STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215090	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Loch Raven	8720 Emge Road Baltimore, MD 21234

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: Number of residents cited: Based on observations and staff interviews, it was determined that the facility failed to ensure food items were stored to maintain the integrity of the specific items. This was evident for 1) the initial observation of the kitchen upon facility entry, and 2) 1 of 1 observation of the second floor nourishment room. This failure has the potential to affect all residents. The findings include: 1) On 09/04/2025 at 8:03 AM, an initial observation of kitchen dry storage room revealed a bag of soft tortillas which were opened and unlabeled, a large box of rice which was opened, unsealed, and unlabeled, a large box of food thickener which was opened, unsealed, and unlabeled, and a packet of ranch dressing seasoning which was opened and labeled with 08/16/25 and 8/22/25 on a strip of white tape, but failed to reveal what each of the dates meant.On 09/04/2025 at 8:09 AM, an observation of the walk-in freezer on the first floor revealed tilapia (a type of fish) which was opened, unsealed, and unlabeled, and a box of corn which was opened, unsealed, and unlabeled. On 09/04/2025 at 8:14 AM, an interview with the Dietary Manager (Staff #31), who was present during the kitchen observation, revealed that the expectation of staff was to seal items once opened, and to label them. She was unable to identify what the white tape labeled dates indicated on the ranch dressing seasoning packet as it was not the labels provided by the kitchen.During the same interview, she further indicated that the staff should have used the kitchen labeling system for the ranch dressing seasoning packet so that the meaning of the two dates could be identified. The surveyor reviewed the concerns indicated above from the initial kitchen observation.2) On 09/04/2025 at 8:46 AM, an observation of the nourishment room on the second floor revealed a cup of soup which failed to reveal that it was labeled or have a lid, an unlabeled food substance in a tupperware container, and an opened and unlabeled bottle of RedHot sauceAt the same time, the Unit Clerk (Staff #25), who was present during the observation indicated that the expectation was to label any food item placed into the fridge with the name of the resident it belonged to and the date. The surveyor identified the items of concern to Staff #25 which she agreed with.

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, medical record reviews, and staff interviews, it was determined that the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This was found to be evident during the recertification survey. This deficiency has the potential to affect all residents.The findings include: 1) On 9/04/2025 at 8:07 AM, an observation was made of Resident #102. Resident #102's urinary catheter bag was observed to be lying on the floor beside the resident's bed. On 9/04/2025 at 8:09 AM, an interview was conducted with Staff #3. The surveyor expressed concern with Resident #102's urinary catheter bag, and Staff #3 recognized that the urinary catheter bag should not be on the floor and stated that they will take care of it after surveyor intervention. 09/05/2025 1:41 PM, an interview was conducted with Director of Nursing (DON). This surveyor expressed an infection control concern with Resident #102's urinary catheter being observed on the floor. The DON recognized the concern and stated that the urinary catheter bags should not be on the floor and would educate staff. 2) Enhanced Barrier Precautions (EBP) - are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. Clinical Safety: Hand Hygiene for Healthcare Workers, 2/27/24, states that a healthcare worker should sanitize their hands before working directly with a resident and to sanitize their hands every time they remove their gloves. On 9/5/25 at 9:16 AM a random observation was made of Resident #55 receiving wound care. Geriatric Nursing Assistant (GNA) #11 and the facility's Wound Care Nurse (WCN) #10 were in the room at the resident's bedside. WCN #10 went to the treatment cart sitting in the doorway of the resident's room to get more supplies and failed to sanitize his hands before preparing supplies to provide wound care for the resident. He removed the gloves and without sanitizing he went back to the treatment cart to prepare a small cup of normal saline solution. He failed to sanitize his hands and came back in the room and put on new gloves. He proceeded to cut the bandages off the resident's lower right leg with bandage scissors. He removed his gloves and without sanitizing his hands he applied new gloves and proceeded to clean the wounds by dipping gauze in the saline solution and wiping the wounds starting with the middle wound moving down the leg then back up to the wound on the knee. He removed his gloves and without sanitizing his hands he started assembling the new dressings on the resident's bed. He put on a new pair of gloves and used some Alcavis 50 solution (a high-level disinfectant used to clean peritoneal dialysis ports. The solution requires vigorous scrubbing and needs 2 minutes for the disinfecting process. It was not designed to clean bandage scissors) and a gauze pad to clean the bandage scissors he used to cut the old dressing off. He wiped each blade once and then immediately started cutting