

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Long Green		STREET ADDRESS, CITY, STATE, ZIP CODE 115 East Melrose Avenue Baltimore, MD 21212	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21859</p> <p>Based on observation and interview with facility staff, it was determined that the facility failed to ensure residents' rights to dignity and privacy as evidenced by 1) not ensuring that a resident's foley drainage bag was covered, this was evident for 1 (Resident #86) of 2 residents reviewed for dignity and 2) the facility staff not putting the residents' clothing away in drawers or hanging them in the armoires. This deficient practice was evidenced in 30 of 33 residents screened during the Medicare/Medicaid survey.</p> <p>The findings include:</p> <p>A foley drainage bag, or urinary drainage bag, is a medical device used to collect urine from a catheterized resident. The drainage bag is usually worn on the leg or attached to a bed.</p> <p>1) During observation rounds on 7/22/24 at 7:50 am, Resident #86 was noted to have a foley catheter bag attached to their bed. The foley drainage bag was uncovered and had amber colored liquid visible. The bag was attached to the door side of the bed. Resident #86's door was open, and the foley drainage bag was visible from the hallway.</p> <p>On 7/22/24 at 10:54 am, the surveyor interviewed Unit Manager Licensed Practical Nurse (LPN) # 39. When asked if residents with foley bags should have covers on the bags, LPN #39 stated foley bags should be covered and that she would ensure that the foley bags were covered.</p> <p>42782</p> <p>2) On 07/09/24 from 7:52 am - 2:48 pm during observation rounds and the resident screening process, the surveyor observed 30 of 33 residents on units [NAME] and Joppa with clothing in trash bags, boxes, and/or stacked in their armoire.</p> <p>On 07/30/24 at 11:14 am during an interview with Assistant Director of Nursing (ADON) #3 they verbalized when the laundry attendants bring the residents' laundry back to their rooms, the Geriatric Nursing Assistants (GNA) are supposed to hang up the residents' clothing. ADON #3 was made aware the surveyor did not observe hangers in the residents' armoires for the GNA's to hang their clothing.</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 07/30/24 at 11:34 am during an interview with Administrator #1, they verbalized when the residents are admitted they are asked to bring clothing for two weeks and the residents' clothing is changed out depending on the season. Administrator #1 verbalized being aware there were a lack of hangers for the residents use and they are in the process of purchasing hangers.</p> <p>On 07/31/24 at 6:01 am during an interview with GNA #52 the surveyor asked what the process is for managing residents' clothing. GNA#52 verbalized when a resident is admitted they document each article of clothing. If clothing comes from the laundry, they must hang the clothing up and put them away. If hangers are not available, they are supposed to fold the clothing and put them in the drawer.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>42782</p> <p>Based on observations and interviews it was determined that the facility staff failed to ensure residents had their call bells readily accessible when assistance was required. This deficient practice was evidenced in 3 (#11, #13, & #14) of 33 residents reviewed for accommodations of needs during the survey.</p> <p>The findings include:</p> <p>On 07/22/24 at 1:58 pm the surveyor observed Resident #11 in bed with a torn diaper. The surveyor asked the resident if they had a call bell and the resident replied, no. The surveyor observed Resident #11 call bell attached to their roommate's bed.</p> <p>Unit Manager #8 confirmed the resident's call bell was on their roommate's bed. Unit Manager #8 verbalized each resident was supposed to have their own call bell to request assistance when needed. Unit Manager #8 was unable to determine why Resident #11's roommate had both call bells.</p> <p>On 07/29/24 at 9:46 am the surveyor observed Residents #13's and Resident #14's call bells on the floor in their room. Resident #13's call bell was on the left side of the bed on the floor. Resident #14's call bell was on the right side of the bed on the floor and their bedside table had several scattered crumbs.</p> <p>On 07/29/29 at 9:49 am the surveyor asked Geriatric Nursing Assistant (GNA) #9 to go to the resident's room. GNA #9 confirmed both resident's call bells were on the floor. GNA #9 verbalized being in the process of working towards the resident's room to provide assistance.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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** 21859</p> <p>Based on observation and interview with facility staff and residents it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was observed on all nursing units.</p> <p>The findings include:</p> <p>The following environmental concerns were observed during the survey:</p> <p>1) room [ROOM NUMBER]: The resident entrance door into the room was observed with chipped wood on the edge of the door frame.</p> <p>2) room [ROOM NUMBER]: 8 floor tiles were lifting from the floor; dark black stains was observed on the vinyl flooring. Food was noted under the bed. The laminate on the over the bed tray table was chipped on the corner approximately 3 inches around the corner with particle board exposed and the footboard was cracked and loose on the right side.</p> <p>3) room [ROOM NUMBER]: The base molding by the air conditioner had approximately 8 inches pulled away from the wall by the radiator. There was a hole on the bottom sheet on the left side. The blue plastic covering on the pillow was torn in multiple locations. The cabinet that held clothes had wood chipped away from the bottom of the right corner approximately 1 inch by 1 inch and the bottom left drawer had wood missing approximately 2 inches which created a sharp edge. The floor had a dark red substance on the floor near the bed. 4 tiles located on the floor near the entrance door was separated. The drywall on the walls was peeling next to bed A.</p> <p>4) During observation on 7/23/24 at 11 am, accompanied by the Assistant Maintenance Supervisor and the Regional Administrator five toilets located in the facility (2 on the first floor and 3 on the second floor) were observed with 3x3 pieces of wood nailed to the floor and the toilet bowl was placed on top of the wood. The toilet on the second between rooms [ROOM NUMBERS] was loose and toilet tank lid was cracked making the edged sharp. On unit one the shower located between 114 and 115 had a 3 by 5 piece of wood located in the entrance to the shower. The board appeared soiled and dirty.</p> <p>5) The carpet located on the entire second floor was soiled and uncleanable. Resident with wheelchairs were noted propelling themselves thru the dirt filled carpet.</p> <p>6) During an interview on 7/23/24 at 12:30 pm with resident #40 s/he stated the facility housekeeping staff is short staffed and sometimes does not clean the units and/or resident rooms.</p> <p>Discussion with the Regional Administrator, Administrator, Assistant Director of Maintenance and the Director of Nursing on 7/24/24 the findings were verified. The Administrator stated he was in the process of getting quotes for the second-floor carpet and the other issues were currently being worked on.