STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215081	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Perring Parkway	1801 Wentworth Road Baltimore, MD 21234

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined the facility failed to ensure a homelike environment. This was evident for 2 of 2 facility floors of the building during the facility's recertification survey. The findings include: During surveyor initial tour of the facility, upon entering the facility's lobby area on 11/24/2025 at 7:30AM, and again at 7:48AM surveyors noted a malodorous smell was present. Carpeting present within 2 out of 2 of the facility's floors was observed to be in worn condition with areas of the carpet's pattern no longer visible as compared to smaller adjacent areas. Surveyors observed dark grey areas and staining and debris present within the carpeting material. On 11/26/2025 at approximately 11:30AM the survey team noted a malodorous smell was present in the hallway near room [ROOM NUMBER]. On 11/26/2025 at 11:40AM a malodorous smell was found by the surveyor to be present in the hallway near the elevator on the first floor of the facility. On 11/26/2025 at 12:40PM the surveyor observed the front reception area desk with damage present to the front lower portion of the desk in several areas with pieces of the covering chipped and missing with a visible triangular shaped hole present, and the surveyor shared their observation and concerns with Clinical Regional Nurse #14 who acknowledged and confirmed understanding of the concern. On 12/01/2025 at approximately 10:05AM a malodorous smell was again noted to be present by the surveyor in the facility's lobby area. At this time, the concerns were shared with the facility's Administrator and a dual observation of the concerns was conducted with them. At this time, the facility Administrator observed, acknowledged, and confirmed understanding of the concerns. The facility Administrator reported to the surveyor that potentially the odor was due to nearby resident rooms located adjacent to the lobby area. On 12/01/2025 at 11:54AM the surveyor conducted an environmental tour of the facility and noted that despite the carpet having been observed to be cleaned by facility staff, the carpeting continued to be observed in worn condition with staining and debris present. Dark areas of staining were observed to be present in the doorways of multiple resident rooms. On 12/01/2025 at 11:57AM the surveyor observed chipped areas present within the flooring of the elevator. On 12/01/2025 at 11:58AM, after surveyor intervention, the reception area damage was observed to be repaired. On 12/01/2025 at 12:01PM the surveyor observed a partially brown stained ceiling tile adjacent to the air vent in the resident hallway near Resident room [ROOM NUMBER]. The air vent was observed to have black debris along the edges of the adjacent ceiling tiles, and the vent was observed to have thick, grey matter present within it. On 12/01/2025 at 12:03PM the surveyor observed three ceiling tiles above the floor 2 nursing station with brown staining present and surrounding tiles were observed to have debris and grey matter present on them. On 12/01/2025 at 12:04PM the surveyor observed the ceiling vent near room [ROOM NUMBER] with dark grey matter present within it. Ceiling tiles adjacent to the vent were observed to have black debris along the edges and areas of grey matter present on surrounding ceiling tiles. On 12/01/2025 at 12:11PM the surveyor conducted an environmental tour of the facility with the facility's Supervisor of Maintenance #16 and Director of Environmental Services (DES) #15 who observed and acknowledged the surveyor's concerns and confirmed understanding of the concerns. During surveyor (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview of DES #15 at this time, they reported to the surveyor that they were in charge of odor control within the facility, and that when staff call to let him know of an odor, he looks in different areas near the odor and usually he had found that it was attributed to dirty incontinence care products in trash cans in the rooms. Supervisor of Maintenance #16 reported they would be cleaning the ceiling vents and was subsequently observed by the surveyor cleaning them.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview it was determined the facility failed to ensure dignity was maintained for Resident #24. This was evident for 1 out of 1 Resident (#24) reviewed for dignity during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility on 11/24/2025 at 8:08AM Resident #24 was observed sitting in their wheelchair in the resident hallway outside of their room with bare feet on the hallway floor and multiple orange stains were observed on the t-shirt they were wearing. On 11/25/2025 at 8:50AM the surveyor observed Resident #24 sitting in their wheelchair in the resident hallway outside of their room wearing the same t-shirt with the same stains on it which was observed by the surveyor the day prior. On 11/25/2025 at 9:05AM the surveyor requested and performed a dual surveyor observation with the facility's Administrator of Resident #24. At this time Resident #24 was observed from the hallway laying in their bed exposed with no clothing on from the waist down. At this time, the surveyor shared the concern with the facility Administrator who acknowledged the concern and asked a Geriatric Nursing Assistant (GNA) to assist the resident with provision of privacy at which time the GNA was observed by the surveyors assisting the resident to cover with a blanket and pulled the privacy curtain for them. On 11/25/2025 at 9:06AM surveyors conducted an interview of Resident #24 with the facility Administrator. Upon entrance to the room a strong odor was present which was acknowledged by the Administrator and linens on the resident's wheelchair were observed to have brown stains on them. The Administrator observed Resident #24 wearing the stained t-shirt with the surveyors and informed Resident #24 of the stains and offered for their shirt to be changed. Resident #24 acknowledged the stains on their t-shirt and stated thank you and accepted the offer to receive a clean shirt. Surveyors reviewed the concerns with the Administrator who acknowledged and confirmed understanding of the concerns and reported they planned to speak with staff taking care of the Resident. Review of Resident #24's medical record on 11/25/2025 at 10:27AM by the surveyor revealed that Resident #24's care plan stated the following information dated as last revised on 10/20/2025: (Resident #24) exhibits ADL Self care deficit as evidenced by need for staff assistance to complete bathing, dressing, toileting, ambulation, bed mobility, and meal set up related to recent illness and subsequent deconditioning, Will be clean, dressed, and well groomed daily to promote dignity and psychosocial wellbeing x 90 days and Assist with daily hygiene, grooming, dressing, oral care and eating as needed.Surveyor concerns were again reviewed during the facility's exit conference on 12/1/2025.