not receive them until sometime in July of 2024, minimally 19 days.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50573</p> <p>Based on observation and interview, it was determined that the facility failed to maintain a homelike environment for the residents as evidenced by failure to 1) keep the utility rooms, and resident shower room clean and organized; 3) ensure that residents were provided with hot water during the survey. This was evident during multiple observations made on the Arcadia Unit and throughout the facility.</p> <p>The findings include:</p> <p>1) On 04/16/25 at 08:43 AM, an initial observation of the Arcadia unit in rooms [ROOM NUMBERS] revealed a toilet paper roll in the bathroom that was hung by a trash bag and tied around a handrail.</p> <p>On 04/17/25 at 08:22 AM, a follow up observation revealed the same concern in both room [ROOM NUMBER] and 23, where their toilet paper rolls were hung by a trash bag.</p> <p>2) On 04/16/25 at 08:43 AM, an observation in room [ROOM NUMBER] revealed the bottom drawer of the (A-bed) nightstand, which failed to reveal it properly fit in the dresser or had a hand knob.</p> <p>On 04/17/25 at 08:22 AM, a follow up observation was made, which revealed the same concern.</p> <p>3) On 04/16/25 at 09:03 AM, an initial observation of the Arcadia Unit in the bathroom between 18 and 19, failed to reveal a door knob on either side of the bathroom doors, which exposed a hole on both bathroom doors.</p> <p>On 04/17/25 at 08:06 AM, an interview with the Arcadia Unit Manager / Registered Nurse (Staff #19) revealed the staff used an online platform, TELS to report maintenance concerns.</p> <p>On 04/18/25 at 11:13 AM, an interview with the Director of Maintenance (Staff #5) revealed he was unaware of any maintenance concerns on the Arcadia Unit.</p> <p>On 04/18/25 at 11:46 AM, the surveyor and the Director of Maintenance (Staff #5) completed a walk through on the Arcadia Unit, and reviewed the concerns noted above from examples 1 through 3.</p> <p>42863</p> <p>4) On 04.16.25 at 08:15 AM the surveyor initiated an observation tour of the unit Arcadia and the following maintenance issues were identified inside resident rooms:</p> <p>a) room [ROOM NUMBER]A/B: no chair for guests was present, the linoleum was warped and cracked outside the bathroom door and missing paint on the wall near the room entry door.</p> <p>b) room [ROOM NUMBER]A/B: there were scratches on the wall paint behind the resident's headboard.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c) room [ROOM NUMBER]A/B: the bedside cabinet was missing the top drawer handle. The toilet paper holder was missing in the bathroom, a plastic bag was tied through the toilet paper roll to a towel holder.</p> <p>d) room [ROOM NUMBER]A/B: the wall behind the resident's headboard had areas of paint missing and there was a non-fitting plastic cover over the top of the toilet.</p> <p>e) room [ROOM NUMBER] A: toilet paper was observed on a roll with plastic bag tied to handle rail safety bar across from the toilet, the toilet roll holder was missing the tension bar piece that would hold the bath tissue. There was an blue uncovered, unprotected water shutoff valve on the right side of the sink, located near the floor.</p> <p>During an interview with the unit nurse manager, staff #19 she confirmed the locked unit had a census of 32 residents at the time of the observation on 04.16.25 at 09:00 AM. On 04.17.25 at 09:10 AM, the unit manager, staff #19 stated that all disrepair or maintenance concerns are reported to the maintenance department via the TELS system.</p> <p>These observations were discussed with the maintenance director during an observation tour of two units with another surveyor on 04.18.2025 that began at 11:39 AM.</p> <p>On 04.28.25 prior to the exit conference, the administrator verified that the maintenance concerns had been shared with her by the maintenance director.</p> <p>50457</p> <p>5) During the initial observation of unit Annapolis and Garden View on 04/16/25 at 7:59 AM, the surveyor entered the shower room and observed a basin placed on top of a trash can, wheelchair pedals placed in front of the trash can, and a mop and broom leaning against it. Next to the toilet, a clear plastic bag and trash were noted on the floor. A brown substance was present on the toilet seat. The tub in the shower room contained a bedside commode bin, a bra, a black sock, a hanger, and a seat cushion. Towels were also noted on the floor.</p> <p>On 04/16/25 at 8:03 AM, the surveyor entered a room labeled as the clean utility room and observed a used clear glove placed on top of a black bin. Next to the back cabinet, the surveyor noted a wall with incomplete paint and an area of the floor missing tile. A box containing papers was observed on the floor, and behind the door, six staff jackets and a fanny pack were hanging.</p> <p>On 04/16/25 at 8:06 AM, the surveyor entered the soiled utility room. Upon entry, a sink full of standing dirty water was observed. The surveyor opened the cabinets to the right of the sink and found soiled shelves, five empty soiled flower vases, a clear plastic bag, a rod, and two telephones.</p> <p>The Administrator #1 and Director of Nursing #2 were both made aware of the observation on 04/16/25 at 8:38AM.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Housekeeping Director #21 on 04/18/25 at 1:22 PM, she stated that floor technicians are responsible for pulling trash from common areas (dining room, clean and dirty utility rooms, shower rooms) and from resident rooms, and housekeeping staff are responsible for cleaning this area throughout the shift. When asked about monitoring cleaned areas, the Housekeeping Director #21 reported that she was responsible for rounding. The surveyor informed the Director of Housekeeping of the observed conditions in the residents' shower room and the clean and dirty utility rooms. She acknowledged the observation and stated that overseeing both housekeeping and laundry services can be challenging.