</p> <p>30440</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 - Many</p>	<p>7) An interview was conducted with resident # 30 on 7/23/24 at 10:54 AM and the resident reported the sink in the room has no cold water and has been that way for a long time. The surveyor observed the sink in the resident room and attempted to turn the cold-water faucet to the on position, and the faucet handle was broken. The inability of the handle to be turned prevented the water from being able to be used. The Administrator was made aware of this concern immediately.</p> <p>During another observation on 7/24/24 at 3:00 PM, the faucet was observed to be repaired and was working.</p> <p>All identified concerns were discussed with the Administration team at the time of exit on 7/31/24 at 4:00 PM.</p> <p>42863</p> <p>8) On 07/19/24 at 10:19 AM the surveyor observed that a resident room occupied by two residents who shared a single closet was filled with 3 large boxes that were piled on top of each other up to the horizontal closet rod. The boxes within the closet were filled with the personal items, shoes, and clothing of both residents (#115 and #116).</p> <p>During an interview on 07.30.24 at 11:34 AM the administrator stated that the residents are asked to only bring two weeks of clothing and to alternate their clothing according to the seasons of the year. The administrator stated the GNA's are responsible for putting away resident's clothing who are not capable of performing these tasks themselves. The administrator stated that the facility was in the process of ordering hangers for the residents.</p> <p>On 07.31.24 at 10:07 AM the surveyor observed that a room shared by residents # 115 and #116 possessed only one closet and within the closet there was no separation of each roommates clothing and personal belongings. Additionally, there was no room for each resident to hang personal clothing. These residents' personal belongings, and clothing were piled up in the closet, wrapped in plastic bags within cardboard boxes.</p> <p>On 07.31.24 at 11:30 AM the surveyor interviewed the unit manager, LPN # 67, who stated that it is the responsibility of the housekeeping to place the hangers in the resident's room. Additionally, it was the responsibility of the geriatric nursing assistants (GNA) staff to ensure the resident's belongings are stored appropriately. Also, she stated that she would make rounds and check with housekeeping regarding the hangers. The surveyor shared with the unit manager, LPN #67, an example of a resident room with their clothes piled in plastic bags and brown boxes within or outside of a closet.</p> <p>This deficient practice was related to the failure of the facility to ensure a homelike environment for the residents was reviewed with the administrative team during the exit conference.</p> <p>49304</p> <p>9) The following observations were made during initial and follow up observations of residents on 7/19/24 and 7/22/24 on the first and second floors.</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 - Many</p>	<p>Resident #58: On 7/19/24 at 8:32 AM during initial observations rounds in the resident's room, the wall that his/her bed was touching was noted to be scraped up. The walls in the room were painted a light brown color however due to the scraping, there are numerous areas where the wall was white due to indentations in the wall and missing paint.</p> <p>10) Resident #78: On 7/19/24 at 8:56 AM during initial observation rounds, the resident's floor was noted to be sticky and some of the tiles on the floor were lifting. There were flies and fruit flies in the room circling and landing on the resident and his/her bedside table. There was also a spiral, yellow, sticky paper with dead flies and fruit flies adhered to it that hung to the left of the resident's bed.</p> <p>11) Resident #36: On 7/19/24 at 8:42 AM during initial observation rounds, the resident's headboard of his/her bed was noted to be peeling. There was a large portion of the top layer of the headboard missing.</p> <p>12) Resident #8: On 7/22/24 at 9:01 AM during follow up observations, the resident's bottom two drawers of his/her dresser were noted to be peeling and crooked. There were multiple areas on the resident's walls that were dirty, chipped, and missing paint. In addition, the white trim along the bottom of the wall was covered with black marks and dirt.</p> <p>On 7/23/24 at 12:58 PM in an interview with Assistant Maintenance Director and the Nursing Home Administrator (NHA), the NHA stated we are an old building, and we try to fix issues as they come up. When asked how maintenance issues are tracked and addressed, Assistant Maintenance Director #62 stated they have a TELS system (a technology-based system for delivering life safety, asset management, maintenance, and repair services to building management professionals), but he was not on it as it usually what the Director of Maintenance does but they did not have one right now. Assistant Maintenance Director #62 further stated most of the stuff [maintenance issues] he will put in a text and send to the NHA.</p> <p>50904</p> <p>13) On 7/19/24 at 08:27 AM, during the initial tour of the facility, the surveyors observed that the sink in Resident #21's room had the tap running with a washcloth in the sink to keep the water in place. Resident #21 told the surveyors that the sink had been like that for a while. At 08:42 AM while the surveyors were still on tour of the facility, the surveyors observed that the air conditioning (AC) vent in Resident #51's room had a gauze in it and cords underneath the AC unit were exposed. At 09:04 AM, surveyors observed that the floor tiles underneath the right side of Resident #63's bed (about 2 feet X 2.5 feet) were missing.</p> <p>14) On 07/29/24 at 02:20 PM, during a random tour of the second floor with Staff #62, surveyors showed him the maintenance issues that had been identified during the initial tour which he confirmed. During an interview after the unit tour, he stated that his daily routine included checking the rooms periodically, maintenance rounds by checking the floors, walls, ceilings, the beds and the TV, and he also informed surveyors that he was the only staff in the maintenance department. He said that the facility is in the process of repairing the floors on the second floor and eventually, all other maintenance concerns would be addressed.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>30440</p> <p>Based on administrative record review and interviews with facility staff it was determined the facility failed to ensure that a resident was free from misappropriation of their funds while residing in the facility. This was found to be evident for 1 (Resident # 111) of 3 resident's reviewed for personal property during the survey.</p> <p>The findings include:</p> <p>MD00178630 was reviewed on 7/24/24 at 9:00 AM for misappropriation of resident funds of \$1000.00 that was reported to be taken without the resident permission from an account.</p> <p>An interview was conducted with the Administrator (Staff # 1) on 7/24/24 at 11:00 AM and he was asked if he remembers Resident # 111 and he stated that he was very familiar with the resident. The Administrator was then asked if he withdrew \$1000.00 from the resident account, and he went on to explain that if a resident has an overage of \$2500.00 the facility would do a care cost spend down. The survey team requested a copy of the resident's account from the date of the resident's admission.