STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215077	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ruxton	7001 Charles Street Towson, MD 21204

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on interview, record review, and policy review, the facility failed to ensure a grievance was adequately documented and investigated to ensure satisfactory resolution for one of 32 sampled residents (Resident (R) 97). This failure had the potential to cause dissatisfaction with care, feelings of helplessness, and fear for R97. Findings include: Review of R97's Admission Record, located under the Profile tab of the electronic medical record (EMR) revealed s/he was admitted to the facility on [DATE]. Review of R97's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/12/24 and located in the MDS tab of the EMR, revealed the facility assessed the resident to have a Brief interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. S/he did not exhibit any mood or behavioral symptoms. Review of R97's Care Plan, dated 11/07/23 and located in the Care Plan tab of the EMR, revealed, Problematic manner in which resident acts characterized by ineffective coping; Demands attention related to: repeatedly using call light to get staff into room, calls [family member] on phone repeatedly [with] unfounded complaints, reporting staff not caring for him/her when care is provided. The approaches included: Document summary of each episode and Maintain standard routines. Do not allow resident to dictate schedule. During an interview with R97 on 10/22/24 at 9:54 AM, s/he stated the last time s/he saw Certified Nurse Aide (CNA) 6, which was right after a state agency complaint investigation, CNA6 entered his/her room and stated, You need to watch what you say to people outside of here because I know people. R97 added, I don't know why she said that. I told her I don't talk to anyone besides my [family member]. I'm not afraid but I'm sure she's mad at me. R97 reported this to his/her family member, who filed a grievance with the facility. R97 stated CNA6 had not worked with him/her since then. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R97's Complaint/Grievance Form, dated 09/25/24 and provided on paper by the facility, revealed R97's family member (F1) filed a grievance with the Assistant Director of Nursing/Infection Preventionist (ADON/IP). The form documented, Expressed mother does not want [CNA] working with him/her because she has a poor attitude. The specific allegations and details were not documented. The grievance was referred to the Somerset Unit Manager (SUM) for follow up, and the SUM documented, Resident did not voiced [sic] any concerns at this time. Under Resolution was documented, [CNA6] will no longer be assigned to work with [R97]. Education provided on professionalism and customer service. The form was signed by the Administrator on 09/25/24. An attached statement from CNA6, dated 09/25/24, documented, On Tuesday night I went to go answer [R97's] light. She asked to be changed. I checked her she wasnt [sic] wet. I ask [sic] my nurse to check her as well an she confirmed she wasnt [sic] wet but I still changed her. Once I was completed, she said thank you an [sic] I left. An attached statement from Licensed Practical Nurse (LPN) 5 dated 09/25/24 documented, I charge nurse [LPN5] was in the room with assigned aide while changing [R97's incontinence brief]. Assigned aide did changed [sic] the [incontinence brief] with no any concern or issues. Resident [incontinence brief] was not wet, however I personally asked the aide to change her anyway, and she did changed [sic] her as instructed. There was no additional investigation documented, including interviews with other residents who received care from CNA6, or specific information provided by F1. In an interview on 10/24/24 at 10:47 AM, the SUM stated he did not speak with F1, he only interviewed R97. He stated he asked R97 if she had any concerns regarding care, and she stated she did not. The SUM stated he did not ask specifically about CNA6 and R97 never mentioned CNA6. The SUM stated he did not interview any other residents who CNA6 had worked with. In an interview on 10/24/24 at 11:00 AM with F1, she stated she had reported to the ADON/IP that CNA6 had made threats to R97 about keeping quiet to outside visitors, as she knew the state surveyors had been in to talk to the resident and CNA6 stated, You better not get me fired. She stated she felt this was verbal abuse and made R97 fearful of retaliation from CNA6. F1 stated the facility told her that CNA6 would be assigned to work on a different unit and would no longer work with R97. She stated she spoke with the Administrator at this point and told him the resolution was unacceptable because CNA6 could continue to abuse other residents or freely go up to R97's unit and retaliate against R97. F1 stated she told the administrator the CNA needed to be walked out of the building and not allowed to return due to her abusive behavior. F1 stated she was not satisfied with the resolution to the grievance and felt like the facility did not take her report seriously. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/24 at 12:49 PM, the ADON/IP stated she did not recall the specifics of the grievance from R97's daughter, but stated she thought it was something to do with the resident requesting CNA6 to take out the trash, and CNA6 responded that housekeeping staff would do that and left the room. The ADON/IP stated, I don't recall exactly; it had to do with the trash can and poor attitude. The ADON denied hearing a complaint regarding CNA6 threatening R97 not to speak with people outside of the facility. When this allegation was reported, the ADON/IP stated she would consider this verbal abuse due to the threatening nature, and she would follow all the steps to suspend CNA6 pending investigation, report the allegation to authorities as required, and complete a thorough investigation. The ADON/IP stated she would have expected the SUM to ask questions specifically regarding CNA6 to R97 and other residents, as she was named in the grievance. During an interview on 10/24/24 at 4:17 PM, the Director of Nursing (DON) stated R97 was a very difficult resident because she could be manipulative by making false accusations. The DON stated at times, what R97 reported to the facility and reported to her daughter have differed. The DON stated additional residents should have been interviewed regarding this grievance; however, they were now being done as part of the abuse investigation. The Administrator was unavailable for interview on 10/24/24. Review of the facility policy titled, Resident and Family Grievances, dated 12/23/22, revealed, The facility will not prohibit or in any way discourage a resident from communicating with external entities including federal and state surveyors or other federal or state health department employees . The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form . [and] take any immediate actions needed to prevent further potential violation of any resident right . The Grievance Official will take steps to resolve the grievance, and record information about the grievance and those actions on the grievance form . The grievance official will issue a written decision on the grievance.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, interviews, record review, and policy review, the facility failed to ensure an ongoing program of meaningful activities was designed for one of one resident (Resident (R) 113) reviewed for activities out 32 sampled residents. This failure had the potential to contribute to feelings of boredom, depression, loneliness, or helplessness for R113. Findings include: Review of R113's Admission Record, located under the Profile tab of the electronic medical record (EMR) revealed s/he was admitted to the facility on [DATE] with diagnoses which included dementia, anxiety, and insomnia. Review of R113's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/15/24 and located in the MDS tab of the EMR, revealed the facility assessed the resident to have a Brief Interview for Mental Status score of zero out of 15 which indicated the resident was severely cognitively impaired. S/he did not exhibit any mood symptoms but wandered daily. R113 was dependent on staff for all activities of daily living other than eating. Review of R113's annual MDS with an ARD of 05/15/24 and located in the MDS tab of the EMR, revealed it was very important to the resident to participate in music and religious activities and it was somewhat Important to go outside and participate in his/her favorite activities. Keeping up with the news was listed as not very important. Review of R113's Activity Quarterly Review, dated 06/27/24 and located in the Evaluations tab of the EMR, revealed, [R113] is provided & engages in one-on-one visits. S/he participates as a passive observer . S/he is receptive & appears to enjoy music and social visits with staff & music therapy sessions . Residents Activity-Related Focus(es) including Needs, Strengths and Preferences: remain appropriate/current as per care plan.Goals were met . Interventions/approaches have been effective in reaching goals. Review of R113's Care Plan, dated 06/05/24 and located in the Care Plan tab of the EMR, revealed, [R113] may need consistent encouragement to participate in structured activities. The approaches included: Will invite/encourage and assist resident to programs of potential interest and Will use an even-voiced, calm approach slow speech & [and] movements. The Care Plan did not address provision of one-to-one visits or music therapy sessions, or address his/her identified interests of religion, music, going outdoors, and doing his/her favorite activities. During an observation on 10/21/24 at 2:09 PM in R113's room, the resident was seated in his/her wheelchair in the corner of the room facing the wall. There was an empty water cup in front of him/her and a Bible on his/her nightstand, but not within reach. The TV was off and there was no music playing. R113 was unable to respond to questions but began singing gospel music when spoken to, while laughing and smiling. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/22/24 from 9:52 AM to 10:56 AM in R113's room, the resident was seated in his/her wheelchair facing the window with a table in front of him/her. There was no TV or music on in the room. There was a Bible on the resident's nightstand, not within his/her reach. During an observation on 10/22/24 from 2:55 PM to 4:00 PM in R113's room, the resident was seated in his/her wheelchair in the center of the room facing the TV. The TV was on and turned to the news. During an observation on 10/23/24 from 9:04 AM to 11:54 PM in R113's room, the resident was seated in his/her wheelchair facing the TV. The TV was on and turned to the news, but the resident was asleep. During an observation on 10/24/24 from 8:30 AM to 9:30 AM in R113's room, the resident was lying asleep in bed. During an observation on 10/24/24 at 11:49 AM in R113's room, the resident was seated in his/her wheelchair facing the TV, which was tuned to the news. In an interview on 10/24/24 at 10:10 AM, the Activity Director stated R113 typically