the xeroform gauze (medication infused gauze to help with healing) into smaller sections to place on the wound. As he cut each piece, he would remove it from packaging and the side he touched was the side he laid on the wound and then he wrapped the leg with a gauze wrap. He proceeded to provide wound care in the same manner on the left leg. Furthermore, the resident was on Enhanced Barrier Precautions which requires staff to wear a gown while providing contact care and neither the WCN nor the GNA had on a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	09/09/2025 4:02 PM medical record review for Resident #55 revealed the attending physician's notes that was an accumulation of visits. According to the notes the resident had end stage renal disease and on 8/20/25 was seen for changes in his/her mental status. Review of the physician's orders revealed on 8/14/25, the resident was ordered to have Enhanced Barrier Precautions due to peritoneal dialysis. According to the wound care orders the resident had abrasions on both legs. An interview with WCN #10 on 9/5/25 at 10:00 AM regarding the observation he reported that he has been a wound nurse since January of 2025 and was a certified wound nurse. He acknowledged that he should have washed his hands or sanitized them between each glove change and that it was standard of practice to clean the wound from the top to the bottom. When asked why he had used the same bandage scissors to remove the dressing and cut the new dressing gauze, he stated that he knows the disinfectant was effective to clean the scissors because they used it for peritoneal dialysis. However, he failed to allow the 2-minute drying time for the disinfectant to work. When asked what Enhanced Barrier Precautions were, he was unable to verbalize it. When shown the sign that was on the resident's door, he stated that he was to wear and gown and gloves when in contact with the resident. When asked why he did not wear a gown to provide wound care, he stated he was not planning on providing the wound care at that time. During an interview with GNA #11 on 9/5/25 at 10:59 AM she reported that she had been educated regarding Enhanced Barrier Precautions. She stated when a resident was on EBP, she should wear and gown and gloves while providing care. She acknowledged that she should have worn one while assisting with wound care for Resident #55, but did not have a reason as to why she did not. An interview on 9/5/25 at 11:15 AM with the Infection Control Nurse revealed she was new to the position and was unable to report the last training that staff had regarding the use of Enhanced Barrier Precautions. When asked how she monitors that staff were compliant with infection control practices, she stated that she makes rounds on both units 3 to 4 times a day. However, she failed to keep documentation of these rounds and the findings. Reviewed Resident #55's wound care observation with her. She stated that WCN #10 and GNA #11 should have worn a gown and gloves. She stated that WCN #10 should have sanitized between glove changes. She reported that there were a supply of bandage scissors in the treatment cart, so staff should not use the same ones to remove the old dressing and then cut the new dressing gauze. If they would need to use the same ones they should be cleaned with the disinfectant wipes that were in the treatment cart. She reported she has not heard of using the Alcavis 50 to clean bandage scissors. On 9/9/25 at 9:39 AM the concerns were reviewed with the Director of Nursing (DON) and she acknowledged the concerns. 3) On 9/05/2025 at 10:40 AM A review of Resident #41's medical record was conducted. The review revealed an active order for Enhanced Barrier Precautions (EBP) to be always maintained, every shift for feeding tube. On 9/05/2025 at 1:40 PM An Enhanced Barrier Protection sign was observed outside Resident #41's room and above their bed. The sign showed the appropriate personal protection equipment to be worn including gloves and a gown. On 9/05/2025 at 2:00 PM The surveyor observed Staff #15 providing toileting care to Resident #41. Staff #15 wore gloves but had no gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/05/2025 at 2:20 PM An interview with Staff #15 was conducted. She confirmed that EBP precautions should have been followed when providing toileting care to Resident #41. When asked why she had no appropriate personal protection equipment, Staff #15 stated that they forgot to wear the gown. On 9/08/2025 at 8:50 AM The surveyor observed Staff #16 administer medication to Resident #41 via a feeding tube. Staff #16 had gloves on but failed to wear a gown. On 9/08/2025 at 8:54 AM A review of Resident #41's medication administration record was conducted. The review revealed that the resident was given Valproic acid. On 9/08/2025 at 8:58 AM An interview with Staff #16 was conducted. When asked if she was aware Resident #41 had EBP precaution orders, she reported yes. The staff further admitted that she was unaware that gowns were needed when caring for or using a resident's feeding tube. On 9/08/2025 at 9:10 AM An interview with the Assistant Director of Nursing (ADON) was conducted. She stated that it was the facility's expectation that all staff should wear the appropriate personal protective equipment listed on the EBP sign when caring for a resident with a feeding tube. On 9/08/2025 at 9:16 AM The surveyor discussed with the ADON the infection control concerns identified. On 9/08/2025 at 10:43 AM The Director of Nursing (DON) was made aware of the concerns. 