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that the facility failed to ensure a resident's right to formulate an Advanced Directive and maintain accurate documentation within their medical record. This was evident for 4 (Resident #2, #5, #64, and #57) out of 6 residents reviewed for Advanced Directives during the survey.The findings include: Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. It is a legal document outlining future healthcare wishes and appointing a healthcare agent. Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. It is a state specific medical document, with signed physician orders. 1. On [DATE] at 11:47 AM, review of the electronic medical record and hard charts for 6 residents revealed that advance directive documentation could not be located for Residents #2 and #5. The surveyor requested assistance locating the documentation from the Director of Nursing. On [DATE] at 10:15 AM, an interview was conducted with Staff #8 and they stated that the MOLST (Maryland Medical Orders for Life-Sustaining Treatment) form was the advance directive. The administrator confirmed that the MOLST form was considered an advance directive. The surveyor informed them at this time that the MOLST form was not considered an advance directive, per CMS regulations. 2. On [DATE] at 1:06PM, the Surveyor discovered an Advanced Directive admission assessment completed on [DATE] which stated Resident #64 has an Advanced Directive currently in place. Further review revealed a Social Service Assessment completed on [DATE] which stated that the resident had an Advanced Directive and the Advanced Directive was on file. On [DATE] at 8:55AM, a review of Resident #64's electronic and paper medical records failed to reveal Advanced Directive documents. The Surveyor requested the Director of Nursing (DON) to provide Advanced Directive documents for the resident. On [DATE] at 10:00AM, the Director of Nursing provided the Surveyor with a copy of the MOLST form for Resident #64, which is not an advanced directive. During an interview with Social Worker (SW) #8 and the Nursing Home Administrator (NHA), the Surveyor expressed the concern that Resident #64 has an Advanced Directive admission assessment completed on [DATE] and a Social Service Assessment completed on [DATE] stating that the resident has an Advance Directive document on file; however, a review of the resident's medical record failed to reveal such documentation. SW #8 stated that Resident #64 has a MOLST and the MOLST was considered the resident's Advance Directive when completing the assessments. The NHA and SW #8 confirmed that they assumed the MOLST was an Advanced Directive. The Surveyor informed the NHA and SW #8, that a MOLST and Advanced Directive are 2 different documents. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Therefore, Resident #64 did not have the opportunity to formulate an Advance Directive because the MOLST was considered to be their Advanced Directive. By the exit conference on [DATE], the NHA confirmed that the MOLST was not an Advanced Directive. 3. On [DATE] at 9:02AM, during a review of Resident #57's electronic medical record, the Surveyor discovered a Social Service Assessment completed on [DATE] which stated that the resident was provided with a copy of the Advance Directive for completion. Additionally, a Social Determinants of Health assessment completed on [DATE] by the Social Service department revealed that the resident always needs to have someone help them when they read instructions, pamphlets, or other written material from their doctor or pharmacy. The resident was their own representative. Further review revealed an Advanced Directive admission assessment completed on [DATE] which stated that if the resident does not have an Advanced Directive and wish to create one, the facility can assist you with this process. According to the assessment, Resident #57 did not have an Advance Directive currently in place and was interested in meeting with a member of the Social Work team to discuss steps to implement an Advance Directive. Additional review of Resident #57's electronic and paper medical record failed to reveal completed Advanced Directive documents or documentation that the facility assisted the resident with their wishes to formulate an Advanced Directive. On [DATE] at 10:20AM during an interview with Social Worker (SW) #8 and the Nursing Home Administrator (NHA), the Surveyor expressed the concern that on [DATE], the resident was provided with a copy of an Advance Directive to complete; however, the resident needed physical assistance to complete the form and there was no documentation to verify the SW assisted the resident. The Surveyor also expressed the concern that Resident #57 failed to have an Advanced Directive formulated after communicating an interest on [DATE] and [DATE] to the SW. The NHA informed the Surveyor that SW #8 was employed by the facility in [DATE]. The SW who completed the assessments was no longer employed by the facility. The Surveyor confirmed that Resident #57 does not have an Advanced Directive but has a MOLST form. SW #8 stated that the resident was no longer their own representative and has a resident representative. The Surveyor expressed the concern that the resident should have had the opportunity to formulate Advance directives while they had their own decision-making abilities.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview with staff, it was determined that the facility failed to ensure the baseline care plan was thoroughly completed and included the resident -specific initial goals based on admission orders needed to properly care for the resident immediately upon their admission. This was evident for 1(Resident #99) out of 4 residents reviewed for care planning during the annual survey.The findings include: The facility must develop and implement a baseline care plan for each resident that includes the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury with the instructions needed to provide effective and person-centered care of the resident and meet professional standards of quality care.On 11/24/2025 at 8:36AM, during a tour of Station 1, the Surveyor observed Resident #99 in their room lying awake in bed. The Surveyor observed a Care Plan Report completed on 11/23/2025 and Order Summary Report on the end of the over-bed table. The Surveyor reviewed the documents.On 11/25/2025 at 10:30AM, during a review of