</p> <p>30440</p> <p>6) An initial tour of the facility was conducted on 4/16/25 at 7:50 AM. While screening residents on the Chesapeake Unit, residents #52 and #18 told the surveyor that the facility was without hot water for 3 days. At this time the surveyor checked the residents' water in the bathroom. The water was turned on for greater than five minutes and did not get warm. Resident #52 was asked how s/he takes a bath or shower, and the resident stated, I do what I have to do and have been taking a bath with cold water because there was no hot water.</p> <p>Further observations were made of the water in room [ROOM NUMBER] and the water was turned on. The water was cold for more than five minutes and it did not get warm. The residents in the room were asked if they had hot water and the residents stated, no, the water had been cold for 3 days.</p> <p>At this time the surveyor approached the nurse supervisor #16 and asked about the water. The nurse stated that the Administration was aware of the water concern and was looking into the issue.</p> <p>During a subsequent observation at 8:44 AM, resident #52 was observed walking in their room from the bathroom. The resident told the surveyor that s/he just finished taking a cold bath. The resident stated that the water was not hot.</p> <p>On the same date at 8:55 AM an interview was conducted with the Administrator, and she stated that she was aware that the Chesapeake Unit did not have hot water in the afternoon of the previous day (4/15/25) and that the facility had a call into a company to get the issue resolved and that they are awaiting someone to be dispatched to the facility. The Administrator was made aware that multiple residents complained of not having hot water for 3 days that was prior to her report of the concern beginning on the previous day. The survey team asked the Administrator to provide documentation of previous temperature logs for the Chesapeake unit as well as current temperatures for the unit.</p> <p>The Administrator and the Maintenance manager returned to the survey team at 10:00AM and provided the team with copies of the temperatures for the unit as follows.</p> <p>3/28/25 the temperature varied from 103, 104, 105, 106, 108, 110 up to 115.</p> <p>4/4/25 temps were 106-114.</p> <p>4/10/25 the temps were 104-115.</p> <p>4/14/25 the temps were 107-114.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Current temperatures for 4/16/24 were as follows:</p> <p>room [ROOM NUMBER] was 68 degrees</p> <p>Room # 84 was 66 degrees</p> <p>room [ROOM NUMBER] was 68 degrees</p> <p>room [ROOM NUMBER] was 65 degrees</p> <p>room [ROOM NUMBER] was 66 degrees</p> <p>room [ROOM NUMBER] was 65 degrees</p> <p>room [ROOM NUMBER] was 68 degrees</p> <p>room [ROOM NUMBER] was 68 degrees.</p> <p>The Administrator stated that they are currently rerouting showers to be done on the Annapolis unit. She stated that the Plumber was scheduled to come to the facility this date.</p> <p>The Administrator provided updated correspondence to the survey team on 4/18/25 at 9:20 AM regarding when the company would resolve the issue. She stated that the Plumber came in and looked at the valve and was waiting for a part. In the interim, residents were being transferred to another unit to shower. Residents who required assistance with baths the water was warmed prior to their bed bath.</p> <p>The plumbing company came into the building on 4/28/25 to work on water concerns. The Administrator stated that the water issue would be resolved this date and hot water would be restored.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>30440</p> <p>Based on administrative record review and interviews with facility staff it was determined the facility failed to ensure the safety of a resident after the resident reported allegations of staff abuse for Resident #146, and failed to ensure a thorough investigation was conducted for a Facility Reported Incident (FRI) regarding Resident #165. This was found to be evident for 2 of 19 residents reviewed for abuse during the survey.</p> <p>Findings include,</p> <p>1) MD00204470 was reviewed on 4/18/25 12:00 PM for allegations of staff abuse. The abuse was unsubstantiated. A review of the facility's investigation revealed a discipline in which staff (#34) received a written warning about the following infraction:</p> <p>Employee (# 34) who is a nurse, was directed to leave the facility immediately and was on off duty due to an allegation of abuse made by Resident #146. The employee was told to leave the building by the Administrator and DON on 4/8/24 at approximately 12:30PM. The employee was found on another unit documenting on a resident at 2:12 PM and did not leave the building until after about 2:20 PM. Employee (#34) wrote a response stating that they were holding keys and did not give report and was waiting to do narcotic count.</p> <p>An interview was conducted with the NHA on 4/21/25 at 12:15 PM and she was asked to explain the facility's procedure when investigating an employee for allegations of resident abuse and she stated the following: The alleged perpetrator was asked to leave the building immediately, however, this employee did not leave and remained in the building. The Administrator was asked how the facility can keep residents safe from retaliation from their alleged perpetrator, and she stated the employee should have been escorted out of the building, and that this employee was not, he was told to leave. The NHA stated that the abuse allegation was unsubstantiated, however, this employee was later terminated for insubordination.