4) On 09/05/2025 at 12:31 PM, an observation of the clean linen room revealed it was a room that was also used as a walk through to get to the Director of Housekeeping (Staff #18's) office. Further observation revealed that the front cover of the clean linen cart was folded up on top of the linen cart (exposing the clean linen), and there were clean linens (also folded) such as resident gowns, reusable bed pads, towels, and sheets at various areas in the room including on top of the clean linen cart and on the folding table. At the same time, the surveyor observed the entry way from Staff #18's office to the clean linen room, which failed to reveal that the door was closed to prevent spread of infection and contamination of the clean linen room. On 09/05/2025 at 12:33 PM, an interview with Staff #18 revealed that staff, including herself, had to walk through the clean linen room to get to her office. Further interview revealed that clean linens should be placed inside the clean linen carts and that the front cover of the clean linen cart should always be down (ensuring infection prevention of linen and safe storage). On 09/09/2025 at 6:51 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated she understood. 5) C. difficile infection (CDI) refers to an infection from a bacterium that causes colitis, an inflammation of the colon, causing diarrhea. Contact precautions refer to measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. A review of Resident #17's medical records on 09/05/25 at 1:31 PM revealed a physician's order for contact isolation for CDI for 10 days. The order was initiated on 08/28/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/05/2025 at 1:49 PM, the surveyor and the licensed practical nurse (LPN) # 2 donned personal protective (PPE) equipment before entering Resident #17's room. After entering the room, LPN #2 asked the resident how she could assist them, and the resident stated the contents in their bedside commode needed to be emptied so they could use it. At that time, the surveyor observed the LPN #2 removing a plastic bag from the commode. The surveyor spoke briefly with the resident. After the conversation, the surveyor removed the PPE gown, used hand sanitizer and asked the LPN #2 where handwashing could be performed. The LPN #2 directed the surveyor to a room down the hall. The surveyor walked to the room, washed hands, and upon exiting, the surveyor observed LPN #2 using hand sanitizer after exiting Resident #17's room and then returned to her medication cart. The surveyor interviewed LPN #2 regarding the hand hygiene process when exiting a resident's room on contact precautions for CDI. The LPN stated that the process was to use hand sanitizer after leaving the room. When asked if she would wash her hand with soap and water after exiting a resident's room on contact precaution for CDI. The LPN #2 again stated the process was to use hand sanitizer. The surveyor informed the LPN #2 that handwashing with soap and water is required when exiting a room of a resident on contact precautions for CDI. The surveyor immediately informed the Director of Nursing and Nurse Unit Manager #6 of the observation and interview with the LPN #2.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a tour of the second floor medication storage room and staff interview, it was determined that the facility failed to discard expired supplies. This was evident for 1 of 1 medication storage rooms that were reviewed during the annual survey. The findings include: On [DATE] at 10:57 AM, a tour of the medication storage room on the second floor revealed expired supplies. The expired items that were found: 6 tubes of antifungal cream with 1% clotrimazole that expired 5/2024. 1 box of 29 xeroform gauze dressings with 3% bismuth tribromophenate and petroleum that expired on [DATE]. 1 box of 47 oil emulsion dressings that expired on [DATE]. 1 box of 5 duoderm dressings that expired on [DATE]. 4 tubes of dynagel moisturizing wound hydrogel with vitamin E and aloe vera. 3 of the tubes expired 2/2024, and 1 tube expired 12/2024. 24 32mm silicone self adhesive catheters that expired on [DATE]. 3 boxes of covid-19 BinaxNow antigen self tests that expired on [DATE]. 4 IV start kits that expired on [DATE]. 3 50unit/5ml heparin lock flush syringes that expired on [DATE]. 1 25gx5/8in 1ml tuberculin safety syringe that expired on [DATE]. 1 24gx0.75in Insyte autoguard IV needle that expired on [DATE]. 1 20gx1in Insyte autoguard IV needle that expired on [DATE]. 1 10ml syringe with 22gx1in needle that expired on [DATE]. 3 3ml syringes with hypodermic needles 25gx5/8in that expired on [DATE]. 12 optifoam gentle ex silicone faced foam and border wound dressing that expired 7/2022. 30 Maxorb II alginate wound dressings with antibacterial silver that expired on [DATE]. 19 Hydralock super absorbent wound dressings with gelling care and water proof backing that expired (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on [DATE]. 2 urinary drain bags with fig leaf covers that expired on [DATE]. 1 22fr silicone foley catheter that expired on [DATE]. 1 foley catheter insertion tray that expired on [DATE]. 18 [NAME] silicone super-absorbent dressings that expired on [DATE]. On [DATE] at 11:46 AM, an interview with the Nursing Home Administrator confirmed that the items were expired. At this time he was made aware of the concern and again at exit on [DATE].