</p> <p>On a subsequent visit, the Administrator provided a copy of resident # 111 account summary. There was no documentation of a care cost balance indicating money was owed to the facility.</p> <p>On the same date at 3:00 PM the Administrator provided the survey team with a copy of a returned check to the resident for \$800.00 dated 1/11/22. The Administrator stated that he was unable to explain or provide documentation as to why the \$800.00 was taken from the resident account, however, he stated that the money was returned to the resident.</p> <p>All concerns were discussed with the Administration team on 7/31/24 at 4:00 PM at the time of exit.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42863</p> <p>Based on record review and interview with facility staff, it was determined that the facility failed to timely report allegations of abuse within the required two hour timeframe to the Survey Agency, the Office of Health Care Quality (OHCQ). This was evident for 2 (MD00204913 and MD00202949) of 5 facility related incident reports reviewed during the survey.</p> <p>The findings include:</p> <p>1) On 07.22.24 at 1:00 PM the surveyor reviewed MD00204913 which was related to the allegation of inappropriate sexual relations between Residents #8 and #81. The alleged incident occurred on 04.11.24 around 4:00 PM per the documentation submitted by the facility. Review of the facility's documentation related to this incident report revealed the administrator did not submit the initial report to OHCQ until 8:15 PM on 04.11.24.</p> <p>During an interview with the DON and the administrator the surveyor reviewed the late submission of the initial report. Both the DON and the administrator stated that they were aware of the requirements to submit initial reports related to abuse within a two-hour time period. The administrator stated that he was not able to provide a reason for latest of the submission other than the incident occurred on a weekend.</p> <p>This deficient practice was reviewed with the administrative team on 07.31.24 during the exit conference.</p> <p>49304</p> <p>2) On 7/24/24 at 4:02 PM, the facility reported incident for Resident #92 revealed that on 2/24/24, Resident #92 reported his/her assigned GNA allegedly struck him/her.</p> <p>Further review of the facility investigation revealed Shift Supervisor #42 wrote in his statement that he was called to the location of the alleged incident at around 9:15 AM and responded immediately. It was noted that the facility submitted the initial report to the state agency on 2/24/24 at 5:58 PM.</p> <p>On 7/29/24 at 9:05 AM in an interview with the DON, she stated the time frame to report an allegation of abuse to the OHCQ is 2 hours. When asked the timing for when resident representatives (RPs) are notified of allegations of abuse, she stated they are notified immediately after an allegation of abuse. In the facility's investigation, it stated that the RP of Resident #92 was notified 2/24/24 around 9:30AM. During the interview, the DON stated, no, the initial report was not submitted in the 2 hour time frame for an allegation of abuse.</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>49304</p> <p>Based on record review and interview with facility staff, it was determined that the facility failed to complete a thorough investigation of an allegation of abuse. This was evident for 1 of 10 residents (Resident #36) reviewed for abuse during the survey.</p> <p>The findings include:</p> <p>The facility's investigation related to facility reported incident MD00206051 was reviewed on 7/24/24 at 3:58 PM and revealed that, on 5/26/24, Resident #36 had reported to the Nursing Home Administrator (NHA) that his/her assigned Geriatric Nursing Assistant (GNA) allegedly threw a cup of water in his/her face. Further review of the facility investigation documents revealed interviews of the alleged incident from the alleged perpetrator, another GNA, and the nursing supervisor of each of the aforementioned staff members. The investigation did not include an interview of the alleged victim, Resident #36.</p> <p>On 7/22/24 at 1:48 PM review of Resident #36's medical record revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicates the resident's cognition was intact.</p> <p>In an interview with the NHA on 7/30/24 at 1:45 PM, he stated a thorough investigation included interviewing the resident, alleged perpetrator, and any witnesses. During the interview the NHA confirmed there was no interview from the alleged victim, Resident #36. In addition, he stated, I can see that I should have gotten a statement from the resident.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>21859</p> <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Based on medical record review and interviews with facility staff it was determined the facility failed to complete a baseline care plan on a resident admitted with a stage four pressure ulcer. This was evident for 1 (Resident # 98) reviewed for pressure ulcers during the facility's annual survey.</p> <p>Findings include:</p> <p>A care plan is a written guideline of care based on the individual resident's needs developed by an interdisciplinary team which includes nursing, rehabilitation staff, and dietary that communicates to other health care professionals. A written care plan decreases the risk of incomplete, incorrect or inaccurate care. A baseline care plan must be completed within 48 hours of a resident's admission to the facility.</p> <p>A stage 4 pressure ulcer, also known as a bedsore, is the most severe type of pressure ulcer and can be life-threatening. It's characterized by full-thickness skin loss that extends through the fascia and into the muscle, bone, tendon, or joint.</p> <p>A medical record review was completed for resident # 98 on 7/22/24 at 1:30pm and it revealed the resident was admitted in March of 2024 with a left buttock stage 4 pressure ulcer. Review of the resident baseline care plan dated 3/18/24, failed to reveal a completed baseline care plan. The interventions section was blank for resident #98 ' s pressure ulcer to the left buttock.</p> <p>An interview was conducted with the Regional Nurse on 7/22/24 at 2:00 PM and she was asked if the resident had a care plan for the pressure ulcer. The Regional Nurse was unable to provide the survey team with a completed baseline care plan for Resident #98 that contained the interventions.</p> <p>During an interview with the ADON (Assistant Director of Nursing) on 7/22/24 at 3pm she stated she was unable to locate a completed baseline care plan for resident #98 that contained interventions for the pressure ulcer.</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>21859</p> <p>Based on review of the medical record, observation and interviews with facility staff, it was determined that the facility failed to ensure comprehensive care plans were developed and implemented. This is evident for 2 (Resident #98 and #88) of 37 residents reviewed during the survey.</p> <p>The findings include:</p> <p>A care plan is a written guideline of care based on the individual resident's needs developed by an interdisciplinary team which includes nursing, rehabilitation staff, and dietary that communicates to other health care professionals. A written care plan decreases the risk of incomplete, incorrect or inaccurate care.