preferred to stay in his/her room and preferred not to leave the unit floor to go to activity groups. S/he stated R113 was seen daily for reality orientation when the activity staff read the Daily Chronicle to him/her, which she stated were his/her one-to-one visits for 10 to 15 minutes a day. She also stated a music therapist visited twice monthly and would see R113 on these visits. The AD stated she did not have any activity participation records or documentation of one-to-one visits for R113. She stated she was unaware she needed to document provision of activities and resident response but had been told earlier in the week to begin doing so. The AD stated she would provide the record of music therapy visits, as the contracted music therapist documented their visits. On 10/24/24 at 11:32 AM, the AD provided the music therapist's documentation which showed an attempted visit on 07/19/24 when the resident was not in his/her room and a visit on 08/02/24. The AD stated she would expect these sessions to be done more often with R113, at least once every two weeks. The AD stated R113's only other activity participation was the 10-to-15-minute delivery and reading of the Daily Chronicle. Review of the facility's policy titled, Activities, dated 12/22/22, revealed, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community . Each resident's interest and needs will be assessed on a routine basis . Activities will be designed with the intent to: Enhance the resident's sense of well-being, belonging, and usefulness, . Promote or enhance emotional health, . reflect resident's interests and age, . [and] reflect cultural and religious interests of the resident. Special considerations will be made for developing meaningful activities for residents with dementia.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, interviews, record review, and policy review, the facility failed to ensure a splint was applied to address a hand contracture for one of five residents (Resident (R) 71) reviewed for limited range of motion out of 32 sampled residents. This failure had the potential to lead to increased contracture, pain, or skin breakdown for the resident. Findings include: Review of R71's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed s/he was admitted to the facility on [DATE] and had diagnoses which included stroke with resulting hemiplegia and hemiparesis on the left side, muscle spasm, muscle weakness, and vascular dementia. Review of R71's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/21/24 and located in the MDS tab of the EMR, revealed the facility assessed the resident to have a Brief Interview for Mental Status Score (BIMS) of 15 out of 15 which indicated the resident was cognitively intact. S/he did not exhibit any mood or behavioral symptoms. R71 had impaired range of motion on one side of his/her body in both the upper and lower extremities. Review of R71's OT [Occupational Therapy] Discharge Summary dated 03/01/24 and provided on paper by the facility revealed R71 was treated for a left hand contracture (fixed resistance to passive stretch of a muscle) with goals of increasing range of motion in his/her left fingers and to increase tolerance of a positioning device in the left hand. At the beginning of therapy services, on 01/25/24, R71 was unable to use his/her current palm guard. During treatment on 02/15/24, R71 was able to wear a carrot splint in the left hand for up to four hours with no discomfort. The summary also revealed upon discharge on 03/01/24, R71 was wearing the carrot splint at all times except during bathing activities. The discharge recommendation was, Pt [resident] to wear left carrot orthosis at all times except during bathing activities. Review of R71's Care Plan, dated 05/16/24 and located in the Care Plan tab of the EMR, revealed, Alteration in musculoskeletal status r/t [related to] contracture. The approaches included: Give analgesics [pain medications] as ordered by the physician. Monitor and document for side effects and effectiveness . Monitor report to MD [physician] s/sx [signs/symptoms] or complications related to arthritis: joint pain; joint stiffness, usually worse on wakening; swelling; decline in mobility; decline in self-care ability; contracture formation/joint shape changes; crepitus (creaking or clicking with joint movement); pain after exercise or weight bearing . [and] Passive range of motion. The Care Plan also documented, [R71 has] ADL [activities of daily living] self-care/mobility deficits as evidenced by physical limitation related to disease process, left-sided hemiplegia, degenerative disc disease. The approaches included: Restorative Palm protector: Incorporate AAROM [assisted active range of motion] to Left UE [upper extremity] and Lower Extremities during ADLS and 'Wash hands daily after splint use, use soap and water. The Care Plan had not been updated to reflect the discontinuation of the palm protector and use of a carrot orthosis at all times except during bathing. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R71's EMR under the Orders tab revealed there was no current physician's order for use of a carrot orthosis or any device in the left hand. Review of R71's Kardex, dated 10/24/24 and provided on paper by the facility revealed, Restorative palm protector and wash hands daily after splint use. In an interview on 10/22/24 at 10:31 AM, R71 stated his/her left hand was contracted into a fist and was bothersome and painful. S/he stated s/he used to receive range of motion exercises when s/he was working with therapy, but that no longer was done since his/her therapy discharge. R71 also stated s/he used to use a splint in the left hand, but that had not been used for a long time. R71 stated s/he did not think s/he could get a splint into his/her hand anymore, as it had gotten tighter and more painful. R71 stated it had been months since s/he had worn a splint, but s/he would be willing to do anything to help his/her hand feel better. R71's left hand was observed balled into a fist with the tips of his/her fingers in contact with the palm of the hand. R71 was unable to move his/her fingers or open his/her hand. S/he was not wearing a splint in his/her hand. During observations of R71 in his/her room on 10/23/24 at 9:20 AM and 10/24/24 at 9:10 AM, s/he did not have a splint on his/her left hand. In an interview on 10/24/24 at 2:00 PM, Occupational Therapist (OT) 1 stated while in therapy s/he was able to get R71's left hand to stretch enough to use the carrot at all times, and his/her discharge recommendation was to continue use of the carrot. OT1 stated there should be a physician's order for the use of the carrot. OT1 also stated she did train with the regular staff on applying the carrot, who would then need to pass the training down to any new agency staff that came in. OT1 stated she met with R71 today, because s/he reported s/he was not using a carrot and had not for some time. She stated R71's left hand seemed tighter, and s/he was only able to get a piece of gauze into the hand rather than the carrot orthosis. OT1 stated it was time to look at further intervention, such as nerve blocks or consultation with a hand specialist. OT1 stated she was unsure how long the resident had not been using the carrot orthosis and thought it had been reported lost a few times. She stated the biggest risk for R71 when not using a device in the left hand is a breakdown in skin integrity, as his/her fingers could dig into his/her palm. In an interview on 10/24/24 at 3:18 PM, Licensed Practical Nurse (LPN) 9 stated she was aware of R71's carrot not being applied today. LPN9 stated she remembered R71 had a device for his/her left hand but could not recall how long ago it had been since it had been applied. In an interview on 10/24/24 at 3:34 PM, the Somerset Unit Manager (SUM) stated he had been working on the floor since July 2024 and had not seen any carrot or splint used for R71. The SUM stated if a device was to be used, there should be a physician's order so the staff could document application and removal and assessment of the skin upon removal. In a concurrent interview on 10/24/24 at 3:55 PM with the Director of Nursing (DON) and Assistant Director of Nursing/Infection Preventionist (ADON/IP) the DON stated she did not always expect a physician's order for use of a splint or device as long as it was reflected in the Care Plan. The DON stated the resident's Care Plan directed staff to apply a palm protector. The ADON added R71's Kardex instructed staff to apply a palm protector. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/24 at 4:48 PM, the Director of Rehab (DOR) stated though R71's hand felt tighter, the contracture had not worsened; range of motion exercises could stretch the hand to be able to use the carrot. The DOR stated the goal of the carrot was promoting hand hygiene and skin integrity, as there was nothing that could be done to release the contracture. The DOR stated R71 came to the facility with his/her hand contracted in the state it is currently and it had not gotten worse. The DOR stated she would input an order for the use of the carrot, and it could be used until R71 was able to see a hand specialist. Review of the facility's policy titled, Prevention in Decline in Range of Motion, dated 01/27/23, revealed, Interventions will be documented on the resident's person-centered care plan. Documentation should include, but not limited to: Type of treatments; Frequency and duration of treatments; Measurable objectives; [and] Resident goals. A nurse with responsibility for the resident will monitor for consistent implementation of the care plan interventions. Refusals of care or problems associated with range of motion will be documented in the medical record. Review of the facility's policy titled, Use of Assistive Devices, dated 12/14/22, revealed, Assistive devices include . orthotic or prosthetic equipment .Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices . Direct care staff will be trained on the use of the devices . a nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622 Based on observation, interview, record review, and facility policy review, the facility failed to provide respiratory care in accordance with professional standards for four of four residents (Residents (R) 18, R22, R120 and R357) reviewed for respiratory care out of 32 sampled residents. This failure had the potential for the residents to be subjected to contaminated respiratory equipment and to not receive proper airflow. Findings include: Review of the facility's policy titled, Oxygen Administration, dated 01/27/23, documented . (5.a) follow the manufacturer recommendations for the frequency of cleaning equipment filters . (5, e.) keep delivery devices covered in plastic bag when not in use. A copy of the manufacturer guidelines was not provided by the facility. 