Resident #99's electronic medical record, the Surveyor discovered the resident was admitted to the facility on [DATE] with diagnoses of, but not limited to, acute and chronic respiratory failure with hypoxia, emphysema, absence of part of the lung, pulmonary hypertension, and major depressive disorder. A review of Resident #99's order summary revealed physician orders for psychotropic medications including diazepam, aripiprazole, duloxetine, and trazadone; a diuretic medication, spironolactone; and opioid medication, oxycodone.On 11/25/2025 at 11:30AM, an interview conducted with Unit Manager (UM) #11 revealed that the baseline care plan should be completed and implemented within 48 hours. The interdisciplinary team will review and complete their sections of the care plan. The nursing staff, including UM #11 are responsible for reviewing the baseline care plan with the resident and/or the resident representative, providing them with a copy of the care plan and their order summary, and answering any questions.On 12/1/2025 at 1:00PM, a review of Resident #99's baseline care plan failed to include the use of psychotropic, diuretic, and opioid medications the resident was currently taking. A resident's baseline care plan should include these medications because they require a clear indication for use, monitoring for effectiveness and side effects, and monitoring of behaviors associated with the use of the medications.During an interview with UM #11 on 12/1/2025 at 1:50PM, the Surveyor expressed the concern that Resident #99's baseline care plan was not thoroughly completed upon admission to include the medications the resident was taking. UM #11 and the Surveyor confirmed that the resident's psychotropic, diuretic, and opioid medications were not included in the baseline care plan and should be because they require specific monitoring and nursing considerations associated with the use of these medications.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview with staff, it was determined that the facility failed to ensure residents and/or resident representatives were offered the opportunity to participate in their care planning process by holding timely quarterly care plan meetings. This was evident for 2 (Resident #31 and Resident #57) out of 4 residents reviewed for care planning during the annual survey. The findings include:A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility.The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs.On 11/25/2025 at 10:20AM, an interview conducted with Social Worker (SW) #8 and the Nursing Home Administrator (NHA) revealed that initial care plan meetings are held within 7-14 days of admission and are then held quarterly, usually within the timeframe of the MDS assessments. Care plan meetings can also be held with a change in condition or at the request of the resident or the resident representative. The Surveyor requested documentation of Resident #31's and Resident #57's quarterly care plan meetings from January 2024-November 2025On 11/25/2025 at 11:35AM, a review of Resident #31's care plan meeting notes revealed that the resident had care plan meetings on 2/1/2024, 6/20/2024, and 9/18/2025. A review of Resident #31's electronic medical record revealed the facility held a quarterly MDS assessment on 3/8/2024, an annual MDS assessment on 6/14/2024, a quarterly MDS assessment on 9/14/2024, 12/8/2024, and 2/18/2025, an annual MDS assessment on 5/21/2025, and a quarterly MDS assessment on 7/25/2025 and 10/25/2025. Further review failed revealed care plan meetings were held quarterly, during the timeframe of the MDS assessments on 9/14/2024, 12/8/2024, 2/8/2025, 5/21/2025, and 7/25/2025. A review of Resident #57's care plan meeting notes revealed that the resident had care plan meetings on 6/9/2024, 11/22/2024, 2/26/2025, 4/24/2025, and 10/9/2025. A review of Resident #57's electronic medical record revealed the facility held an annual MDS assessment on 3/19/2024, a quarterly MDS assessment on 5/2/2024, 8/3/2024, 11/3/2024, 12/20/2024, an annual MDS assessment on 3/20/2025, and a quarterly MDS assessment on 6/20/2025 and 9/20/2025. Further review failed to reveal care plan meetings were held quarterly, during the timeframe of the MDS assessments on 3/19/2024, 8/3/2024, and 6/20/2025.On 11/25/2025 at 11:50AM, during an interview with the NHA, the Surveyor expressed the concern that the facility failed to ensure timely quarterly care plan meetings were held for Resident #31 from 6/20/2024 until 9/18/2025 and failed to ensure timely quarterly care plan meetings were held for Resident #57 during the timeframe of 3/19/2024, 8/3/2024, and 6/20/2025. The Surveyor requested additional documentation that quarterly care plan meetings were held during that timeframe for those residents. The NHA informed the Surveyor that they completed a care plan meeting audit because they identified an issue with timely care plan meetings and documentation of care plan meeting notes. The entire care plan process was reviewed, and the facility was working on getting caught up.By exit conference, held on 12/1/2025 at 2:27PM and after multiple requests, the NHA was unable to provide the Surveyor with supporting documentation of timely quarterly care plan meetings for Resident #31 and Resident #57.

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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** Based on observation, record review, and interviews, it was determined that the facility failed to ensure a resident was offered the opportunity to participate in facility sponsored group activities. This was evident for 1 (Resident #54) out of 2 residents reviewed for activities during the annual survey.The findings include:On 11/24/2025 at 12:00PM, during an interview conducted with the resident representative, the Surveyor was informed that Resident #54 was provided with coloring activities in their room but has not observed facility staff offer to take the resident to group activities or observed the resident at group activities. The resident representative stated that that would be nice for the resident to get out of their room and go to group activities because they would really enjoy it. The resident uses a wheelchair and would need staff assistance with transportation around the facility.On 11/25/2025 at 12:30PM, during a review of Resident #54's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE]. Further review revealed an admission and Annual Activities Assessment completed on 10/24/2025 which stated that the resident's preferred activity setting was small groups, enjoyed crafts, music, watching TV/movies, dogs, likes to play/watch sports, and would like to be invited to church. The Surveyor reviewed the resident's activity care plan created on 10/28/2025 with