</p> <p>All concerns were discussed with the administration team at the exit conference on 4/28/25 at 2:45 PM.</p> <p>50573</p> <p>2) On 04/23/25 at 11:09 AM, review of facility documentation for MD00212656 revealed that Resident #165's representative made the facility aware of an allegation Resident #165 had made regarding Geriatric Nursing Assistant (Staff #39).</p> <p>At the same time, review of the facility documentation revealed that Resident #165 indicated to their representative that Staff #39 was rough with her/him during repositioning/ morning care and that Staff #39 turned the resident on their right side during care which they did not want to be turned on.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/23/25 at 11:12 AM, further review of the facility documentation for MD00212656 revealed a document titled, Abuse- Investigation Statement which failed to reveal indication that the allegation was addressed (if Staff #39 was rough during Resident #165's repositioning/ morning care and/or if the staff member had turned the resident on the side they did not want to be turned on).</p> <p>On 04/23/25 at 11:13 AM, further review of the facility documentation failed to reveal indication that the staff was interviewed or made a statement regarding the specific allegation made.</p> <p>On 04/24/25 at 10:29 AM, the surveyor reviewed the concern with the Nursing Home Administrator (Staff #1). Staff #1 said they would look into it and see if they had any further documentation to provide that would address the specific allegation made.</p> <p>On 04/24/25 at 12:35 PM, Staff #1 indicated they had no further documentation to provide that would indicate what the surveyor requested.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>30440</p> <p>Based on medical record review and interviews with facility staff it was determined the facility failed to ensure accuracy when coding a resident Minimum Data Set (MDS). This was found to be evident for 1 (Resident # 107) of 6 residents reviewed for accidents during the survey.</p> <p>Findings include:</p> <p>The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need.</p> <p>The Matrix is used to identify pertinent care categories for :1) Newly admitted residents in the last 30 days who are still residing in the facility and 2) All other residents. The facility is responsible for completing this form. Column # 10 is to be completed if the resident has a Fall (F), Fall with injury (FI), Fall with Major injury (FMI).</p> <p>Review of the facility's matrix on 4/16/25 at 12:45 PM revealed resident # 107, column # 10 for Falls indicated F, and FI.</p> <p>Review of the MDS Quarterly Assessment with an Assessment Reference Date (ARD) of 1/5/25 revealed under section J1900 (B) number of falls since admission or prior assessment-injury was coded one (1) for injury. Section J0300 Pain assessment interview is coded (0) No.</p> <p>Continued review revealed, a nurse note with a date of 10/6/24 at 6:34 AM indicating that during morning routine check-ups, writer noted Resident # 107 sitting on the floor. Assessment done and pain score 0/10 indicating no pain. No physical injury noted.</p> <p>Further review of the resident falls care plan revealed the last update was on 5/8/23.</p> <p>Review of nurse progress notes and pain assessments revealed the resident did not have pain on the following assessments dates: 10/6/24 Day (D) Shift, 10/7/24, Day shift and 10/8/24 Day shift. The Medication Administration Record (MAR) for pain evaluation was marked zero (0) for each of the above dates.</p> <p>Further review of a physician note dated 10/7/24 revealed the resident indicated pain in the arm and an x-ray was ordered to rule out fracture. The results of the x-ray were negative for fracture.</p> <p>An interview was conducted with the NHA on 4/22/25 at 10:40 AM and she stated that the resident did not have a fall with injury and that the documentation on the matrix was incorrect.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the MDS Coordinator (Staff # 22) on 4/22/25 at 11:08 AM and she was asked if the resident had a fall with injury. She stated that the resident had a fall on 10/6/25 and it was captured on the 1/5/25 assessment. She stated that if the resident has pain, it will be coded as an injury. The surveyor informed her that according to the assessment that was done after the fall, the resident did not c/o pain and there was no injury. She confirmed that the MDS was coded incorrectly.</p> <p>All concerns were discussed with the Administration team during the exit conference on 4/28/25 at 2:45 PM.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50457</p> <p>Based on record reviews and interviews, it was determined that the facility failed to develop a care plan to manage bowel and bladder incontinence for a resident. This deficient practice was evident for 1 (#106) resident reviewed for comprehensive care plans during the survey.</p> <p>The findings include:</p> <p>On 04/17/25 at 8:20 AM, a review of Resident #106's medical records indicated that the resident is incontinent of bowel and bladder. Further review of medical records failed to show that a care plan was developed to address bowel and bladder incontinence.</p> <p>During an interview with Director of Social Worker (SW) #3 on 04/22/25 at 10:46 AM, the surveyor asked who was responsible for auditing resident's medical records to ensure residents' care plans accurately address plan of care. The SW #3 explained that an interdisciplinary team meets quarterly and annually to review each resident's plan of care, and the nurse unit manager is responsible for ensuring the nursing portion of the plan is up to date.</p> <p>On 04/17/25 at 11:05 AM, a review of Resident #106's Minimum Data Set (MDS) section bowel continence indicated that the resident is always incontinent of bowel. Review of section urinary continence also reflected the resident is always incontinent of bladder.