1. Review of R18's undated Admission Record located under the Profile tab of the electronic medical record (EMR), revealed R18 was admitted on [DATE] with diagnoses which included pneumonia due to other specified infectious organisms and chronic obstructive pulmonary disease (COPD) with (acute) exacerbation. Review of R18's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 08/10/24, located in the EMR under the MDS tab, revealed R18 had a Brief Interview for Mental Status (BIMS) score of six out of 11, which indicated the resident was moderately cognitively impaired. Review of R18's Order Summary Sheet, located in the EMR under the Orders tab, dated October 2024, did not indicate how often the oxygen concentrator should be cleaned. Review of R18's Medication Administration Record (MAR) dated October 2024 did not indicate how often the oxygen concentrator or filter should be cleaned. Review of R18's Care Plan, dated 08/06/24, located in the EMR under the Care Plan tab, revealed the following: R18 has altered respiratory status/difficulty breathing r/t [related to] COPD, respiratory failure with hypoxia, pneumonia of the left lower lobe and administer medications. During an observation 10/21/24 at 11:30 AM, R18's oxygen concentrator was dusty. During an observation on 10/22/24 at 8:44 AM, R18's oxygen concentrator was still dusty. During an observation on 10/22/24 at 3:49 PM, R18's oxygen concentrator was still dusty. During an interview on 10/22/24 at 3:49 PM, R18 stated the staff did not clean his/her oxygen machine. During an observation and interview on 10/22/24 at 4:00 PM, the Assistant Director of Nursing (ADON) verified the oxygen concentrator was dusty. The ADON did not know how often the concentrators should be cleaned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R22's Admission Record, located under the Profile tab of the EMR, revealed R22 was admitted [DATE] with diagnoses which included obesity and acute on chronic diastolic congestive heart failure (CHF). Review of R22's admission MDS with an ARD of 08/16/24 located in the EMR under the MDS tab with an ARD of revealed the resident had a BIMS of six out of 15, which indicated R22 was severely cognitively impaired. Review of R22's Order Summary Sheet, located in the EMR under the Orders tab, dated October 2024, did not indicate how often the oxygen concentrator should be cleaned. Review of R22's Care Plan located in the EMR under the Care Plan tab, dated 03/20/24, revealed R22 has altered respiratory status/difficulty breathing r/t COPD and provide oxygen as ordered. During an observation on 10/21/24 at 2:45 PM, R22's oxygen concentrator was dusty, and the filter had a build-up of dust on it. During an observation on 10/22/24 at 3:08 PM, R22's oxygen concentrator was dusty, and the filter had a thick build-up of white dust on it. During an interview on 10/22/24 at 3:44 PM, Licensed Practical Nurse (LPN) 1 verified the filter was covered with dust and the concentrator was dusty. LPN1 did not know how often the filter or machine should be cleaned. 3. Review of R120's Admission Record, located under the Profile tab of the EMR, revealed R120 was admitted [DATE] with diagnoses which included COPD, primary pulmonary hypertension, and asthma. Review of R120's quarterly MDS with an ARD of 10/07/24 and located in the EMR under the MDS tab revealed the resident had a BIMS of 14 out of 15 which indicated the resident was cognitively intact. Review of R120's Order Summary Sheet, located in the EMR under the Orders tab, dated October 2024 did not indicate how often the oxygen concentrator should be cleaned. During an observation on 10/21/24 at 3:16 PM, R120's oxygen concentrator and filter were dusty. The filter was covered with a thick layer of white dust. During an observation on 10/22/24 at 10:00 AM, R120's oxygen filter was covered with a thick layer of dust which will block air flow. During an observation on 10/22/24 at 3:32 PM, R120's oxygen filter was covered with white dust. During an interview on 10/22/24 at 3:41 PM, LPN1 verified the filter was covered with dust and the machine was dusty. LPN1 did not know how often the filter or machine should be cleaned. During an interview on 10/22/24 at 4:30 PM, the Director of Nursing (DON) stated she did not know how often the oxygen concentrator or filters should be cleaned. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R357's undated Admission Record located under the Profile tab of the electronic medical record (EMR), revealed R357 was admitted to the facility on [DATE] with diagnoses which included traumatic subdural hemorrhage with loss of consciousness, and sequela cerebral infarction, unspecified. Review of R357's admission Minimum Data Set (MDS), with an assessment reference date (ARD) of 07/29/24, located in the EMR under the MDS tab, revealed R357 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R357 was cognitively intact. Review of R357's Medication Administration Record (MAR) dated September 2024, revealed R357 was administered Nocturnal Oxygen & Aerosol Trach Collar: The resident to receive supplemental Oxygen via ATC while sleeping and PRN if needed for increased WOB [without breath] or SOB [shortness of breath]. Settings are at 40%/3LPM [liters per minute] (Compressor/Concentrator). Review of R357's Care Plan, dated 07/23/24, located in the EMR under the Care Plan tab, revealed the following: R357 has Tracheostomy r/t [related to] Impaired breathing mechanics, airway compromise, acute respiratory failure, respiratory arrest. Give humidified oxygen as prescribed, Use universal precautions. Assist with coughing as needed. During an observation 10/22/24 at 9:33 AM, R357's oxygen mask was laying on the bedside table, and the resident's tracheostomy collar was hanging on hook of the machine. During an observation 10/22/24 at 1:30 PM, R357's oxygen mask was laying on the bedside table, and the resident's tracheostomy collar was hanging on hook of the machine. During an observation on 10/23/24 at 12:15 PM, R357's tracheostomy collar was hanging on hook of the machine. During observation on 10/22/24 9:33 AM The O2 mask laying on bedside table, Trach collar hanging on hook of machine. During an on 10/23/24 at 2:30 PM, when asked how do you store the oxygen mask and the R357's trach collar, LPN4 stated, You would store them in a clean place. During an interview on 10/23/24 at 2:45 PM, when asked how do you store oxygen masks and R357's trach collar, The ADON stated, O2 [oxygen] masks and a trach collar would be stored in a clean clear plastic bag. The DON who was present during the interview added if the masks and/or the trach collar were left out of a bag, they would need to be replaced.