a focus, [Resident] prefers not to attend group activities due to little motivational interest, a goal [Resident] will adjust positively to facility by participating in either independent or group activities of interest x 90 days, and an intervention to Encourage participation in group activities of interest.During an interview conducted with Activity Director (AD) #12 on 11/25/2025 at 12:49PM, the Surveyor was informed that Resident #54 likes to color, and the activity staff brings the resident coloring packets. AD #12 stated that they were unsure why the resident does not come out of the room for activities. Activity staff should let the residents know what the activities are for the day when they pass out the Daily Chronicle in the morning and offer to take those residents who may need assistance. The Surveyor requested documentation to verify the resident participation in activities.On 11/25/2025 at 1:35PM after a review of Resident #54's activity Participation Log with AD #12 for October 2025 and November 2025, the Surveyor confirmed that the activity staff reviewed the Daily Chronicle with the resident in October and the resident had 2 prayer room visits, reviewed the Daily Chronicle, watched TV, and was provided with coloring activities in November 2025. The facility documented that the resident attended a Veterans Day ceremony on 11/11/2025.On 11/26/2025 at 12:28PM, during an interview conducted with the resident's caregiver, the Surveyor was informed that the resident is very sociable and would love to go to group activities including music entertainment, games, and manicures. The caregiver stated that they visit the facility often, but they can't always get to the facility to take the resident to group activities. The caregiver was unaware that the facility staff can also take the resident to activities.On 11/26/2025 at 1:00PM during an interview with AD #12, the Surveyor expressed the concern that Resident #54 was not offered the opportunity to participate in activities outside of their room.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review it was determined the facility failed to ensure a resident's dry skin condition was identified and failed to ensure they received intervention to address the condition. This was evident for 1 out of 1 Resident (#24) reviewed for skin conditions during the facility's recertification survey. The findings include: During the surveyor's initial tour on 11/24/2025 at 8:08 AM Resident #24 was observed in their wheelchair in the hallway with no socks or shoes and the surveyor noted the resident's lower extremities appeared to have very dry skin with visible flaking present. On 11/24/2025 at 11:37AM the surveyor observed Resident #24 laying in their bed and noted they continued to have very dry visibly flaky skin on both lower extremities. Review of Resident #24's medical record by the surveyor on 11/25/2025 at 9:41AM revealed there was no documentation present for the Resident's dry flaky skin on their lower extremities having been identified or addressed. Review of Resident #24's diagnoses revealed they had a diagnosis of lymphedema. On 11/25/2025 at 10:06AM the surveyor conducted an interview of Registered Nurse Unit Manager #11 who reported to surveyors that they perform wound rounding for the entire building, and stated that Unit Manager (UM) #17 was the Unit Manager for Resident #24 and regarding the dry skin on Resident #24's legs, I would have to talk to (UM #17) about that, I'm not sure. At this time, the surveyor requested an interview of UM #17. On 11/25/2025 at 10:32AM the surveyor conducted an interview of UM #17 who confirmed they observed Resident #24's lower extremities and the skin condition and stated: it's dry, I would definitely get an order for some lotion. Review of the medical record during the interview revealed that Resident #24 was dependent upon staff for the task of personal hygiene. When the surveyor inquired to UM #17 as to if the skin condition had been addressed prior to surveyor intervention, they stated: No, I have not, I'll have to talk to (Physician #19) about it, the podiatrist has seen him/her. UM #17 acknowledged that Resident #24's dry skin condition was an issue that needed to be addressed, but had not yet been addressed at the time of the interview. Review of the medical record by the surveyor on 11/25/2025 at 10:23AM revealed that the condition of the Resident's lower extremity skin was not present in the progress notes. Review of the medical record by the surveyor on 11/25/2025 at 10:24AM revealed the following care plan problem and intervention dated 10/20/25 for Resident #24: (Resident #24) has a hx (history) of skin breakdown and remains at risk for skin alteration related to: limited mobility, intermittent incontinence, BLE (bilateral/both lower extremities) edema, lymphedema, Observe skin condition with ADL care daily; report abnormalities. After surveyor intervention, review of the medical record by the surveyor on 11/25/25 at 12:23PM revealed the following medical order dated 11/25/25 at 11:28AM was observed to have been placed: Ammonium lactate external cream 12% Apply to bilateral lower legs topically every day and evening shift for dry skin. Review by the surveyor of Resident #24's prior documented assessments on 11/21/25, 11/24/25, 11/29/25, and weekly skin assessments revealed the condition of their skin was not captured.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with the resident and the staff, it was determined that the facility failed to ensure a resident receives proper treatment and scheduled follow-up appointments to maintain vision. This was evident for 1 resident (Resident #57) reviewed for vision services during the annual survey.The findings include:On 11/24/2025 at 11:30AM, during an interview with Resident #57, the Surveyor was informed that Resident #57 had cataract surgery on the right eye and was supposed to have cataract surgery on the left eye, but the facility never scheduled the surgery.On 11/24/2025 at 1:26PM, a review of Resident #57's electronic medical record revealed an eye care group note dated 4/22/2024 with a completed assessment that included Cataract, mixed; Bothersome; Both eyes; VA stable, but patient is not satisfied with level of vision and a plan in which Cataract surgery recommended; ophthalmology consult; Follow-up: 4-5 months; Referral: Ophthalmology consult; Please schedule an appointment for this patient the see an outside ophthalmologist such as [Eye Group] for further evaluation and extraction of bothersome cataract-further evaluation to [rule out] [NAME] at that time as well.Further review revealed another eye group note dated 6/27/2025 with a competed assessment that included, Cataract, mixed; [left] eye; Patient had cataract