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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 observations and staff interview, it was determined that the facility failed to treat dependent residents with dignity while dining. This was evident for 1 (Resident #41) of 2 dependent residents observed during the dining observation, a facility task in the recertification survey.The findings include:On 9/4/2025 at 12:00 PM A dining observation was conducted on the second floor. During this lunch meal observation, the surveyor noted that independent residents were served meals as they sat on their respective tables. On 9/04/2025 at 12:08 PM The surveyor observed one table that had 2 residents who needed assistance with meals. Staff #8 was assisting one resident while Resident #41 observed and waited for their meal. On 9/04/2025 at 12:15 PM Resident #41 was observed raising their hand and making incoherent sounds. On 9/04/2025 at 12:18 PM Resident #41 was observed reaching for the other resident's food, Staff #8 redirected the resident and asked Resident #41 to wait for their turn. On 9/04/2025 at 12:31 PM Resident #41 was served their meal and Staff #8 started to assist the resident with their meal. On 9/04/2025 at 12:55 PM An interview with Staff #8 was conducted. She stated that she was the only staff assigned to dining and therefore it was her task to feed residents who needed assistance with meals. She further stated that some dependent residents had to wait longer because she could only assist one resident at a time. For this lunch meal Staff #8 reported that she had only 2 residents who needed assistance, but sometimes she could have up to 3 or 4 residents who required assistance with meals.On 9/05/2025 at 07:22 AM The Director of Nursing (DON) and Administrator were made aware of the concerns.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interviews, it was revealed the facility failed to provide quarterly financial statements. This was found to be evident for 1 (Resident #10) out of 3 residents reviewed for accounting and records during the recertification survey. The findings include: On 09/04/2025 at 12:21 PM, an interview with Resident #10's family member revealed that they were not receiving the Resident's quarterly statements from the facility's business office. On 09/08/2025 at 10:33 AM, an interview with the Business Manager (Staff #17) revealed that she had not been sending quarterly statements to the residents representative. She further indicated that she doesn't send the resident's quarterly statements unless it was requested. On 09/09/2025 at 7:08 AM, the surveyor reviewed the concern with the Director of Nursing (DON), she understood the concern and indicated that the business office manager should send the statements quarterly to residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on interviews and record review, it was determined that the facility failed to protect residents' clothing from loss. This was evident for 1 (Resident #13) out of 3 residents reviewed for loss of personal property during the recertification survey.The findings include:On 9/04/2025 at 9:04 AM An interview was conducted with Resident #13's representative. They reported that the resident was admitted into the facility with gray sweatpants, 1 pair of jeans, funnel pajamas and 1 sweater and that these items were lost during laundry. The representative also stated that they had communicated these concerns to the laundry staff, Staff #12, but the facility had not found the missing clothes or replaced the items. On 9/04/2025 at 9:24 AM A review of Resident #13's admission records was conducted. The review revealed an inventory list that was dated 5/16/25. The inventory list included a sweater and 1 pair of jeans. On 9/04/2025 at 9:44 AM An interview with the Assistant Director of Nursing (ADON) was conducted. She reported that the facility process is to update each resident's inventory list as new items are received. The ADON confirmed that there was no updated inventory list for Resident #13. On 9/05/2025 at 11:03 AM An interview with laundry aide, Staff #12, was conducted. When asked if she was aware of Resident #13's missing clothes, she reported that the resident's representative had mentioned there were missing clothes a while ago. She further stated that when a resident or resident representative reports missing clothes, laundry aides will look for the missing items and if found the clothes are returned to the respective resident, if clothes are not found, the laundry aides are expected to notify the unit manager or the laundry supervisor. When asked if she had reported to anyone regarding the missing clothes for Resident #13, she stated that she had not reported to anyone yet. Staff #12 was notified that this was a concern. On 9/05/2025 at 11:41 AM The Director of Nursing (DON and the facility administrator were also notified of the concern.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that facility staff failed to ensure that residents were free of exploitation. This was evident for 1 (#114) of 5 residents reviewed for misappropriation of resident property. The findings include:A complaint was received alleging the facility applied for Medicaid for Resident #114 without proper consent and had not used the resident's veteran benefits. They alleged that because the resident was approved for Medicaid, money was removed from the resident's personal bank accounts. On 9/4/25 at 12:11 PM an attempt to reach the complainant was unsuccessful. An email was sent to the complainant with no response received. A review of Resident #114's medical record on 9/8/25 at 9:47 AM revealed under the census tab the resident was admitted on [DATE] and had Medicare A until 1/4/24 when the resident's payment changed to Medicaid. A review of the resident's profile tab revealed the resident had 2 people listed on his/her account. Review of the admission MDS [minimum data set] with the assessment reference date of 9/25/23 revealed the resident had moderate cognitive impairment. On 9/9/25 at 12:54 PM Resident #114's paper medical record was reviewed and revealed that on 10/6/23 the attending physician and nurse practitioner had signed certifications deeming the resident incapable of making decisions to include medical decisions.An interview with the Business Office Manager (BOM) on 9/9/25 at 1:13 PM revealed that when a resident was admitted to the facility, she would have them sign the forms for Medicaid without dating them, so they were ready if the resident needed them. She stated she could not remember if Resident #114 signed them at the time of admission or when they helped him/her apply for Medicaid. She reported the signatures were sent to a financial consulting company and they complete and submit the Medicaid application. She stated that if