</p> <p>On 04/17/25 at 11:10 AM, during an interview with Nurse Unit Manager (UM) #18, the surveyor informed the UM #18 that the resident had been identified as incontinent of both bowel and bladder since admission, however, a review of the quarterly care plans revealed that no plan of care had been developed to address the incontinence. Both the surveyor and the UM #18 reviewed the resident's medical records, and he acknowledged that a care plan should have been created. After surveyor intervention, on 04/22/25, a care plan was initiated to address the resident's bowel and bladder incontinence.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50457</p> <p>Based on record reviews and interviews it was determined that facility staff failed to ensure that resident records were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This deficient practice was evident for 3 (#66, #86, #101) residents out of 4 residents reviewed for care plan meetings and quarterly assessment during the facility survey.</p> <p>The findings include:</p> <p>1.) On 04/16/25 at 10:41 AM, during an interview, Resident #66, reported that they have not participated in care plan meetings.</p> <p>During an interview with the Director of Social Work (SW) #3 on 04/18/25 at 09:50 AM, she stated that resident care plan meetings are conducted within 14 days of admission, quarterly, annually, and upon change in medical condition. She also reported that invitations to the meetings are sent to the residents and their families. The surveyor requested documentation verifying that comprehensive and quarterly care plan meeting were held, and invitations notices were provided for 2024 and 2025.</p> <p>On 04/18/25 at 12:44 PM, the SW #3 provided the surveyor with care plan meeting notes dated 6/7/23, but no meeting invitation. Additional documents included care plan meeting notes dated 8/28/24, a care plan invitation dated 8/8/24, and care plan invitations dated 11/13/24 and 4/23/25. The SW #3 stated she was unable to provide proof that a care plan meeting was conducted on 11/2004 and acknowledged that she is behind on completing resident care plans.</p> <p>50573</p> <p>2.) On 04/17/25 at 12:28 PM, an interview with Resident #86 revealed he/she had concerns regarding her/his routine care plan meetings not being quarterly.</p> <p>On 04/18/25 at 09:50 AM, an interview with the Director of Social Services (Staff #3) revealed that the expectation was for care plan meetings was that resident care plans were revised to be quarterly.</p> <p>During the same interview, the surveyor requested Resident #86's care plan meeting documentation for 2024.</p> <p>On 04/18/25 at 12:26 PM, Staff #3 provided documentation for a care plan meeting for 7/11/24, and informed the surveyor that she was only able to provide documentation for the one (7/11/24) care plan meeting.</p> <p>2a.) On 04/22/25 at 9:00 AM, review of complaint intake MD00202691 revealed a concern that Resident #86 was supposed to be in rehabilitation services.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/22/25 at 09:27 AM, an interview with the Director of Rehabilitation Services (Staff #23) revealed that residents were screened quarterly for rehabilitation services along with the care plan revision.</p> <p>At the same time, further interview with Staff #23 revealed that Resident #86 was screened for rehabilitation services on 8/8/2023, was put into rehabilitation services, and was discharged on [DATE].</p> <p>On 04/22/25 at 09:27 AM, during the same interview, Staff #23 indicated that the resident had not been screened again for rehabilitation services until 4/11/24.</p> <p>On 04/22/25 at 11:55 AM, the surveyor reviewed the concern with the Nursing Home Administrator (Staff #1).</p> <p>51712</p> <p>3.) On 4/22/25 at 8:40 AM, review of records revealed that Resident #101 was provided Physical Therapy (PT) and Occupational Therapy (OT) services for Contracture Management, starting on 11/4/24, and was discharged from these services on 12/13/24. OT Goals were to prevent further contractures. Discharge recommendations were for nursing to apply splints daily and remove them every night. Resident #101 was last seen by OT on 12/13/24. The review of orders did not reflect that orders were placed for nursing staff to complete the discharge recommendations. The care plan review did not reflect the discharge recommendations for therapy.</p> <p>On 4/22/25 at 9:47 AM, the surveyor interviewed with the Director of Rehab (DOR #23) and the OT therapist (OT #40) regarding resident #101. When asked if OT was still seeing the resident, they stated no. The surveyor inquired about whether they perform quarterly evaluations on residents that have been seen by OT, and they confirmed that they do. The surveyor then asked when was the last quarterly evaluation conducted for the resident, DOR #23 and OT #40 were unable to answer. When the surveyor asked who was responsible for entering the orders into the EMR, the DOR was unable to provide an answer. They stated that they would return with the necessary information.</p> <p>On 4/22/25 at 11:44 AM, the Admin was interviewed and was asked how orders from PT/OT services were entered into the Electronic Medical Record (EMR). The Admin stated that when orders are recommended for nursing, PT/OT therapy is supposed to place the orders in the EMR for nursing.</p> <p>On 4/22/25 at 12:53 PM, DOR #23 and OT #40 returned to the surveyor and stated that the orders were never placed for Resident #101 to get the discharged recommendations from OT therapy. OT #40 stated that she would complete Resident #101's quarterly evaluation today and enter the recommendations and orders from OT into the system for nursing to follow-up.