</p> <p>A pressure ulcer (also known as pressure sore or decubitus ulcer) is any lesion caused by unrelieved pressure or friction that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), and Stage IV (full thickness skin loss with extensive damage to muscle, bone, or tendon).</p> <p>1) A medical record review was completed for resident # 98 on 7/24/24 at 1:30pm it revealed the resident was admitted in March of 2024 with a left buttock stage 4 pressure ulcer. Review of the resident care plans, failed to reveal a comprehensive care plan for a stage 4 pressure ulcer to left buttock. Review of the Treatment Administration Record revealed the resident had several treatment order changes.</p> <p>An interview was conducted with the Regional Nurse on 7/24/24 at 2:00 PM and she was asked if the resident has a care plan for the pressure ulcer. The Regional Nurse stated she was unable to locate any care plans for a pressure ulcer.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 7/24/24 at 3:00 PM, she stated she was unable to locate a care plan for resident #98 for pressure ulcers; however, one would be developed.</p> <p>As of exit on 7/31/24 at 4:30pm the resident remained without a plan of care for the stage 4 pressure ulcer.</p> <p>42782</p> <p>2) On 07/24/24 at 11:55 am the surveyor reviewed Resident #88's medication administration record (MAR) which revealed the resident was prescribed psychotropic medications. Further review of the electronic medical record (EMR) revealed the resident did not have a comprehensive, patient-centered care plan for the administration of psychotropic medications prescribed.</p> <p>(continued on next page)</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>On 07/29/24 at 2:13 pm during an interview with the ADON when asked if a resident who is prescribed psychotropic medication, should have a care plan. The ADON verbalized a resident who is prescribed psychotropic medication should have a care plan. The surveyor made the ADON aware Resident #88 did not have a patient-centered care plan for the use of psychotropic medications.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21859</p> <p>Based on record review, observation, and interview with facility staff and residents, it was determined that facility staff failed to follow professional standards of nursing practice when administering medications to residents. This was evident for 2 (Resident #9 and #88) of 7 residents selected for a medication administration audit record (MAAR) review during the survey.</p> <p>The findings include:</p> <p>1) During observation rounds on 7/23/24 at 11:30am Resident #9 stated s/he does not receive his/her medications on time. Review of the Medication Administration Record (MAR) on 7/23/24 at 1pm revealed a physician order to administer Methadone HCL 30mg (milligrams) by mouth two times a day for opioid dependency. According to the MAR, the medication was scheduled to be administered at 9am and 9pm.</p> <p>Review of the MAAR revealed the following:</p> <p>On 6/8/24 the resident's 9:00am dosage of Methadone was not signed off as being administered until 6/8/24 at 11:32am.</p> <p>On 6/13/24 the resident's 9:00am dosage of Methadone was not signed off as being administered until 6/13/24 at 10:19am.</p> <p>On 6/22/24 the resident's 9:00am dosage of Methadone was not signed off as being administered until 6/22/24 at 14:08 pm.</p> <p>On 6/23/24 the resident's 9:00am dosage of Methadone was not signed off as being administered until 6/23/24 at 10:30am.</p> <p>On 7/12/24 the resident's 9:00am dosage of Methadone was not signed off as being administered until 7/12/24 at 10:33am.</p> <p>During an interview with Licensed Practical Nurse (LPN, staff #10) on at 7/29/24 3:30 pm, he stated it is difficult to administer medications and sign them off at the same time. Staff #10 stated the medications are given on time; however, he does not always sign the medication off after they are given. Staff #10 verified the standard of practice is to administer medication one hour before or one hour after the scheduled time.</p> <p>During an interview with the ADON on 7/29/24 at 4pm she stated all staff will be reeducated on medication administration.</p> <p>42782</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 07/31/24 at 9:58 am the surveyor reviewed Resident #88's MAAR which revealed that from 03/01/24 - 04/11/24 the resident's medication was signed off as given 1 hour or later than the prescribed medication time. There were at least 20 nurses including Unit Manager #8 and 1 Certified Medication Aide (CMA) who signed the MAAR at least 1 hour past the scheduled medication time. There were over 85 times when Resident #88's medications were signed off as given 1 hour or more after the scheduled time during 03/01/24 - 04/11/24.</p> <p>On 07/31/24 at 10:10 am during an interview with Assistant Director of Nursing (ADON) #3 who verbalized the nurses are giving the medications on time and sometimes they help on the floor by assisting with breakfast and lunch. The standard of practice is when a medication is given the medication is supposed to be signed as given.</p> <p>On 07/31/24 at 10:36 am during an interview with CMA #53 he/she verbalized they give medications on the units [NAME] and Joppa. If a resident needs assistance and if no one is available, they stop to help. They give all their medications on time and the standard of practice is to give the medication on time and sign it off. If they medication is signed off late, the nurse or supervisor is made aware.</p> <p>On 07/31/24 at 11:20 am during an interview with LPN #68 he/she verbalized they usually don't give medications late; something may have happened, and the medications were signed off late. The supervisor is made aware if medications are given late or signed off late and the standard of practice is to sign off the medications when they are given.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>42782</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on medical record review and interview it was determined that the facility staff failed to reassess a resident's blood pressure (BP) when it was outside of the resident's usual parameters. This deficient practice was evident in 1 (#68) of 1 resident reviewed for follow up after abnormal vitals during the survey.</p> <p>The findings include:</p> <p>On 07/24/24 at 9:11 am a review of Resident #68 vital signs revealed on 07/23/24 at 10:07 pm the documented BP was 180/92. There was not another BP documented after the elevated BP was recorded. The surveyor checked the nursing notes for documentation from Certified Medication Aide # 66 who recorded the BP or from the nurse overseeing the resident's care. The resident was ordered Hydralazine 100 mg by mouth at 10 pm. The medication was signed off as given. A review of Resident #68 care plan for coronary heart disease dated 08/14/23 revealed medication for hypertension should be given as ordered and a response to the medication should be documented.</p> <p>On 07/24/24 at 10:32 am Director of Nursing #2 (DON) was made aware Resident #68's BP was elevated and a follow up BP was not documented and there wasn't a clinical note in the electronic medical record (EMR) or the paper chart. DON#2 verbalized CMA#66 should have notified the nurse of the BP and the nurse should have retaken the resident's BP and report the findings to the physician.