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on record review, interview, and facility policy review, the facility failed to ensure residents received appropriate supervision during medication administration for three of 161 residents (Resident (R) 122, 97, and 103) reviewed during initial tour. This failure could result in unwarranted medication side effects and mismanaged medical conditions. Findings include: Review of the facility's policy titled, Medication Administration, implemented 12/14/22, revealed Observe resident consumption of medication. Review of the facility's policy titled, Medication Storage, implemented 12/14/22, revealed During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. Review of R122's undated Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R122 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, unspecified, type 2 diabetes mellitus without complications, hyperlipidemia, essential hypertension, and depression. 1. Review of R122's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 07/22/24, revealed R122 had a Brief Interview for Mental Status (BIMS) score of three out of 15 which indicated the resident was severely cognitively impaired. R122 was coded for total dependence on staff for most activities of daily living. Review of R122's Care Plan located under the Care Plan tab of the EMR, last revised 03/17/24, revealed care planning for impaired cognitive function with an intervention to administer medications as ordered. Review of R122's Physician Orders located under the Orders tab in the EMR, revealed orders for numerous morning medications including metformin (antidiabetic agent), amlodipine (antihypertensive), aspirin, atenolol (antihypertensive), losartan (antihypertensive), Myrbetriq (for overactive bladder), sertraline (antidepressant agent), docusate (stool softener), pantoprazole (for reflux disease), sennosides/docusate (laxative), and chlorpromazine 25 mg (antipsychotic agent for hiccups). Review of R122's Medication Administration Record (MAR), dated 10/2024 and located under the Reports tab in the EMR revealed R122 received metformin, amlodipine, aspirin, atenolol, losartan, Myrbetriq, sertraline, docusate, pantoprazole, sennoside/docusate capsule, and chlorpromazine for the morning doses on 10/21/24. During observations on 10/21/24 from 11:00 AM to 11:32 AM, R122 was observed sitting up in bed with a medication cup in front of him/her on a bedside table. The medication cup contained approximately 10 dosage forms. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 10:01 AM R122's roommate, R31 (BIMS 15), stated the day before, the nurse had left R122's medication cup with R122 because R122 was not ready to take his/her morning medications. R31 stated when the nurse arrived around noon to give R31 his/her medications with lunch, R31 told the nurse that R122's medications were still on his/her table, so the nurse gave R122 his/her medications then. During an interview on 10/21/24 at 12:44 PM, Licensed Practical Nurse (LPN) 10 stated R122 did not want his/her morning medications so she set the medication cup down on the bedside table, got busy and forgot she had left the medication cup with R122. LPN10 stated she was expected to stay and observe residents take their medications. During an interview on 10/23/24 at 11:10 AM, the Director of Nursing (DON) stated it was the facility's policy to stay and observe residents to take their medication. The DON reviewed R122's electronic MAR (eMAR) which showed documentation by LPN10 that morning medications were administered on 10/21/24 at 10:34 AM. The DON confirmed LPN10 had documented medication administration for R122 prior to R122 taking his/her morning medications. The DON stated LPN10 should have documented the administration after observing R122 taking the medications. 2. Review of R97's Admission Record, located under the Profile tab of the EMR, revealed s/he was admitted to the facility on [DATE] with diagnoses including stroke, major depression, and chronic pain. Review of R97's quarterly MDS assessment, with an ARD of 09/12/24 and located in the MDS tab of the EMR, revealed s/he scored 15 out of 15 on the BIMS, indicating intact cognition. S/he did not exhibit any mood or behavioral symptoms. Review of R97's Care Plan, dated 10/10/24 and located in the Care Plan tab of the EMR, revealed, The resident has a behavior problem r/t [related to] not allowing staff to check his/her blood sugar, refusing showers, refusing to get out of bed, refuses medications, refusing bowel regimen. The approaches included, Administer medications as ordered. Monitor/document for side effects and effectiveness and Reoffer medication/treatment after few mins [minutes]. Review of the Care Plan revealed it did not address the resident's ability to store medications in his/her room or self-administer medications. During an observation of R97's room on 10/22/24 at 9:54 