a resident does not have capacity, then they talk to a Resident Representative (RR) for consent. She stated that she was unaware that Resident #114 lacked capacity. She stated that the resident had RR who lived with the resident and was difficult to contact. When the resident and RR decided that the resident would not stay long-term, the RR would not pick the resident up on the scheduled discharge date . She stated that the resident decided to open a personal funds account at the facility and that was how the facility obtained the resident's bank information. She stated the RR was not aware of what was going on until s/he stopped receiving the resident's social security checks. On 9/9/25 at 2:44 PM the Business Office Manager (BOM) provided financial forms for Resident #114 upon surveyor's request. In the packet was a copy of the resident's Medicare Card and a VA (veteran) benefit card. Also, there were 13 documents that were blank (except for places to fill in the facility name) that were signed by the resident but there was no date on them and pages 14-17 of a Maryland Medicaid Application that was blank and contained 2 signatures, one on page 14 and the other on page 17. The 13 documents gave consent for the facility to apply to Medicaid and appeal if needed, one gave the facility access to the resident's bank account but the information was blank, there were a few forms for notification to the Social Security Administration asking them to send the resident's benefit checks to the facility, and a Resident's Funds Management Services that was blank when the resident signed it. These forms were signed by a resident who lacked the capacity to make these financial decisions. A subsequent interview with the BOM and the Nursing Home Administrator (NHA) on 9/10/25 at 12:05 PM revealed the BOM was not sure when the forms had been signed. When asked if the facility attempted to use the resident's VA benefits, the BOM manager stated she had not tried to use the resident's VA benefits. The NHA reported that the financial consulting company was contacted about sending the resident's Medicaid application. However, there were no signatures on the form that they sent. An interview with the financial consulting firm staff on 9/11/25 at 11:00 AM revealed the blank signature pages that were provided to the surveyor earlier was the consent that they used to apply for Medicaid for the resident. He stated that he assumed the resident had capacity because the facility usually sends a form stating the resident was not capable of signing. However, at this time he was not aware (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that they had received one for Resident #114. The BOM was interviewed on 9/11/25 at 12:25 PM and she stated that she knew the RR was the resident's point of contact for financial needs, but she failed to look in the medical record to see if the resident had capacity to sign the forms for Medicaid. On 9/11/25 at 12:30 PM the NHA was made aware of the concerns and acknowledged them.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined that the facility staff failed to code the resident's status accurately on the Minimum Data Set (MDS) assessment. This was evident for 1 (Resident #7) of 5 residents reviewed for unnecessary medications during the annual survey.The findings include:On 09/08/2025 at 9:28 AM, review of Resident #7's medical record revealed the resident had an order for Dasatinib (a chemotherapy medication pill by mouth) for everyday administration. Further review of the medical record revealed the resident received the medication everyday in August of 2025. On 9/10/25 at 1:17 PM, review of section O of the MDS assessment with an Assessment Reference Date (ARD) of 8/9/25 failed to reveal that the chemotherapy medication was coded on the assessment.The Assessment Reference Date (ARD) is the specific end point of look-back periods of resident status for the MDS assessment process.On 09/11/2025 at 9:01 AM, an interview with MDS coordinator (Staff #33) revealed that if a resident were receiving chemotherapy medication within the ARD of the MDS that it should be coded. During the same interview the surveyor reviewed the concern with Staff #33 regarding Resident #7's MDS with an ARD of 8/9/25. She indicated she understood and it should have been coded.

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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 record review and staff interviews, it was determined that the facility failed to create and implement a baseline care plan for 1) a resident with a stage 4 sacrum pressure ulcer and 2) a resident with Chronic Myeloid Leukemia (CML) requiring chemotherapy medication. This was found to be evident for 2 (Resident #73 and Resident #7) of 5 residents reviewed for care planning during the recertification survey.The findings include: 1) On 09/05/2025 at 09:00 AM, a review of the resident #73's admission MDS from 08/16/2024, revealed that the resident was admitted with a stage 4 pressure ulcer on their sacrum. On 09/05/2025 at 09:09 AM, review of the resident #73's weekly wound assessment from admission, dated 08/12/2025, revealed that the resident was admitted to the facility with the stage 4 sacrum pressure ulcer that was present on admission. On 09/05/2025 at 09:48 AM, a review of the resident #73's care plan from admission revealed a focus on a stage 4 sacrum pressure ulcer. On 09/05/2025 at 10:04 AM, a review of the resident #73's baseline care plan from admission on [DATE], failed to reflect the resident's existing stage 4 pressure ulcer on their sacrum. On 09/05/2025 at 10:14 AM, a review of the physician admission history and physical notes, dated 08/12/2024, revealed that the resident #73 was admitted from the hospital with a pressure ulcer on the sacrum. On 09/05/2025 at 11:41 AM, an interview with the Director of Nursing (DON) confirmed that resident #73 was admitted with the pressure ulcer and that it should have been reflected on the baseline care plan. At this time DON made aware of the concern. 2) CML is a slow growing blood cancer caused by abnormal white blood cells (the body's cells that fight off infection and disease). On 09/08/2025 at 9:28 AM, review of Resident #7's medical record revealed that the resident was admitted to the facility on [DATE] with an active diagnosis of CML. At the same time, review of Resident #7's baseline comprehensive care plan failed to reveal a care plan focus of the CML, and the plan of care regarding the residents diagnosis. On 09/09/2025 at 6:51 AM, an interview with the Director of Nursing revealed that if a resident were admitted with a diagnosis that was being treated at the facility, that she would expect the baseline comprehensive care plan to include it. The surveyor reviewed the concern regarding Resident #7 and she understood.