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>30428</p> <p>Based on medical record review and interview with facility staff, it was determined that the facility failed to: 1) implement wound and skin care orders for a resident admitted after a surgical amputation and identified pressure ulcer; 2) provide services as order by the physician; and 3) maintain professional standards of practice when documenting a resident's showers. This was identified for 4 of 4 (#160, #106, #66, #108) residents reviewed for orders and documentation during the survey.</p> <p>The findings include:</p> <p>1. Review of the medical record on 4/25/25 at 12:13 PM for Resident #160 revealed admission to the facility with diagnosis including aftercare following surgical amputation, gangrene and peripheral vascular disease. The hospital discharge summaries provided in the resident's medical record stated that prior to admission to this facility, Resident #160 was admitted to the hospital for a gangrenous infection of the left first toe. The podiatry team completed multiple debridement's and then finally an amputation of the toe to prevent the infection from spreading. Resident #160 was admitted to the facility according to an admission summary with 22 staples to the amputated toe site on the left foot.</p> <p>Resident #160 was screened by the wound physician on 8/26/24. He verbalized wound care orders. On 4/28/25 at 9:31 AM staff #27, the wound care physician was interviewed. He reviewed his notes and returned at 9:36 AM. He stated that he only saw the resident on 8/26/24 and had made recommendations at that time. He was asked why he didn't see Resident #160 again after that and he stated that he is given a list when he comes in to the facility of who to see and checks the list off as he goes. He further stated that he is just a consultant and sees who the facility requests him to see.</p> <p>At 9:40 AM staff #28 the Regional Clinical Consultant was notified that for Resident #160, no wound care orders for the amputation or the identified heel wound identified on admission could be found. Staff #28 was also notified that Resident #160 was admitted to the hospital for a follow-up procedure a month after admission to the facility for another surgical procedure. Those admission assessments were requested.</p> <p>At 1:38 PM on 4/28/25 this surveyor met with the facility DON regarding the status of the concerns for Resident #160. She was unaware and had not been notified of the concerns from staff #28 and had not looked for information to relay to this surveyor.</p> <p>Prior to exiting the facility, the DON provided nursing notes from the wound care nurse that documented wound care measurements for the heel and that care was provided weekly for Resident #160. The ongoing concern was presented to the DON at this time that during Resident #160's month long stay, there were no treatment orders put in for either the monitoring of the surgical site of the amputation or the wound care of the heel and therefore there was no place for staff to sign off that either were completed consistently.</p> <p>50457</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) On 04/16/25 at 10:37 AM, during the initial screening of Resident #66, the surveyor noted a past medical history of cerebrovascular disease. The resident was observed not wearing Thrombo-Embolic Deterrent Stockings (TEDS). A review of the medical records revealed that the resident was ordered for TEDS to be applied at 9:00AM and removed at 9:00PM daily.</p> <p>An observation on 04/18/25 at 10:54 AM, revealed that Resident #66 was not wearing TEDS. A review of the medical record did not indicate that the resident refused to wear the TEDS, and there was no evidence that the physician had been notified of a refusal.</p> <p>On 04/21/25 at 11:50AM, during a follow up observation, the surveyor noted that Resident #66 was not wearing TEDS.</p> <p>On 04/21/25 at 11:54 AM, the surveyor asked Nurse Unit Manager (UM) #18 about staff expectation regarding physician orders. The UM #18 stated that staff are expected to review orders prior to providing treatment or services and follow the written instructions. If staff are uncertain about the orders, they are expected to speak with a supervisor. The surveyor informed UM #18 of the observations made for Resident #66 and that there was no documentation explaining why the resident was not wearing TEDS. The UM #18 stated that he would review the residents medical records for supporting documentation; however, no documentation was provided by the end of the day.</p> <p>On 04/22/25 at 9:09AM, the surveyor informed the Administrator #1 of observations related to Resident #66 and pending documentation from the UM #18. The Administrator stated that they were not able to locate any documentation confirming that the resident refused to wear TEDS. The Administrator stated that nursing staff will receive education on following physician's orders and nursing documentation.</p> <p>3) During an interview with the Administrator #1 and Director of Nursing (DON) #2 on 04/21/25 at 8:16 AM, the surveyor asked about the expectation of nursing staff prior to administering blood pressure medication. The DON #2 stated that staff are expected to review the resident's Medication Administration Record (MAR) for instructions and administer the medication according to the provider's orders.