</p> <p>On 07/24/24 4:10 pm DON#2 confirmed the staff did not take a follow up BP. The surveyor received a note with two BP results that were taken for Resident #68. The results were 144/80 at 11:30 am and 142/78 at 2:19 pm. The follow up BP was taken over 12 hours after the elevated BP was recorded in Resident #68 EMR.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>21859</p> <p>Based on medical record review and staff interview it was determined the facility failed to ensure that treatment that was ordered for a resident with urinary incontinence was implemented. This was evident for 1 (#93) of 3 residents reviewed for bladder incontinence.</p> <p>The findings include:</p> <p>During observation rounds on 7/26/24 at 12 noon resident #93 was sitting in the hallway with his/her Foley bag sitting in the wheelchair. The Foley bag was filled to the top with a yellow-colored fluid and a large piece of tape was noted attached to the bag. This surveyor asked the resident why, his/her foley bag was not attached to the wheelchair and the resident stated, my Foley bag has a hole in in. I told the nurse instead of changing it he just taped it.</p> <p>Review of the medical record on 7/26/24 at 12:30pm revealed a physician order to change the catheter/foley bag when needed and to empty the foley drainage bag at least once every eight hours or when it becomes half to 2/3 full. The DON Director of Nursing was made aware of the findings at 12:45pm.</p> <p>During a follow-up interview with the DON on 7/26/24 at 1:30 pm, she stated that staff #44 was aware that the foley catheter was full and possibly leaking; however, staff #44 was passing out medications. Review of the staffing schedule on 7/26/24 at 2pm revealed that the unit also had a Unit Manager assigned.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>49304</p> <p>Based on surveyor observation, interview with facility staff, and review of the medical record, it was determined the facility staff failed to provide necessary respiratory care services for residents by failing to date label oxygen administration equipment and failing to administer oxygen as prescribed. This was evident for 1 (Resident #60) of 37 residents reviewed during the survey.</p> <p>The findings include:</p> <p>On 7/19/24 at 8:07 AM Resident #60 was observed receiving oxygen via nasal cannula at a flow rate of 4.25 liters per minute (L/min). A nasal cannula is a device that delivers oxygen directly to a person's nostrils via a flexible plastic tube.</p> <p>During a second observation that took place on 7/19/24 at 2:16 PM, Resident #60 was noted to still be receiving oxygen at a flow rate of 4.25 L/min.</p> <p>On 7/19/24 at 2:21PM in an interview with Licensed Practical Nurses (LPN) #14 when asked about oxygen administration equipment he stated the tubing should be labeled with initials and the date/time it was changed. During the interview he stated if the humidifier bottle is running out, that is also changed and labeled with the date/time and initials. Furthermore, LPN #14 stated we [nurses] do morning rounds and oxygen equipment is checked during that time.</p> <p>On 7/19/24 at 2:32 PM in an interview with the Assistant Director of Nursing (ADON) when asked about expectations for oxygen administration equipment, she stated oxygen tubing should be changed every Monday and as needed and labeled with the date it was changed and staff's initials. During the interview, she confirmed the humidifier bottle is also labeled with the date and initials when changed. Then, the ADON and surveyor entered Resident #60's room, looked at the oxygen equipment, and conversed with the resident. Resident #60 was observed to still be receiving oxygen at a flow rate of 4.5 L/min.</p> <p>The surveyor and ADON exited the room and when asked, the ADON stated the label on the oxygen tubing was dated 5/29/24 and initialed by C.M. who she confirmed was Registered Nurse (RN) #4. The ADON also confirmed the humidifier bottle was not labeled. During the interview when asked how many liters of oxygen Resident #60 was currently receiving, the ADON re-entered the resident's room and stated, Who bumped you up to this? The ADON exited the resident's room and stated, the resident was on 1L when I just checked, but I accidentally bumped it to 5L and now he/she is on 2L. The surveyor shared a picture taken 7/19/24 at 8:07AM showing the oxygen flow meter ball between 4 and 4.5 L.</p> <p>Resident #60's medical record was reviewed on 7/19/24 at 2:43 PM which revealed an order for Oxygen at 2L/min via Nasal Cannula continuous for SOB (shortness of breath) dated 6/6/23.</p> <p>The ADON pulled up Resident #60's oxygen order on 7/19/24 at 2:45 PM. The order dated 11/2/23 stated, Oxygen at 2L-3L via N/C (nasal cannula) continuously with the goal of 88-92% every shift for COPD.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/19/24 at 2:46 PM in an interview with the ADON when asked, when she entered Resident #60's room, was the resident on the physician ordered 2-3L NC that was on the order just provided, she stated, No. ADON indicated the order from 6/6/23 should have been discontinued, but could not tell the surveyor why it was not. The 11/2/23 order was put in by the doctor when Resident #60 went out to the hospital. The 6/6/23 order was on hold and yes it should show in the electronic health record.</p> <p>On 7/24/24 at 9:30 AM review of Resident #60's medical record revealed an order dated 11/2/2023, Oxygen tubing change weekly. Label each component with date and initials. every night shift every Tue. Label each component with date and initials.</p> <p>On 7/22/24 at 8:01 AM, review of the facility's Oxygen Administration policy stated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Further review revealed Policy Explanation and Compliance Guidelines:</p> <p>1. Oxygen is administered under orders of a physician, except in the case of emergency. In such cases, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.</p> <p>5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measure include:</p> <p>b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.</p> <p>c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>21859</p> <p>Based on a review of the medical record and interview with facility staff, it was determined that the facility failed to respond to the pharmacy recommendations after a monthly clinical review was done and failed to ensure the attending physician reviewed the pharmacy reviews. This was evident for 2 (Resident # 93 and #88) of 5 residents reviewed for unnecessary medications during the survey.</p> <p>The findings include:</p> <p>1) Resident # 93's medications were reviewed on 7/30/24 at 1:00pm for unnecessary medications. Upon review of the Consultant Pharmacist Medication Regimen Review Medical Director Report dated 6/20/24, it indicated the following:</p> <p>Recommendation: Please clarify a frequency for Magnesium Hydroxide PRN (when needed) (ex. once daily PRN.) Magnesium hydroxide is used to treat occasional constipation in adults on a short-term basis.</p> <p>There was no response indicated on the form.</p> <p>An interview was conducted with the Assistant Director of Nursing (ADON) on 7/30/24 at 1:20pm, she was asked to provide copies of the facility's response to the pharmacist's recommendations. During a follow-up interview on 7/30/24 at 3pm she stated that she has looked everywhere and was unable to find any responses to the pharmacy review for 6/20/24. She stated she had contacted the Nurse Practitioner and the resident primary physician to address the issue.