surgery [right] eye months ago and was supposed to return for [left] eye, but was never scheduled according to the patient and a plan in which, Cataract surgery recommended; ophthalmology consult; Follow-up:5-6 months; referral: Ophthalmology consult; Please schedule an appointment for this patient to see an outside ophthalmologist for further evaluation and extraction of bothersome cataracts. Additional review failed to reveal an appointment scheduled for Resident #57 to see the ophthalmologist for cataract surgery on the left after the eye exam conducted on 6/27/2025.On 11/26/2025 at 2:00PM during an interview with the Director of Nursing (DON), the Surveyor was informed that the resident is a patient of [Eye Group]. The Surveyor expressed the concern that the resident had an eye exam on 6/27/2025 with orders recommending cataract surgery and for the facility to schedule an appointment for the resident to see an outside ophthalmologist for further evaluation and extraction of bothersome cataracts of the left eye. A review of the resident's electronic medical record failed to reveal documentation of a scheduled ophthalmology appointment since the eye exam on 6/27/2025 or cataract surgery performed on the left eye as the resident requested and as recommended by the optometrist. The DON stated they would look into the concern.On 12/1/2025 at 12:30PM, the Surveyor was provided with a physician's order dated 12/1/2025 at 10:50AM which stated that Resident #57 had an ophthalmology appointment scheduled for 12/5/2025 at 11:00AM.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review it was determined the facility failed to ensure consistent incontinence care was provided. This was evident for 1 out of 1 Resident (#4) reviewed for bowel and bladder incontinence during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility on 11/24/25 at 8:05AM Resident #4 was observed in their bed wearing a visibly wet, yellow incontinence care product. Review of Resident #4's medical record by the surveyor on 11/24/2025 at 10:42AM revealed Resident was documented consistently by various nursing staff on the Task Documentation Survey Report throughout the month of November 2025 as having total dependence upon staff for toileting needs for incontinence of bowel and bladder. Surveyor review on 12/01/2025 at 11:31AM of Resident #4's incontinence care documentation in the medical record revealed that incontinence care was documented as being provided on the following dates and times: 11/28/25 at 12:35AM and 7:34PM, 11/29/25 at 1:05AM, 9:08AM, and 7:09PM, 11/30/25 at 1:53PM, and 12/1/25 at 10:39AM. The surveyor noted that upon the review of the medical record, there was no evidence found to indicate that Resident #4 was provided with consistent incontinence care each shift. On 12/01/2025 at 11:31AM the surveyor conducted an interview of Unit Manager (UM) #17 who reported to the survey team that all Geriatric Nursing Assistants document on the task list every shift on the care that they provide. UM #17 confirmed Resident #4 was dependent on staff for incontinence care and was incontinent. At this time UM #17 reviewed the incontinence care documentation with the surveyor and stated: It doesn't look like it was documented, our 3-11 shift was at 82% yesterday for documentation. UM #17 reported to the survey team that they determine who the GNA was that did not complete the documentation, and stated: Our supervisor for the weekends is supposed to be looking at that. When the surveyor inquired to UM #17 as to how they know it was a documentation issue and that the care had actually been provided, UM #17 reported: I would ask the nursing staff if I'm not available, but rounds should be made. During the interview, on 12/01/2025 at 11:43AM UM #17 confirmed with the surveyor that every shift all staff are required to document on the tasks. At this time, the surveyor shared their concern with UM #17 who acknowledged the concern and stated: Okay, thank you. The surveyor noted that throughout the facility's recertification survey, all surveyors noted daily odors present within all resident hallways including adjacent areas.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review it was determined the facility failed to: 1.) ensure respiratory tubing and the humidification saline bottle was dated and timed in accordance with professional standards and ensure a respiratory nebulizer machine, face mask, tubing and saline bottle was stored off of the floor's surface. This was evident for 2 out of 2 Residents (#98, #10) reviewed for respiratory during the facility's recertification survey. The findings include:1.) On 11/24/2025 at 8:09AM the surveyor observed Resident #98 wearing their nasal cannula oxygen tubing which had no label indicating date or time of when it was placed or would expire. On 11/24/2025 at 8:09AM the surveyor observed Resident #98's humidification bottle for their oxygen with no labeling indicating date or time of when it was placed or when it would expire.On 11/24/2025 at 8:09AM the surveyor observed Resident #98's nebulizer machine and face mask directly laying on the floor's surface next to their bed. On 11/24/2025 at 8:10AM the surveyor requested a dual observation of the concerns with Licensed Practical Nurse #10 who observed the concerns and stated to the surveyor: I'm going to throw this tubing and mask away, no it should not be stored on the floor. On 11/26/2025 at 8:58AM the surveyor conducted an interview of the facility's Director of Nursing who reported their expectation was for nursing staff to have respiratory tubing dated and timed with a label and they confirmed with the surveyor that respiratory nebulizer equipment should not be stored on the floor's surface. At this time the surveyor shared their concern with the DON who acknowledged and confirmed understanding of the surveyor's concerns. Review of the medical record of Resident #98 by the surveyor on 11/26/2025 at 9:37AM revealed the November 2025 treatment administration record which documented the following order signed off by various nursing staff dated as beginning on 11/03/2025: Oxygen tubing change weekly label each component with date and initials, every night shift every Mon label each component with date and initials. On 12/01/2025 the concern was again shared by the survey team during the facility's exit conference. 