</p> <p>On 04/21/25 at 08:48 AM, a review of Resident #106's MAR revealed an order for clonidine Oral Tablet 0.3 milligram (mg) tablet to be administered through a Percutaneous Endoscopic Gastrostomy (PEG) tube every 8 hours for hypertension, with instructions to hold the medication if the systolic blood pressure (SBP) was less than 110 or if the heart rate(HR) is less than 60. Further reviews showed that the medication was administered outside of the ordered parameter on the following dates:</p> <p>3/4/25=SBP 107</p> <p>3/11/25=SBP 106</p> <p>3/22/25=SBP 108</p> <p>3/25/25=SBP 108</p> <p>3/30/25=SBP 109</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4/6/25=SBP 108</p> <p>4/15/25=SBP 104</p> <p>4/14/25=SBP 101</p> <p>4/21/25=SBP 103</p> <p>A review of the medical records failed to show documentation that the nurse notified the physician when the resident's blood pressure was outside the ordered parameters for the medication.</p> <p>On 04/21/25 at 12:19 PM, the surveyor informed the Administrator #1 that blood pressure medication had been administered for Resident #66 outside of the ordered parameters, and that there was no documentation indicating that the physician had been notified.</p> <p>On 04/22/25 at 9:09AM, the Administrator stated that they were not able to locate documentation confirming that the physician was notified of the resident's SBP. The Administrator #1 stated that nursing staff will receive education on following physician's orders and nursing documentation.</p> <p>50573</p> <p>4) On 04/17/25 at 10:39 AM, review of complaint MD00212813 revealed a concern regarding Resident #108 receiving showers between October 2023 and December 2023.</p> <p>On 04/17/25 at 10:42 AM, review of Resident #108's medical record revealed an order with a start date of 10/03/2023, which indicated for the resident to receive a shower on Tuesdays and Fridays.</p> <p>On 04/17/25 at 10:43 AM, review of Resident #108's Treatment Administration Record (TAR) from October 2023 through December 2023 revealed 8 days (Tuesday 10/10/2023, Tuesday 10/24/2023, and Tuesday 10/31/2023, 11/07/2023, 11/17/2023, 12/08/2023, 12/22/2023, and 12/29/2023) which the order was documented as N (No), but failed to reveal why the resident had not gotten a shower.</p> <p>On 04/21/25 at 11:34 AM, an interview with the Director of Nursing (Staff #2) revealed that when staff document N for a shower, the expectation was for staff to document why the resident had not received a shower.</p> <p>On 04/17/25 at 10:43 AM, review of Resident #108's TAR revealed 2 days (11/24/2023 and 12/12/2023) which the shower order failed to be documented on.</p> <p>On 04/21/25 at 11:34 AM, an interview with the Director of Nursing (DON) revealed that the expectation of staff was to document every shift based on orders, including shower documentation on the TAR.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>51712</p> <p>Based on observations, staff interviews, and record review, it was determined that the facility failed to ensure that residents with a limited range of motion receive appropriate treatment and services to prevent further decrease in range of motion. This was evident for 1 out of 1 resident observed for limited range of motion during this survey.</p> <p>The findings include:</p> <p>Contracture management is a variety of techniques aimed at preventing or improving limited joint movement due to shortening of muscles, tendons, or surrounding tissues. These methods include physical therapy, splinting, medication, and in some cases, surgery. Early intervention and consistent management are crucial for maximizing functional outcomes.</p> <p>Review of medical record revealed Resident #101 was a long-term care resident who has the following but is limited to medical history: morbid obesity, protein-calorie malnutrition, and a PEG tube. Resident #101 was bed-bound with a limited ROM to all extremities.</p> <p>On 4/17/25 at 12:13 PM, Resident #101 was observed in bed resting comfortably. The surveyor observed that the resident's right hand was in contracture.</p> <p>On 4/22/25 at 8:40 AM, review of records revealed that Resident #101 was provided Physical Therapy (PT) and Occupational Therapy (OT) services for Contracture Management, started on 11/4/24, and was discharged from these services on 12/13/24. OT Goals were to prevent further contractures. Discharge recommendations were for nursing to apply splints daily and remove them every night. Resident #101 was last seen by OT on 12/13/24. The review of orders did not reflect that orders were placed for nursing staff to complete the discharge recommendations. The care plan review did not reflect the discharge recommendations for therapy.</p> <p>On 4/22/25 at 9:47 AM, the surveyor interviewed the Director of Rehab (DOR #23) and the Occupational Therapist (OT #40) regarding Resident #101. When asked if OT was still seeing the resident, they stated no. The surveyor inquired about whether they perform quarterly evaluations on residents that have been seen by OT, and they confirmed that they do. The surveyor then asked when was the last quarterly evaluation conducted for this resident completed. OT #40 was unable to provide an answer. When the surveyor asked who was responsible for entering the orders into the EMR, the DOR #23 was unable to provide an answer. They both stated that they would return with the necessary information.</p> <p>On 4/22/25 at 11:44 AM, the Administrator (Admin #1) was interviewed and was asked how orders from PT/OT services were entered into the Electronic Medical Record (EMR). The Admin #1 stated that when orders are recommended for nursing, PT/OT therapy is supposed to place the orders in the EMR for nursing.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/25 at 12:53 PM, DOR #23 and OT #40 returned to the surveyor and stated that the orders were never placed for Resident #101 to get the discharge recommendations from OT therapy. OT #40 stated that she would complete Resident #101's quarterly evaluation today and enter the recommendations and orders from OT into the system for nursing to follow-up.</p>