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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 reviews and interviews, it was determined that the facility failed to revise resident's care plan after a change in condition. This was evident for 1 resident (Resident #3) out of 2 residents reviewed for hospitalization after a change in condition during the recertification survey. The findings include:The care plan provides an opportunity to see if it meets the residents' needs by reviewing what strategies are working and which are not. It can also identify changes in the resident's condition or behavior that will require revisions of the care plan.Blood glucose refers to the level of sugar (glucose) in the bloodstream. It is the primary source of energy for the body's cells, including the brain, muscles, and organs. On 09/04/2025 at 11:33 AM, review of Resident #3's electronic health record showed a progress note dated 06/21/2025 at 8:20 PM documenting that the resident was found unresponsive. Vital signs were within normal limits; blood glucose was 157 mg/dL; the resident was administered oxygen via non-rebreather mask, and oxygen saturation was 100%. Emergency medical services were called, and the resident was transferred to the hospital. A follow-up note on 06/22/2025 at 7:48 AM indicated that the resident had been admitted to the intensive care unit (ICU) and diagnosed with respiratory distress.On 09/05/2025 at 12:07 PM, review of the resident's care plan showed the last revision was completed on 04/17/2025, which included a goal stating, Resident will have no signs and symptoms of poor oxygen absorption. There was no evidence that the care plan was revised to reflect the respiratory distress event or the hospitalization that occurred on 06/21/2025.On 09/08/2025 at 8:35 AM, during an interview with the Director of Nursing (DON), when she was asked if Resident #3's care plan was revised after the respiratory distress event which led to the resident's hospital transfer and admission into the ICU, she confirmed that the care plan was not revised following the event. She acknowledged that the care plan should have been revised to reflect the change in condition and stated that the facility would ensure care plans were updated promptly in the future.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, it was determined that facility staff failed to follow a physician's order. This was evident for 1 (#111) of 2 residents reviewed for pain management.The findings include:A medical record review for Resident #111 on 9/9/25 at 9:43 AM revealed a medication administration record (MAR) for May of 2025, which noted the resident was ordered an opioid 10 mg as needed every 4 hours for a pain level of 7-10. However, on the following dates and times facility staff failed to follow the physicians orders and gave the medications for a pain level less than 7; 5/7 at 9:00 PM for pain level of 6, 5/9 at 1:22 PM for a pain level of 0, 5/13 at 12:09 AM for a pain level of 0, 5/14 at 6:30 PM for a pain level of 6, 5/17 at 1:18 PM for a pain level of 0, 5/27 at 9:44 PM for a pain level of 6, 5/28 at 6:00 PM for a pain level of 0, 5/28 at 11:59 PM of a pain level of 6, 5/29 at 2:15 PM for a pain level of 0, 5/30 at 8:41 PM for a pain level of 6, and 5/31 at 10:10 AM for a pain level of 4. The following dates were for June 2025; 6/2 at 2:17 PM for a pain level of 0 and 6/5 at 5:08 PM for a pain level of 0. An interview with Licensed Practical Nurse (LPN) #34 on 9/10/25 12:21 PM revealed that she was aware that the medication was to be given based on the physician's parameters of a pain level of a 7-10. She reported Resident #111 was demanding when s/he requested their pain medication and would not give a pain score at times. Reviewed the MAR with LPN #34 when she documented a pain score of 0 on 6/5/25 and administered the pain medication. She reported she could not recall if the resident did not give a pain score or if it was a typographical error. When asked if she had documented a pain assessment in the progress notes she reported she had not. During an interview with the Director of Nursing (DON) on 9/10/25 at 1:49 PM she reported staff were expected to provide and level of pain for the resident and then give the medication according to the parameters. The DON acknowledge the concern.

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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 surveyor observation, review of the medical records, and interview with facility staff, it was determined the facility failed to provide quality care to residents by 1) not following physician orders for oxygen therapy and 2) not reporting a change in condition. This was found to be evident for 2 residents (Residents #45 and #47) out of 4 residents observed on oxygen therapy and 1 resident (Resident #115) of 2 residents reviewed for pressure ulcer complaints during the facility's recertification survey.The findings include:1) Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from the health care provider. Oxygen saturation or SpO2, is a medical measurement that indicates the percentage of oxygen-carrying hemoglobin in the blood compared to the total amount of hemoglobin. It is a key indicator of how well oxygen is being distributed from the lungs to the rest of the body. An oxygen flow rate is the volume of oxygen delivered to a patient per minute, usually measured in liters per minute (LPM). On 09/04/2025 at 8:08 AM, during the initial tour of the facility, Resident #45 was observed in bed with a nasal cannula in place and oxygen flowing at 3.5 liters per minute (LPM). On 09/04/2025 at 8:21 AM, in an interview with Registered Nurse (RN#3), when asked how many liters of oxygen was prescribed for Resident #45, she stated it was 3 LPM. When called to verify the oxygen flow rate, she confirmed it was set to 3.5 LPM and stated she would readjust it since the surveyor had noticed the discrepancy. When asked how often oxygen flow rate was checked, she stated that it was checked every other day and that it was also checked during the tubing changes. When asked when it was last checked, she stated that she did not know. On 09/04/2025 