</p> <p>On 7/30/24 the Nurse Practitioner was in the facility and added a frequency to the medication per the pharmacy recommendation.</p> <p>42782</p> <p>2) On 07/24/24 at 2:58 pm during an interview with the ADON who verbalized they were waiting for pharmacy to send the pharmacy reviews for Resident #88. The ADON was made aware the surveyor requested the pharmacy reviews over an hour prior and he/she verbalized they would be printed. The ADON reported the pharmacy reviews were not in his/her computer as previously stated. When asked what the process was to receive and review the pharmacy recommendation the ADON stated; they bring the recommendation to clinical for the physician to review and decide if they want to move forward with the recommendation. The physician will sign the recommendation; afterwards the recommendation is faxed back to the pharmacy. Clinicals are held Monday thru Friday.</p> <p>On 07/24/24 at 3:31pm the surveyor received the pharmacy recommendations from the ADON which were not signed. The surveyor asked the ADON if the physician reviewed the recommendations, why are they not signed. The ADON was unable to answer the surveyor's question.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/24/24 at 3:44 pm the surveyor reviewed the pharmacy recommendations dated 02/21/24, 03/13/24, 04/09/24, and 06/19/24. Review of Resident #88 medication administration record revealed (MAR) there were no changes to the medication regimen where the pharmacist indicated the resident was receiving duplicate medication therapy for at least two medications. Also, the pain patches the resident was receiving were not being used according to the manufacturer's recommendation. Blood work was not completed as clinically indicated.</p> <p>On 07/29/24 at 2:05 pm the surveyor asked if the pharmacy recommendations were addressed, the ADON verbalized they must find out if they were addressed.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>21859</p> <p>Based on a review of the medical record and interviews with facility staff it was determined that the facility failed to respond to the pharmacy recommendations after a monthly clinical review was done. This was found to be evident for 1(Resident # 93) of 5 residents reviewed for unnecessary medications during the facility's annual survey.</p> <p>The findings include:</p> <p>Anxiolytic drugs, also known as anti-anxiety medications or minor tranquilizers, treat anxiety and related conditions.</p> <p>Resident # 93 medications were reviewed on 7/30/24 at 1pm for unnecessary medications. Upon review of the Consultant Pharmacist Medication Regimen Review Medical Director Report dated 6/20/24 it indicated the following:</p> <p>The resident has a PRN (when needed) order for an anxiolytic, without a stop date. Recommendation: is to consider discontinued PRN Diazepam, tapering as necessary. If medication cannot be discontinued at this time, please document the indication for use. The intended duration of therapy and the rationale for the extended time of period. There was no response indicated on the form.</p> <p>An interview was conducted with the ADON on 7/30/24 at 1:20pm, she was asked to provide copies of the facility's response to the pharmacist's recommendations. During a follow-up interview on 7/30/24 at 3pm she stated that she has looked everywhere and was unable to find any responses to the pharmacy review for 6/20/24. She stated she has contacted the Psychiatric Nurse Practitioner and the resident primary physician to address the issue.</p> <p>On 7/31/24 the Psychiatric Nurse Practitioner was in the facility and discontinued the PRN Diazepam.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50904</p> <p>Based on observations and interviews it was determined that the facility failed to ensure: 1) appropriate temperature monitoring was maintained for the medication refrigerator, 2) expired medications were properly discarded, and 3) appropriate labeling and storage of medications. This was evident in 2 out of 2 medication storage rooms observed in the facility and 4 of 7 medication carts observed in the facility.</p> <p>The findings include:</p> <p>On 07/29/24 at 08:29 AM, the surveyors and charge nurse, Staff #54, conducted an observation of the second-floor medication storage room located behind the nurse's station. The temperature log was not documented from 07/28/24 to 07/29/24 and there was no date/signature on the second page of the temperature log to ensure proper monitoring.</p> <p>On 07/29/24 at 08:38 AM, the surveyors found the following expired items on a shelf in the medication storage room: adhesive remover wipes with expiration date of 12/20/21, self-adhesive fabric with expiration date of 04/2020, and fluocinonide ointment with expiration date of 03/17/2024.</p> <p>On 07/29/24 at 08:53 AM, surveyors observed that the treatment cart located in the medication room had the following items in it: an opened and undated bottle of Dakin's solution, collagenase santyl ointment with the name of one resident cleaned off with a black marker and another resident's name written with a black marker, dyna gel moisturizing wound gel was opened and not dated, triamcinolone acetonide ointment was also opened with no date/name and Vit A&D ointment was also opened without a date as well. The charge nurse, Staff #54 discarded the expired and undated medications in the trash box located in the medication storage room.</p> <p>On 07/29/24 at 09:28 AM, surveyors observed a medication cart on the first floor that a house stocked bottle of Senna tablets and another house stocked bottle of Multivitamins tablet were opened but not dated.</p> <p>On 07/29/24 at 12:08 PM, surveyors observed a new unopened Lantus insulin pen that stated REFRIGERATE IF NOT OPENED in a tray with opened insulin pens in the medication room on the first floor. The Regional Director of Nursing, who was with the surveyors at that time stated that the insulin pen should have been placed in the refrigerator because it was not opened, and she placed it in the refrigerator.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Long Green		STREET ADDRESS, CITY, STATE, ZIP CODE 115 East Melrose Avenue Baltimore, MD 21212	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/29/24 at 01:47 PM, the Assistant Director of Nursing (ADON) was informed about the findings and confirmed that the night nurses fill the refrigerator temperature logbook. She also said that it was the duty of the unit managers to check the temperature logbook at the beginning of their shift and ensure that it was properly filled, dated and signed, then the Director of Nursing (DON) or the ADON followed up after the unit managers. She added that dates and signatures should have been on both pages of the temperature log books and that she would create a signature sheet as soon as possible. She also stated that house stocked medications are dated as soon as they are opened and such medications should be used within 30 days and discarded afterward. She also said that charge nurses, unit managers, DON/ADON are responsible for checking that expired medications are discarded properly, and that unopened/new insulin pens are stored in the refrigerator.