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>30428</p> <p>Based on medical record review, the review of a complaint and interview with facility staff, it was determined that the facility failed to ensure the timely scheduling with an Infectious Disease consultant for a resident that was admitted with multiple comorbidities requiring specialty consultation. This was evident for 1 of 3 residents (Resident #162) reviewed with orders for outside services/consultations.</p> <p>The findings include:</p> <p>The complainant for MD00206860 was interviewed on 4/23/25 at 8:53 AM. Amongst other concerns, he/she reported that regarding their loved one, Resident #162, had multiple care concerns surrounding the evolving status of a wound. The complainant reported to this surveyor and acknowledged that Resident #162 admitted to the facility with the wound, however, verbalized concern over the worsening status of the wound.</p> <p>Resident record review continuing from 4/23/25 at 8:19 AM revealed admission diagnosis in March of 2024 including infection following fasciotomy (a surgical procedure to cut through the fascia surrounding a group of muscles to relieve pressure) procedure and urinary tract infection. According to the hospital discharge summary Resident #162 was admitted to the facility with a wound vac (medical device used to help wounds heal by applying suction to remove fluid and debris and encourage tissue growth) at the surgical site.</p> <p>During the first 2 months of the residents stay in the facility, the sacral wound was noted to increase and was monitored, assessed and x-rayed multiple times to rule out osteomyelitis which was determined present in August of 2024.</p> <p>A physician progress note on 8/19/24 addressed Resident #162's sacral wound infection that required antibiotics and an infectious disease (ID) consult secondary to an elevated C-reactive protein level (CRP is a protein level that shows inflammation when elevated normal range is less than .3mg/L).</p> <p>On 8/5/24 the CRP for Resident #162 was 132, the level increased to 198 on 8/12 and remained 198 on 9/3/24 despite the IV antibiotics. A level of 198 mg/L shows severe inflammation, levels above 200 mg/L are used as a marker to indicate sepsis.</p> <p>On 8/23/24 a nursing progress note again address the need for an ID consultation and the Residents responsible party was updated.</p> <p>On 8/26/24 a skin/wound note was completed with measurements of the sacral wound, noting that it had increased 3 cm in length and 1 cm in width in a week, the ID consultation was noted as still pending. Resident #162 was continued on the intravenous (IV) antibiotics at this time. The attending physician on this day ordered a culture and sensitivity of the wound, that continued to show active infection.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Chevy Chase		STREET ADDRESS, CITY, STATE, ZIP CODE 8700 Jones Mill Road Chevy Chase, MD 20815	
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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 a nurse practitioner note continued to address the need for an ID consultation and that Resident #162 was to continue IV antibiotics until the consultation was completed.</p> <p>A late entry nursing progress note on 9/17/24 at 7:40 PM documented that Resident #162 saw the ID specialist that day, 28 days after the initial order was put in, however the actual consultation was not available for review. The ID consultation report was requested on 4/25/25 at 9:25 AM as there was no actual documentation of it in the electronic health record for Resident #162.</p> <p>The DON followed up with this surveyor on 4/25/25 at 10:21 AM and stated that she was unable to locate the consultation. The concern about Resident #162's worsening wound and need for the ID consult initially requested on 8/19/24 was reviewed at this time. The DON was asked if 28 days was too long to get a consultation, and she stated that she would look into it.</p> <p>On 4/25/25 at 12:12 PM the DON followed up again with this surveyor and was unable to provide the consultation report or documentation of interventions that occurred with Resident #162 prior to his/her required hospital transfer and admission with diagnosis of sepsis 2 weeks after the ID consultation was documented as completed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>50573</p> <p>Based on observations, staff interviews, and record review, it was determined that the facility failed to ensure that medical records were complete and accurately documented. This was evident for 2 residents (Resident #101, #108) out of 54 residents reviewed for medical records during the survey.</p> <p>The findings include:</p> <p>1) On 04/17/25 at 10:42 AM, review of Resident #108's medical record revealed an active order with a start date of 10/03/2023, which indicated for the resident to receive a shower on Tuesdays and Fridays.</p> <p>On 04/17/25 at 10:43 AM, further review of the resident's medical record revealed an active kardex task which indicated the resident was to receive a shower on Mondays and Thursdays.</p> <p>On 04/21/25 at 11:34 AM, an interview with the Director of Nursing (Staff #2) revealed that a resident's kardex task regarding showers should reflect the resident's shower order.</p> <p>51712</p> <p>2) On 4/22/25 at 8:40 AM, review of records revealed that Resident #101 was bed-bound with limited ROM to all extremities and was provided Physical Therapy (PT) and Occupational Therapy (OT) services for Contracture Management. Services started on 11/4/24, and was discharged from these services on 12/13/24. OT Goals were to prevent further contractures. Discharge recommendations were for nursing to apply splints daily and remove them every night. Resident #101 was last seen by OT on 12/13/24. The review of orders did not reflect that orders were placed for nursing staff to complete the discharge recommendations. The care plan review did not reflect the discharge recommendations for therapy.