2.) During the surveyor's initial tour of the facility on 11/24/2025 at 8:04AM Resident #10 was observed with no labeling present on their oxygen tubing. Review of the medical record of Resident #10 by the surveyor on 11/26/2025 at 10:43AM revealed the following November 2025 treatment administration record order signed off by nursing staff dated as beginning on 7/23/25: Oxygen tubing change weekly, label each component with date and initials, every night shift every Wed, for SOB label each component with date and initials. On 11/26/2025 at 10:49AM the surveyor conducted an observation of Resident #10's respiratory tubing which was observed to have no label with date or time present and the Resident's humidification bottle was observed sitting directly on the floor's surface attached to the concentrator by extension tubing. On 11/26/2025 at 10:50AM the surveyor conducted an interview of Unit Manager (UM) #17 and requested for them to observe the concern and shared the concern with them. UM #17 acknowledged and confirmed understanding of the concern and stated to the surveyor: Okay I'll go take care of that now. On 11/26/2025 at 10:52AM the surveyor shared the concern with the facility's Administrator who acknowledged and confirmed understanding of the concern and stated to the surveyor: Okay, and you let (Unit Manager #17) know about it? Okay, thank you. On 12/01/2025 the concern was again shared by the survey team during the facility's exit conference.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interviews with staff, it was determined that the facility failed to ensure an appropriate storage method was implemented for medications awaiting final disposition consistent with standards of practice. This was evident for an observation in 1 medication room (Station 2) out of 2 medication rooms observed during the annual survey. The findings include:Disposition is the process of returning and/or destroying unused medications. On 11/26/2025 at 7:49AM, an observation of the medication room on Station 2 revealed a medication bottle of levetiracetam oral solution for Resident #79 and a white paper bag with a ONETOUCH Ultra 2 device, strips, and lancets for Resident #100. On 11/26/2025 at 9:45AM, a review of Resident #79's electronic medical record revealed that levetiracetam oral solution was discontinued on 11/20/2025. A review of Resident #100's electronic medical record revealed that the resident was discharged on 10/14/2025. On 11/26/2025 at 10:53AM, the Surveyor conducted an interview with Unit Manager #17 in Station 2's medication room. The Surveyor expressed the concern that Resident #79's bottle of levetiracetam oral solution remained on the counter in the medication room after being discontinued on 11/20/2025 and Resident #100's ONETOUCH Ultra 2 device, strips, and lancets remained on the counter in the medication room after the resident had been discharged on 10/14/2025. UM #17 and the Surveyor observed the medications sitting on the counter and UM #17 confirmed the Surveyor's findings. UM #17 stated that the expectation for discontinued medications and remaining medications of residents who have been discharged is to be placed and stored in a pharmacy-provided white plastic bag labeled return to pharmacy, located in the medication room. Medications placed in the white return to pharmacy bag are identified as ready for disposition by a representative from the pharmacy and will be collected once the bag is full. Therefore, the discontinued levetiracetam oral solution for Resident #79 and the remaining ONETOUCH Ultra 2 device, strips, and lancets for Resident #100 should have been placed and stored in the white plastic bag labeled return to pharmacy for the pharmacy representative to know they are ready to be picked up.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record review and interviews with the resident and staff, it was determined that the facility failed to assist the resident in obtaining routine dental care. This was evident for 1 resident (Resident #57) reviewed during the annual survey.The findings include:On 11/24/2025 at 11:30AM, during an interview with Resident #57, the Surveyor was informed that the resident has not been examined by a dentist in a long time and has been requesting to see a dentist for routine services related to existing dentition and general oral hygiene.During a review of Resident #57's electronic medical record on 11/24/2025 at 1:30PM, the Surveyor discovered a dental consult note dated 2/16/2024, which was the last documentation of dental services provided to the resident. Further review failed to reveal documentation of any scheduled routine appointments.On 11/26/2025 at 1:20PM during an interview conducted with Registered Nurse (RN) #21, the Surveyor was informed that Resident #57 had requested to see the dentist.On 11/26/2025 at 2:00PM, an interview with the Director of Nursing (DON) revealed the facility does provide dental services to residents. The DON stated that the [Dental Company] has a premium and requires eligibility to join; however, the [Dental Company] will see residents who require emergency services, without joining. For those residents who don't qualify for the [Dental Company], the facility can assist with locating outside dental services. The Surveyor expressed the concern that Resident #57's last documented dental exam was on 2/16/2024, that the resident has been requesting dental services with no appointments scheduled, and that the facility failed to assist the resident with obtaining routine dental services. The DON stated they would look into the concern and speak with the resident.By exit conference on 12/1/2025 at 2:27PM, the facility did not provide the Surveyor with an order for a scheduled dental appointment for Resident #57.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observations, interviews and resident medical record review it was determined the facility failed to provide a diet that meets the residents special dietary needs and taking consideration of the resident's preferences. This was evident for 1(Resident #8) out of 6 residents reviewed and observed during the annual survey. The findings include the following: During observational rounds and interview on 11/242025 at 8:45 AM Resident #8 stated, I am not allergic to beef and on my meal ticket it says I am allergic to beef. I was also supposed to get bacon and Oatmeal Cereal for breakfast but there is no bacon on my plate and there is no Oatmeal Cereal. We never get drinks with our meals, and I want my coffee with my breakfast. They bring it too late, not at all and I am either done with my food or if I wait for them to bring it to me, my food is cold. Resident #8 meal tray was found to have scrambled eggs, 2 sausage patties, 1 piece of white toast with no juice, no coffee, no tea, and no Oatmeal Cereal. Resident #8 meal ticket dated 11/24/2025 Breakfast that was present on his/her meal tray, stated that resident was to receive a Carbohydrate Controlled Diet (CCD), 4 slices of bacon, 12 oz of Oatmeal Cereal, 12 oz of Coffee or Hot tea, 8 oz of Orange Juice, Allergies: Dairy Allergen and Beef Allergen. During observation rounds and interview