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42863</p> <p>Based on administrative record reviews, observations, and interviews the failed to (1) ensure sanitary practices were followed in accordance with professional standards for food service safety, (2) maintain a clean working environment, #3) to remove expired canned food from the kitchen, (4) maintain safe temperatures in a unit refrigerator, and (5) to remove outdated food from unit refrigerators. These deficient practices related to the unit refrigerators were identified to be present on 2 out of 4 clinical units and the facility kitchen.</p> <p>The findings include:</p> <p>On 07.19.24 at 07:50 AM the surveyor performed the initial observation of the kitchen as part of the facility task and escorted by Staff #16, director of dietary services. The tour initiated in the dry storage area. The surveyor observed that two of the closed bins in which dry cereal was stored did not have an expiration date on the sticker/label. Also, the surveyor found one can of pears with an expiration date of 05.2023 on another shelf.</p> <p>On 07.19.24 at 0800 AM the surveyor continued the tour of the kitchen work area and found that the two ovens appeared brown, greasy, and dirty both inside, including the shelving and on both doors of the oven. Staff #16 stated that the oven was in constant use because the facility does not have a separate warmer and Staff #16 was not able to provide the surveyor with a cleaning schedule for the equipment in the kitchen.</p> <p>At approximately, 08:05 AM the surveyor observed the area designated for rinsing dirty dishes was found unkempt with food particles left in the strainer, as well as what appeared to be a cigarette butt. When questioned by the surveyor, Staff #16 stated that sometimes the residents will take their plate outside while smoking and leave a cigarette butt on the plate.</p> <p>At 1:20 PM on 07.22.24 the surveyor was accompanied on the second tour of the kitchen by director of operations for dietary services, staff # 23 and observed the dirty ovens with burned on grease present on the shelves, walls, and the glass doors. The surveyor asked staff #23 whether she felt if it was acceptable to have kitchen remain in this condition. Staff # 23 did not provide an explanation nor did she provide a cleaning schedule for the kitchen equipment.</p> <p>On 07.26.24 at 11:39 AM the surveyor conducted a tour of the kitchen with staff #23. The general workspace of the kitchen was cleaner and better organized. The two oven doors were clean as well as the interior walls and shelves.</p> <p>07.30.24 at 11:15 AM the surveyor was escorted by staff #15, regional DON to unit Melrose's nourishment room. The surveyor found a plastic bag with room [ROOM NUMBER] and the resident's name written on the outside of the bag but no date and time for the expiration of the food items was visible. At 11:27 AM staff #15 escorted the surveyor to unit [NAME] unit nourishment refrigerator. The surveyor found a food item in a plastic bag without a label and date, a plastic bag of green grapes was unlabeled as well.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 11:32 AM staff #15 escorted the surveyor to the Joppa clinical unit whose nourishment refrigerator was located behind the nurses' station and the temperature was 52 degrees. The surveyor observed that a container of a resident's food (baked scalloped potatoes) that was brought from home was greater than 3 days old based on the black marker.</p> <p>During an interview with the facility administrator, the administrator stated that he does not perform direct supervision of the contracted kitchen staff. However, if there pending issues then he would confer with the kitchen staff.</p> <p>The deficient practices related to the kitchen were discussed with the administrative staff during the exit interview.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50904</p> <p>Based on record review and interview with facility staff, it was determined that the facility failed to ensure that resident's medical records were accurately documented in accordance with accepted professional standards. This was evident for 1 (Resident #68) out of 8 resident's records reviewed during the survey.</p> <p>The findings include:</p> <p>On 07/22/24 at 03:12 PM, during an interview with Resident #68's daughter, she told surveyors that the resident had lost some weight.</p> <p>On 07/24/24 at 09:01 AM surveyors reviewed the section K of the Minimum Data Set (MDS) assessment dated [DATE] and it showed that Resident #68 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months.</p> <p>On 07/24/24 at 09:05 AM, surveyors reviewed Resident #68's weights in the Electronic Health Record and discovered significant weight discrepancies. On 03/05/25, it was recorded that resident weighed 151.9 lbs and a month later, on 04/1/24, it was recorded that the resident weighed 150.3 lbs. On 04/02/24 (one day later), it was recorded that the resident weighed 138.8 lbs. And on 04/04/24 (two days later), it was recorded that the resident weighed 134.6Lbs with inconsistency in the weighing scales used (wheelchair, Hoyer and mechanical lift). Later weights were as follows: 4/10, 144.4 lbs; 4/17, 145.8 lbs; 4/25, 146.0 lbs.</p> <p>The dietician's note on 04/04/24 stated weight warning, weight value of 138.8lbs, nursing manager made aware to obtain a reweigh, she also added that she would follow up when reweight was obtained. No other notes were seen for the weight discrepancy between 04/01 and 04/03/24.</p> <p>On 07/24/24 at 10:39 AM surveyors discussed the findings with the Director of Nursing (DON), and she stated that the facility uses different types of weighing scale for residents and listed that the facility had a standing scale, mechanical lift, Hoyer lift and another scale that wheelchairs were rolled into. She added that when residents are newly admitted, the Hoyer lift is used but during the second day weighing, some of the residents refuse the Hoyer, therefore a mechanical lift is used. When shown the discrepancy in the weights from 04/01/24 to 04/04/24, she stated it was impossible for a resident to lose about 12 pounds in one day. She also stated that it was a documentation error made by RN #54 which the facility failed to correct and confirmed that an education would be given to the staff and other staff members on accurate documentation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>21859</p> <p>Based on observations and interviews with facility staff it was determined the facility failed to ensure that infection control practices were maintained to prevent the spread of germs and transmission of microorganisms. This was evident for 1 (Resident #39) of 37 residents reviewed and found to be present when observations were made during the survey.</p> <p>The findings include:</p> <p>1) On 7/26/24 at 11:30 AM an observation was made of the food on the floor in the Atrium near the dining room. There were round substances that resembled meatballs that were noted underneath the equipment stored in a cove in this area. Along a side wall there was a splatter noted to the base boards. The Administrator who was walking past the area at the time of the observation was made aware. The Administrator stated that he would have housekeeping services clean the area. Housekeeping services arrived at 11:40 AM to clean the area.