8:23 AM, Registered Nurse (RN#3) informed the surveyor that after checking the physician's order for Resident #45, he/she was to receive oxygen at 2 LPM. She immediately adjusted the flow meter to 2 LPM. On 09/04/2025 at 8:43 AM, during the continued tour of the facility, Resident #47 was observed in bed with oxygen running at 2.5 LPM via a nasal cannula. On 09/04/2025 at 8:45 AM, in an interview with Licensed Practical Nurse (LPN#4) when asked how many liters of oxygen was prescribed for Resident #47, she stated that he/she was prescribed 2 liters of oxygen and when asked for dual observation of the oxygen flow rate, she confirmed it was set to 2.5 LPM and readjusted it to 2 LPM. On 09/04/2025 at 12:02 PM, review of Resident #45's order on 09/05/2024 showed “Oxygen Inhalation (via nasal cannula at 2 LPM) to keep oxygen saturation greater than 90% related to Chronic Obstructive Pulmonary Disease (COPD) every shift for shortness of breath”. On 09/04/2025 at 12:13 PM, reviewed of Resident #47's order on 10/06/2024 showed “oxygen at 2L/min via nasal cannula continuously every shift”. On 09/04/2025 at 1:48 PM, in an interview with the Director of Nursing (DON) while the Nursing Home Administrator (NHA) was present, when she was asked how often the oxygen flow meters were (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked, she stated that the nurses checked it weekly when changing the tubing. When she was asked how the nurses would know the amount of oxygen the residents were getting every shift, if it was checked weekly, she stated “There was no how the nurses would have known.” When she was informed about the concerns with oxygen flow rate for the residents and staff not following the order for the amount of oxygen level every shift, She acknowledged the error and stated that she would provide in-service education on following physician's order and to ensure flow meters were checked every shift going forward so as to prevent future occurrences of increased or decreased oxygen rate. 2) On 9/4/25 at 10:53 AM a review of a complaint received regarding Resident #115 revealed that the resident was sent to the hospital from the facility 4 days after admission in 2023. The complainant reported that the resident had low blood sugar and was septic from his/her wounds. The complainant reported that when the facility nurse called to report the resident was being sent to the hospital but was unable to provide any details as to what was going on with the resident. A medical record review for Resident #115 on 9/8/25 at 5:03 PM revealed a discharge summary from the acute care hospital dated 6/8/23. It was documented that the resident came to the hospital due to low blood pressure and anemia. The summary read that the resident had an extended stay in the hospital between April and May of 2023 and was bedbound at home which caused a sacral pressure ulcer. A review of the history and physical conducted by the attending physician on 6/9/23, revealed the resident was being treated for the following conditions; end stage renal disease and required peritoneal dialysis, type 2 diabetes, hypothyroidism, gastrointestinal bleeding, leukocytosis, sacral ulcer, and delirium related to high doses of steroid treatment during hospitalization. Review of the admission minimum data set (MDS) with the assessment reference date of 6/12/23 revealed that the resident had no cognitive impairment. Review of the progress notes revealed that on 6/12/23 at 9:59 AM it was noted the resident was refusing to eat breakfast. Then at 1:34 PM Registered Nurse (RN) #23 wrote that the resident reported s/he had vomited 4 times in the morning but there was no evidence of emesis and no staff reported vomiting so the nurse will continue to monitor. There was no change in condition found or a progress note documenting that the nurse conducted an assessment of the resident for this change in condition or notification to a practitioner. Further review of the progress notes revealed at 4:44 PM the same nurse wrote the resident was found to be lethargic and she obtained an order to send the resident to the hospital. RN #23 started a change in condition evaluation and upon review of the document it was revealed the nurse failed to obtain vital signs at the time of the change, she failed to obtain a blood sugar level, and failed to complete a thorough assessment of the resident prior to sending them to the hospital. On 9/9/25 at 9:45 AM a review of the emergency department (ED) report dated 6/12/23 for Resident #115 revealed that EMS (emergency medical system) reported that the resident's blood sugar was 37 (normal blood sugar levels are between 70 – 110) and they administered a glucose (sugar) past and IV (intravenous) fluids prior to arrival to the ED. The ED physician documented that the resident was able to report that s/he was feeling ok but was having pain in the sacrum. On 9/9/25 at 8:56 AM and 9:39 AM contact information for RN #23 was requested, but facility staff failed to provide the information. Therefore, the nurse was unavailable for an interview. An interview with Licensed Practical Nurse (LPN) #6 on 9/9/25 at 8:56 AM revealed that as the Unit Manager she remembered Resident #115 as a pleasant person who was cognitively intact. She would have expected the nurse to complete a change in condition (an assessment form) for a resident who was complaining of vomiting and to notify the practitioner. She stated that when the nurse found the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident lethargic, she would have expected her to obtain a set of vital signs and check the resident's blood sugar since she was diabetic and reported vomiting earlier in the day. Furthermore, she stated that the change in condition form should have been fully completed prompting the nurse to do a thorough assessment. She stated that the nurse was an agency nurse and was not currently working at the facility. Requested the last known contact for the nurse. On 9/9/25 at 9:39 AM the concerns were reviewed with the Director of Nursing (DON) and she acknowledged the concerns.