on 11/24/2025 at 9:15 AM Resident #8 was observed to still not have received juice, coffee or tea and was finished with his/her breakfast. The Director of Nursing was made aware of the observation and stated that he/she would look into it. Review of Resident #8's medical record on 11/24/2025 at 10:05 AM revealed a diet order dated 11/21/2025 that resident was to receive a Regular Diet, Regular Texture, Double Portions. Further review of the Resident #8's chart stated that residents Allergies are Beans, Cheese and Lactose and no documentation found of Resident #8 being allergic to beef. Resident #8's meal ticket for 11/24/2025 Breakfast stated resident diet was Carbohydrate Controlled Diet (CCD). During interview on 11/24/2025 at 10:30 AM staff # 5 confirmed and agreed that Resident #8's meal ticket stated and confirmed that resident #8 was to be served a Carbohydrate Controlled Diet (CCD), bacon, Oatmeal Cereal, drinks and would look into it. Staff #5 was made aware of Resident #8's concerns about not being allergic to beef and that no drinks were served to resident with his/her breakfast. During interview on 11/24/2025 at 11:50 AM, the Director of Nursing was made aware of Resident #8 stating that he/she was not allergic to beef and confirmed that his/her meal ticket stated that resident was allergic to beef. The Director of Nursing also confirmed that Beef was not listed as an allergy in Resident #8's medical records.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, review of facility documentation and interviews and it was determined the facility failed to follow the menu for residents' meals. This was evident for 2 (Resident #8 and #58) out of 6 residents reviewed during the survey.The findings include the following: During observational rounds and interview on 11/242025 at 8:45 AM Resident #8 stated, I was also supposed to get bacon and Oatmeal Cereal for breakfast but there is no bacon on my plate and there is no Oatmeal Cereal. We never get drinks with our meals, and I want my coffee with my breakfast. They bring it too late, not at all and I am either done with my food or if I wait for them to bring it to me, my food is cold. Resident #8's meal tray was found to have scrambled eggs, 2 sausage patties, 1 piece of white toast with no juice, no coffee, no tea, and no Oatmeal Cereal. Resident #8 meal ticket dated 11/24/2025 for Breakfast, that was present on his/her meal tray, stated that resident was to receive 4 slices of bacon, 12 oz of Oatmeal Cereal, 12 oz of Coffee or Hot tea, 8 oz of Orange Juice. During observation rounds and interview on 11/24/2025 at 9:30 AM Resident #58 stated, I did not receive French Toast Casserole for breakfast. Resident #58 meal ticket dated 11/24/2025 for Breakfast stated that resident was to receive French Toast Casserole - 2 squares. There was no French Toast Casserole observed on Resident #58's meal tray. Review of residents' menu for 11/24/2025 posted in hallway near the Director of Nursing office on 11/24/2025 at 9:45 AM stated Breakfast - French Toast Casserole, Bacon, Hot or Cold Cereal, Choice of Two: Milk, Juice, Coffee or Tea. During interview on 11/24/2025 at 10:30 AM staff # 5 confirmed and agreed that Resident #8 meal ticket stated Resident #8 was to get bacon, Oatmeal Cereal, drinks and would look into it. Staff #5 also confirmed that residents did not get served French Toast Casserole this morning as stated on the daily resident menu. During interview on 11/24/2025 at 10:45 AM staff #6 stated and confirmed, The residents should have gotten bacon, Oatmeal Cereal and or French Toast Casserole, but the food truck did not come and at times the food supply company is out of stock of the items we order. Staff #6 further confirmed and stated, the facility did not have French Toast Casserole or bacon in stock to serve this morning for Breakfast. During interviews on 11/24/2025 with facility staff, no one was able to provide documentation or verification to surveyor that the residents were made aware of the menu changes or provided resident choices when items were not delivered or out of stock.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to 1.) ensure a resident admitted with severe cognitive impairment had two physician certifications completed and in the medical record, and failed to ensure the MOLST form reflected surrogacy as the basis of the orders and failed to ensure physician documentation of advanced directives and the molst form being reviewed was present in the medical record, and 2.) failed to ensure accuracy of a documented indication for use of a medication in a medical order. This was evident for: 1.) 1 out of 5 Residents (#10) reviewed for advanced directives, and 2.) 1 out of 1 Resident (#24) reviewed for skin conditions during the facility's recertification survey. The findings include: Based on interview and record review it was determined the facility failed to ensure medical records were complete and accurately documented for residents. This was evident for 1 out of 5 residents (Resident #10) reviewed for advanced directives, and 1 out of 1 resident (Resident #24) reviewed for skin conditions during the facility's recertification survey. The findings include: 1.) On 11/24/2025 at 11:41AM the surveyor conducted a review of the medical record of Resident #10 which revealed one Maryland Medical Orders for Life Sustaining Treatment (MOLST) form dated 8/23/25 which indicated that Resident #10 had a health care agent as named in the resident's advanced directive. Further review of Resident #10's medical record revealed there was no advanced directive present, and only one certification of incapacity form signed by one physician dated 7/23/25 was present. Review of Resident #10's face sheet documented a healthcare surrogate was designated. Review of Resident #10's hospital Discharge summary dated [DATE] documented the resident had a surrogate decision maker prior to their admission to the facility on 7/22/25. No documentation was able to be found within the medical record regarding review of the Resident's advanced directives by a facility physician. On 11/26/2025 at 11:43AM the surveyor reviewed Resident #10's medical record and again observed the same pre-existing documentation was present consisting of the MOLST form without supporting advanced directive, one certification of incapacity form, and the Resident's face sheet listing a surrogate. Two evaluations completed by social work were reviewed by the surveyor at this time which were dated 7/24/25 and 9/2/25 which documented the following information: 7/24/25 Has one daughter, [Resident's friend] also involved in his/her plan of care, and yes resident has advanced directives document; and 9/2/25 yes has an advanced directive, yes advanced directive on file, advanced