AM, R97 was in the bathroom and there was a medicine cup, visible from the hallway, containing eight pills of assorted shapes and colors. In an interview with R97 on 10/22/24 at 9:56 AM, R97 stated the nurse had recently brought the pills to his/her room; however, s/he was not ready to take them yet and told the nurse to come back later. S/he stated the nurse typically did not leave pills unattended in his/her room and watched him/her take his/her pills. In an interview on 10/22/24 at 9:58 AM in R97's room, Licensed Practical Nurse (LPN) 1 verified there was a cup containing eight pills on the bedside table in R97's room, unsupervised by staff. LPN1 stated R97 was not ready to take his/her pills and wanted to wait, so s/he left the pills in R97's room and went to the nurses' station to do paperwork. LPN1 stated these were R97's morning medications and included several vitamins and blood pressure medications. LPN1 stated she should not leave pills unattended in the resident's room, and she should observe as residents take their medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R97's EMR under the Orders tab revealed s/he did not have an order to self-administer medications. Review of R97's Evaluations tab of the EMR revealed there was no assessment of the resident's safety with storing medications in his/her room or self-administering medications. During an interview on 10/24/24 at 4:06 PM, the DON stated in this situation, the nurse should have taken the medications out of the resident's room until the resident was ready to receive them. She stated she expected the nursing staff to observe residents taking their pills. 3. Review of R103's Admission Record, located in the Profile tab of the EMR, revealed s/he was admitted to the facility on [DATE] with diagnoses of vascular dementia, Alzheimer's disease, history of small strokes, and depression. Review of R103's quarterly MDS assessment, with an ARD of 09/28/24 and located in the MDS tab of the EMR, revealed s/he scored nine out of 15 on the BIMS, indicating moderate cognitive impairment. R103 did not exhibit mood or behavioral symptoms. During an observation of R103's room on 10/22/24 at 9:50 AM, a bottle of Claritin allergy medication, approximately 1/4 full, was on the bedside table next to the bed. The resident was not in the room. During an observation of R103's room on 10/23/24 at 9:25 AM, a bottle of Claritin and a bottle of Citrical calcium supplement were observed on the resident's bedside table. During an observation and interview on 10/24/24 at 9:37 AM in R103's room, LPN9 verified she found bottles of Claritin and Citrical on the resident's bedside table. LPN9 stated those medications should not be left in R103's room because s/he was confused and forgetful. LPN9 also verified R103 did not have orders for the Claritin or Citrical and s/he was not able to self-administer his/her medications. LPN9 stated the resident's daughter may have brought the medications in. During an interview on 10/24/24 at 4:06 PM, the DON stated R103's medications should not be stored in a resident's room, should be administered by the nursing staff, and should only be used with a physician's order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006 Based on observations, record review, interviews, and policy review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn for two of four sample residents (Resident (R) 107 and R205) reviewed for transmission-based or enhanced barrier precautions out of 32 sampled residents. These failures have the potential to contribute to spread of infection among staff and residents. Findings include: 1. Review of R107's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed s/he was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of gastritis and diarrhea. Review of R107's EMR under the Orders tab indicated a new diagnosis of recurring clostridium difficile (c-diff - an infection that causes diarrhea and colitis and forms spores that are highly transmissible), was added on 04/03/24 and revealed an order, dated 04/03/24, for contact isolation due to reoccurring c-didf [sic]. The orders also indicated R107 received an oral antibiotic (vancomycin) to address the c-diff. Review of R107's Care Plan, dated 08/28/24 and located in the Care Plan tab of the EMR, revealed, Infection of GI [gastrointestinal] tract - reoccurring c-diff. The approaches included, Infection Precautions: Contact Isolation for C-DIFF (reoccurring)(FYI). During an observation outside of R107's room on 10/22/24 at 9:39 AM, a yellow sign indicating Contact Precautions was posted on the room door and instructions to don (put on) a gown and gloves before entering the room were included. Certified Nurse Aide (CNA) 4 entered the room without donning a gown and gloves prior to entering the room. R107 was lying in bed, and CNA4 spoke to the resident at the bedside, opened the bathroom door and entered briefly, and exited the room. CNA4 did not don any PPE while in R107's room and did not perform hand hygiene after leaving the room. In an interview with CNA4 on 10/22/24 at 9:40 AM, she stated she did not know why the Contact Precautions sign was on R107's door, as she was told there were no residents in her assigned group that required precautions. She stated R107 had recently recovered from COVID-19, so the sign may have just been left up accidentally. CNA4 stated she was only required to don a gown and gloves when providing direct care to the resident. CNA4 stated if a resident was on Contact Precautions, she would don a gown and gloves prior to entering the room, and added, I know s/he's not on precautions. I think [the PPE] is just there for when I'm providing care. During an observation outside of R107's room on 10/22/24 at 4:17 PM, a yellow sign indicating Contact Precautions was posted on the room door and instructions to don a gown and gloves before entering the room were included. CNA3 and CNA5 both entered R107's room without donning a gown or gloves. R107 was in his/her bed. The CNAs conversed with the resident and give report, then exited the room. Neither CNA performed hand hygiene before moving on to enter the next room to give report. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/22/24 at 4:20 PM, CNA5 stated she did not know if R107 was on any precautions and stated, You should check with the nurse. CNA5 stated she did not typically work with this group of residents, and she was not told she needed to use PPE for residents in her assigned group. CNA5 stated if a resident required Contact Precautions, she would don a gown and gloves before entering the room. CNA3 stated she was from a staffing agency and stated she had not seen the Contact Precautions sign on the door. CNA3 stated a gown, and gloves should be worn when entering R107's room. During an observation outside of R107's room on 10/23/24 at 8:11 AM, a yellow sign indicating Contact Precautions was posted on the room door and instructions to don a gown and gloves before entering the room were included. CNA4 entered R107's room to deliver the breakfast tray and placed it on the bedside table and moved the table. CNA4 then exited the room and without performing hand hygiene, took another breakfast tray off the cart and delivered it to another resident's room. In an interview on 10/23/24 at 8:15 AM, CNA4 stated she did not don PPE to enter R107's room because she knew the resident did not have COVID and when asked whether R107 was on contact precautions, CNA4 stated, you would have to ask the manager. In a subsequent interview on 10/23/24 at 9:06 AM, CNA4 stated R107 was on precautions because s/he used a urinary catheter. When asked about the sign on the door instructing staff to use Contact Precautions, she stated, I don't know, that's just what I was told. During a concurrent interview on 10/24/24 at 4:21 PM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) and Director of Nursing (DON) stated R107 was on contact isolation related to a diagnosis of c-diff. The DON stated staff should don a gown and gloves any time they enter the resident's room to adhere to contact precautions. Review of the facility's policy titled, Transmission-Based (Isolation) Precautions, dated 09/01/24, revealed, An order for transmission-based precautions/isolation will be obtained for residents who are known or suspected to be colonized with infectious agents that require additional controls to prevent transmission effectively . Signage that includes instructions for use of specific PPE will be placed in a conspicuous location outside the resident's room . Contact Precautions: . Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. c-difficile). 2. Review of R205's Admission Record, located in the Profile tab of the EMR revealed s/he was admitted to the facility on [DATE] with diagnoses including multiple pressure ulcers and gastrostomy (an artificial external opening into the stomach for use with a feeding tube). Review of R205's EMR under the Orders tab revealed R205 received all nutrition and medication through the gastrostomy tube, used an indwelling urinary catheter, and had an open wound that required treatment. The Orders the physician's order, dated 10/14/24, Enhanced Barrier Precautions to be maintained at all times. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R205's Care Plan, dated 08/28/24 and located in the Care Plan tab of the EMR, revealed, [R205] requires enhanced barrier precautions for [indwelling urinary catheter], g- [gastrostomy] tube, [and] wounds. The approaches included, Ensure the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care and Staff to follow EBP [enhanced barrier precautions] for high-contact resident care activities include dressing, bathing/showering, transferring, toileting, providing hygiene, changing linens or briefs, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care. During an observation on 10/24/24 at 9:57 AM outside of R205's room a sign was posted on the room door instructing staff to follow Enhanced Barrier Precautions and don a gown and gloves while providing care. Upon entering the room, Licensed Practical Nurse (LPN) 1 was administering crushed medications and water flushes to R205, who was laying in bed, via gastrostomy tube. LPN1 was wearing gloves but was not wearing a gown. In an interview on 10/24/24 at 10:00 AM, LPN1 stated she was administering medications and water flushes via R205's gastrostomy tube. She stated only gloves were required because the enhanced barrier precautions were in place to address potential splashing during indwelling urinary catheter care. LPN1 stated a gown was not needed when administering medications via gastrostomy tube. In an interivew10/24/24 at 4:21 PM, the ADON/IP stated R205 was on enhanced barrier precautions and LPN1 should have donned a gown while administering medications and water flushes via gastrostomy tube. Review of the facility policy titled, Enhanced Barrier Precautions, dated 09/01/24, revealed, An order for enhanced barrier precautions will be obtained for residents with . wounds . and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes .). PPE for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact resident care activities include: . device care or use:. feeding tubes.