</p> <p>2) An observation was made on 7/30/24 at 11:40 AM of the hallway that leads to the laundry area and kitchen. Trash was observed on the floor and the floor was dirty with large dark marks noted along the length of the floor. There was an entrance door leading into the main kitchen along this hallway. The door was open and there was a large area of standing water noted on the floor. A linen cart was observed uncovered in the entrance way of the clean linen room and the hallway, confirmed by Laundry Staff # 69 to be a clean linen cart. There was a large fan located in the hallway, next to the uncovered, clean linen cart that was blowing air, causing the trash and particles observed on the floor to blow around in the hallway.</p> <p>The Administrator was made aware of the concern on the same date at 11:55 AM and he stated that he would inform housekeeping services to clean the area.</p> <p>All concerns were discussed with the Administration team at the time of exit on 7/31/24 at 4:00 PM.</p> <p>30440</p> <p>3) On 7/19/24 at 2:21 PM Licensed Practical Nurse (LPN) #14 was observed holding a medication capsule in his bare hand and a cup of water with a spoon inside in the other hand. The surveyor did not observe the nurse wearing a glove on either of his hands. In an interview with LPN #14 when asked about the medication, he stated it is Gabapentin for Resident #39. During the interview when asked if it ever appropriate to handle and hold a resident's medications without gloves, LPN #14 stated I did not touch the medication itself. I just touched the capsule, not the actual medication inside of it. Also, I just washed my hands. When asked for clarification if it is ever appropriate for a nurse to handle and hold a resident's medications without gloves, LPN #14 stated No, it is not ok for a nurse to ever touch a resident's medication.</p> <p>At that moment, 7/19/24 2:32 PM, the Assistant Director of Nursing (ADON) was observed walking down the hallway by the elevator on the first floor. In an interview with the ADON when asked if it is ever appropriate for facility staff to handle and hold a resident's medication without gloves, she stated, No.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Medication Administration, on 7/22/24 at 8:15 AM revealed number 13. Remove medication from source, taking care not to touch medication with bare hand.		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30440</p> <p>Based on observations and interviews with facility staff it was determined the facility failed to ensure that the resident's environment was maintained in a safe and homelike manner. This was found to be evident for multiple residents that resided in rooms (#121, 122, 123, 124, 126, 219 and 226) of 7 resident rooms observed during the facility's survey.</p> <p>The findings include:</p> <p>MD00178628 was reviewed on 7/25/24 at 9:30 AM for multiple concerns including concerns regarding the resident's physical environment.</p> <p>On 7/25/24 at 11:50 AM a tour of the building was conducted and while touring the first floor the following concerns were identified:</p> <p>Observations were made of the air conditioner (ac) units in the following rooms: #121, #123, #124 and #126 and there was dust, dirt and debris present on the front of the units and inside along the screen filters.</p> <p>On the same date at 12:10 PM the Administrator (Staff #1) and the Director of Nursing (DON) (Staff #2) was made aware of the concerns that were observed and summoned the Maintenance Assistant (MA) (Staff # 62) to accompany the surveyor and administration team to the first floor. The Administrator confirmed the above-mentioned findings and stated that the maintenance assistant will do an assessment of all the rooms and the AC units and start the process of cleaning them. The surveyor requested to see maintenance logs for the past 6 months.</p> <p>On 7/25/24 at 2:10 PM the Administrator submitted a copy of the facility's current maintenance log with a date of 7/24/24. The Administrator stated that monthly maintenance is done to air conditioner units, and provided maintenance logs for January, April and May 2024. There was no maintenance log provided for February, March and June 2024.</p> <p>On 7/29/24 at 11:38 AM the survey team observed the AC unit in room [ROOM NUMBER] that had a tan/brown substance noted on the front of the unit and the AC unit in room # 219 had dust, dirt and debris noted inside the front of the AC unit.</p> <p>An interview was conducted with the Administrator on 7/29/24 at 11:50 AM and he was made aware of the identified concern and stated that maintenance will be conducting an audit of the second floor and the units will be cleaned.</p> <p>All identified concerns were discussed with the Administration team at the time of exit on 7/31/24 at 4:00 PM.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>30440</p> <p>Based on observations and interviews of facility staff it was determined the facility failed to ensure an effective pest control program as flies and fruit flies were observed throughout the building. This was found to be evident during the facility's survey.</p> <p>The findings include:</p> <p>1) Observations were made of flies noted in the conference room on July 23, 24, 25, 26, 29, 30 and 31, 2024. The conference room is located on the first floor along the hallway where resident rooms are also located.</p> <p>On July 25, 2024, at 11:50 AM flies were observed in the hallway along the first floor, and in resident rooms # 121, and 123. Flies were also observed in the bathroom located between these rooms.</p> <p>On the same date at 12:10 PM the Administrator (Staff #1) and the Director of Nursing (DON) (Staff #2) was made aware of the concerns that were observed, and the Administrator summoned the Maintenance Assistant (MA) (Staff # 62) to accompany the surveyor and administration team to the first floor. The Administrator confirmed the above-mentioned findings.</p> <p>Review of the pest control service summary report on the same date at 1:00 PM revealed the following:</p> <p>An invoice for 7/24/24 for general pest control maintenance. Further review of the report indicated that on 6/17/24 standing water was noted in the main kitchen which was noted to be conducive for small fly activity.</p> <p>On 7/30/24 at 11:40 AM during an observation of the hallway leading into the kitchen and laundry area, standing water was noted on the floor in the main kitchen area. (Cross Reference F-880) Please note that the hallway is located on the first floor and near resident rooms and the conference room where flies were observed.</p> <p>The Administrator was made aware of this finding immediately.</p> <p>All concerns were discussed with the Administration team at the time of exit on 7/31/24 at 4:00 PM.</p> <p>49304</p> <p>2) During the survey multiple observations were made of flies and fruit flies throughout the building.</p> <p>On the first day of the survey on 7/19/24, surveyors were placed in one of the facility's rooms with multiple flies and fruit flies observed in the room.</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/19/24 at 8:56 AM flies and fruit flies were observed in Resident #78's room circling and landing on the resident and his/her bedside table. There was also a spiral, yellow, sticky paper with dead flies and fruit flies adhered to it that hung to the left of the resident's bed.</p> <p>On 7/19/24 at 1:18 PM in an interview with the Nursing Home Administrator (NHA), he was made aware of the flies and fruit flies in the residents' rooms and throughout the facility.</p> <p>07/31/24 11:39 AM in an interview the NHA, he was again made aware of the flies and fruit flies. He stated Resident #78 engages in behaviors which contributes to the issue, but he will look into it.</p>		