</p> <p>On 4/22/25 at 9:47 AM, the surveyor interviewed with the Director of Rehab (DOR #23) and the OT therapist (OT #40) regarding resident #101. When asked if OT was still seeing the resident, they stated no. The surveyor inquired about whether they perform quarterly evaluations on residents that have been seen by OT, and they confirmed that they do. The surveyor then asked when was the last quarterly evaluation conducted for the resident. When the surveyor asked who was responsible for entering the orders into the EMR, the DOR was unable to provide an answer. They stated that they would return with the necessary information.</p> <p>On 4/22/25 at 11:44 AM, the Admin was interviewed and was asked how orders from PT/OT services were entered into the Electronic Medical Record (EMR). The Admin stated that when orders are recommended for nursing, PT/OT therapy is supposed to place the orders in the EMR for nursing.</p> <p>On 4/22/25 at 12:53 PM, DOR #23 and OT #40 returned to the surveyor and stated that the orders were never placed for resident #101 to get the discharged recommendations from OT therapy.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>42863</p> <p>Based on observations, review of administrative documents, and interviews it was determined that the facility failed to repair broken kitchen equipment, These factors were found evident to be true during three of multiple observations facility observations of the kitchen made during the survey.</p> <p>The findings include:</p> <p>1) On 04/16/25 at 07:34 AM the surveyor initiated the tour of the kitchen dietary aide. Refrigerator number # 3, labeled Back Room, the temperature outside the refrigerator read 51 degrees Fahrenheit. When the door of refrigerator #3 was opened by the surveyor, the shelves and the food containers were warm to touch. The contents within the refrigerator were applesauce, grape jelly, soy sauce, mayonnaise and iced tea. Refrigerator # 3 temperature was not in compliance with the food safety storage procedures.</p> <p>Refrigerator #4 labeled back room, appeared to be unplugged and the outside temperature was 65 degrees. Within the interior of refrigerator #4 were dry goods, such as pasta, noodles, large cans of tomato sauce, grape jelly, and bread. The surveyor observed that refrigerator #4 was being used as a storage unit for dry goods and was not operational as a refrigerator.</p> <p>On 04.16.25 at 10:05 AM the surveyor met with the registered dietician, staff #13, the regional dietary manager #14, and the facility dietary manager, staff # 15 to tour the kitchen area again and to review the original concerns found by the surveyor. Staff #14, regional food service director. The facility dietary manager #15 stated that he was unaware that refrigerator # 3 labeled back of kitchen refrigerator was not functional: the temperature log for 04.16.25 was written as 41 degrees Fahrenheit.</p> <p>Refrigerator #4 which was labeled as the back room of kitchen refrigerators per the dietary manager, staff #15 was not functional and the facility staff are using it a storage area for the 3 day emergency /menu /supply storage of dry goods such as pasta, spaghetti noodles, tomato sauce, and fresh loaves of bread. All the items in Refrigerator #4 were labeled appropriately.</p> <p>On 04.25.25 at 11:45 AM the surveyor toured the facility kitchen and was informed by the regional dietary manager, staff #14 that the kitchen's ice machine was not operational. The regional dietary manager, staff #14 stated the kitchen is reliant on the units to assist with providing the residents with ice with meals. Also, the surveyor discussed the status of the two broken refrigerators in the kitchen. Staff #14 also stated that she would provide the surveyor with documentation of the work orders related to the pending for kitchen equipment.</p> <p>On 04.28.25 at 1:05 PM staff #14 presented the surveyor with copies of work orders for the proposed repair of the kitchen equipment.</p> <p>These potential deficiencies were discussed during the exit conference to facility and regional administrative staff on 04.28.25 as well.</p> <p>50573</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) On 04/16/25 at 09:31 AM, an anonymous complaint revealed that staff often say the ice machine is broken when residents request for ice water.</p> <p>On 04/17/25 at 08:39 AM, an observation of the main dining room of the long term care unit revealed it was not administering ice when the surveyor attempted to test the machine.</p> <p>On 04/18/25 at 11:13 AM, an interview with the Director of Maintenance (Staff #5) revealed that staff were able to use an online platform called, TELS to report maintenance concerns. He was unaware of a concern regarding the main dining room ice machine.</p> <p>On 04/18/25 at 12:18 PM, an observation during a walk through with the Director of Maintenance (Staff #5) revealed the main dining room ice machine was not administering ice.</p>

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<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>50573</p> <p>Based on observation and interview, it was determined that the facility failed to ensure a resident's mattress properly fit the bed frame. This was evident for 1 (Resident #108) of 1 resident bed observed during a random observation of the Annapolis Unit.</p> <p>The findings include:</p> <p>On 04/18/25 at 11:42 AM, an observation of Resident #108 in bed revealed that his/her mattress was hanging over the bed frame approximately 8 inches on the right side of the bed.</p> <p>On 04/18/25 at 12:19 PM, the surveyor and the Director of Maintenance observed Resident #108's mattress hanging over the right side of the bed frame. He indicated that the mattress was too big for the bed frame.</p>		