directives: SEE MOLST. On 11/26/2025 at 11:46AM the surveyor requested and conducted a dual observation of the medical record and an interview of Unit Manager #17 and shared the concerns. UM #17 reported to the surveyor that they were going to go get the facility Social Worker. On 11/26/2025 at 11:49AM the surveyor conducted an interview of Licensed Practical Nurse #19 who confirmed with the surveyor that the second certification of incapacity and the advanced directive should be located within the Resident's medical hard chart. On 11/26/2025 at 11:57AM the surveyor conducted an interview of Director of Social Services (DSS) #8 who reported to the surveyor that the MOLST form on the Resident's medical record that the facility was currently following had been last completed by the hospital on 8/22/25. At this time, the surveyor shared their concerns with DSS #8 who acknowledged and confirmed understanding of the concerns. On 11/26/2025 at 12:03PM the surveyor shared concerns with the facility's Director of Nursing (DON) and Physician #18, and after surveyor intervention, it was confirmed with the surveyor that the Medical Director was being contacted to perform a second certification because there was no second certification of incapacity that could be found. At this time, the facility's DON and Physician #18 acknowledged and confirmed understanding of the surveyor's concerns. On 11/26/2025 at 12:09PM the surveyor conducted an interview of UM #17 who reported to the surveyor that there should be a facility physician reviewed MOLST form present and confirmed with the surveyor that two certifications of incapacity should be present and only one was present (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	within Resident #10's medical record. At this time, the surveyor shared concerns with RN #11, UM #17, and DSS #8. On 11/26/2025 at 1:03PM further review of the medical record by the surveyor revealed a surrogacy form was present dated 7/23/25. On 11/26/2025 at 1:31PM the surveyor conducted an interview of Physician #18 who reported they recalled reviewing advanced directives with the Resident's surrogate and them wishing to continue current status determined by hospital physicians prior to admission. An opportunity was provided by the surveyor for any further documentation to be provided for surveyor's review. On 11/26/2025 at 1:57PM the facility's DON and Regional Clinical Nurse (RCN) #14 provided hospital documentation of the Resident having appointed surrogates during hospitalization. The DON and RCN #14 confirmed with the surveyor that although advanced directives had been reviewed and discussed, there was no documentation present in the medical record. On 11/26/2025 at 2:22PM the surveyor conducted an interview with RCN #14 and inquired as to the resident's second certification of incapacity, at which time RCN #14 stated: I couldn't find it. At this time, the DON informed the surveyor that (Physician #18) reached out to (Medical Director #20) to complete the second certification, they are going to have that done. On 11/26/2025 at 2:32PM RCN #14 and Physician #18 informed the survey team that they planned to put in the missing documentation. Both RCN #14 and Physician #18 acknowledged the surveyor's concerns and confirmed understanding of the concerns. After surveyor intervention, the surveyor was provided with two certifications of incapacity for Resident #10 both dated 11/26/25, one by Physician #18 and one by Medical Director #20. On 12/1/25 at 12:39PM after surveyor intervention, one MOLST form was observed in the Resident's medical record signed by Physician #18 indicating the certification for the basis of the orders was the patient's surrogate. On 12/1/25 the concerns were reviewed during the facility's exit conference. 2.) On 11/25/2025 at 12:23PM the surveyor conducted a review of the medical record of Resident #24 which revealed the following medical order was present dated as beginning on 10/19/2025: Empagliflozin Oral Tablet 10MG Give 1 tablet by mouth one time a day for dm (Diabetes Mellitus). Review of the medical record by the surveyor on 11/25/2025 at 12:23PM revealed Resident #10's a diabetic diagnosis was not present on their diagnoses list. Review of the medical record by the surveyor on 11/25/2025 at 12:23PM revealed the Resident's care plan did not include a diagnosis or interventions for Diabetes. Review of the medical record by the surveyor on 11/25/2025 at 12:23PM revealed there was no diagnosis of Diabetes observed to be found within physician progress notes of Resident #10. On 11/25/2025 at 12:28PM the surveyor conducted an interview of the facility's Director of Nursing (DON) who reported to the surveyor that they did not think Resident #24 was diabetic. At this time the surveyor shared their concern with the DON and Regional Clinical Nurse #14 and the DON proceeded to review the Resident's medical record regarding the concern. On 11/25/2025 at 12:32PM the surveyor conducted an interview of Medical Director #20 who confirmed with the surveyor that the Empagliflozin medication was not being given to Resident #24 for an indication of Diabetes Mellitus. At this time the surveyor shared their concern with Medical Director #20 who acknowledged and confirmed understanding of the concern. On 11/26/2025 at 1:57PM the surveyor conducted an interview of the facility's Director of Nursing and Regional Clinical Nurse #14 who both confirmed with the surveyor that Resident #24 did not have a diabetic diagnosis and was receiving the medication for a different indication. After surveyor intervention, the surveyor reviewed the medical record of Resident #24 on 11/26/2025 at 2:07PM which revealed the medical order for the Empagliflozin medication was revised to the following on 11/26/25: Empagliflozin Oral Tablet 10MG, Give 1 tablet by mouth one time a day for CHF (Congestive Heart Failure).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215081	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Perring Parkway	1801 Wentworth Road Baltimore, MD 21234

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, it was determined that the facility failed to ensure tube feeding equipment was properly dated to prevent potential infection control risks. This deficient practice was evident for 1 (Resident #9) of 1 resident reviewed for tube feeding.The findings include:On 11/24/2025 at 10:27 AM, Resident #9 was observed to be using a tube feeding that was not dated. Staff #10, who was assigned to Resident #9, was located and confirmed that the tubing and nutrition bottle were undated. Staff #10 stated it was the responsibility of the nurse to ensure the tube feeding equipment was dated. On 11/25/2025 at 10:48 AM, the Director of Nursing was made aware of the findings.