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview with staff, and record review, it was determined that the facility failed to implement an intervention, determined to be necessary, for residents who were identified as a fall risk. This was evident of 2 of 5 residents (Resident #11 and Resident #55) reviewed for accidents during the annual survey.The findings include:A fall mat is a cushioned, low-profile floor mat designed to reduce the impact and severity of injuries from falls, particularly for elderly or at-risk individuals, by absorbing the force of impact. A fall risk assessment is an evaluation used to determine an individual's likelihood of experiencing a fall. 1) On 09/04/25 at 9:09 AM, during an interview with Resident #55, the surveyor observed the resident sitting in a recliner positioned to the left of the bed. A catheter was connected to the resident and attached to a peritoneal dialysis machine located on the right side of the bed. The resident's legs were elevated, and the surveyor observed scabs that appeared to be newly opened with dried blood along the resident's leg. On 09/04/25 at 9:18 AM, a licensed practical nurse (LPN) #2 entered the resident's room with wound care supplies and began cleansing the resident's legs. The survey asked the LPN how the resident obtained the scabs. The LPN #2 stated that the resident had a fall last night. When asked about the resident's mental status, the LPN #2 explained that the resident has become confused since admission. No safety mats were observed in the resident's room. 09/04/25 at 4:48 PM, a review of Resident #55's electronic medical record showed the resident was admitted to the facility on [DATE], with multiple diagnoses, including a history of repeated falls. A review of progress notes and evaluation records indicated that the resident had a fall on 08/16/25 and 08/17/25. On 08/19/25, the facility's interdisciplinary team held a meeting to discuss the resident's falls, however no adjustments were made to the resident's care plan. Additional falls were documented on 08/27/25 and 08/28/25. A review of the resident's care plan revealed a new intervention, fall mats to bilateral sides of bed, with an initiation date of 08/28/25. The resident had additional falls on 08/31/25 and 09/04/25. A review of the care plan showed another intervention, bilateral fall mats, initiated on 09/01/25. On 09/05/25 at 7:18 AM, the surveyor entered Resident #55's room and observed the resident sitting in a recliner next to their bed. No safety mats were present in the room. The surveyor exited the room and proceeded down the hall to speak with staff regarding the facility's fall protocol. At 7:21 AM, the surveyor observed the night LPN #5 supervisor walking toward the resident's room carrying fall mats. The surveyor overheard a staff ask LPN #5 if the mats were for Resident #55, which the nurse supervisor responded, yes. On 09/05/25 at 7:49 AM, during an interview with the Director of Nursing and Nurse Unit Manager (UM) #6, the surveyor discuss the multiple falls Resident #55 experienced between 08/16/25 and 09/04/25. The surveyor inquired about interventions in place to ensure the resident's safety. The DON explained that residents with a history of falls should have safety interventions included in their care plan and staff are expected to perform frequent rounding on residents with multiple falls. The surveyor informed the DON and UM #6 of documentation indicating fall mats should be in place as an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention, however, observations showed that no fall mats were present. The UM #6 acknowledged that she was responsible for ordering fall mats for the resident and stated that she failed to follow up to ensure the fall mats were in place. 2) A medical record review for Resident #11 was conducted 9/4/2025 at 12:15 PM. It was observed that Resident #11 had an order in their medical record dated 1/18/2024 that stated, please make sure bed lowered to ground and fall mat in place. The resident was observed lying in bed in their room on 9/4/2025 at 12:30 PM, no fall mat was noticed by survey team. An additional observation was conducted on 9/5/2025 at 11:20 AM. Resident #11 was observed lying in bed in their room, no fall mats were seen in room by the survey team. Further medical record review on 9/8/2025 at 8:59 AM revealed that Resident #11's care plan included interventions related to previous falls in the facility. Resident #11's most recent fall assessment conducted by the facility dated 8/15/2025 was scored a 10 (moderate risk of falls). On 9/8/2025 at 9:50 AM, the survey team toured Resident #11's room with UM #6. UM #6 confirmed that there were no fall mats in place in the resident's room. UM #6 stated that fall mats are requested through the maintenance department and would look to see if a request was placed for the ordered fall mats. UM #6 stated to surveyor on 9/8/2025 at 10:13 AM that no request had been made for fall mats for Resident #11.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, record reviews, and interviews, it was determined that facility staff to 1.) ensure safe and sanitary storage of dialysis equipment and supplies, 2.) establish dialysis specific infection control policy, and 3.) assess and document care of peritoneal catheter access site. This deficient practice was evident for 2 (#17, #55) of 2 residents reviewed for dialysis during the annual survey.The findings include: Dialysis - A process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis that are currently in common use are hemodialysis (HD) and peritoneal dialysis (PD)1.) On 09/04/25 at 9:18 AM, during an interview at the entryway of Resident #55's room with the licensed Practical Nurse (LPN) #2, the surveyor observed a delivery person bringing multiple boxes of PD supplies. The delivery person stacked and stored the boxes on stand, and the remaining boxes were stored on the floor inside the resident's room. Due to the way the boxes were stored and arranged, a person standing at the doorway could not see the resident from the entryway. The following items were delivered and stored in the resident's room:1 fleet of Stay Safe 1.5% Dextrose1 fleet of Stay Safe 2.5% Dextrose3 fleet of Liberty Cycler Solution1 fleet of Alcavis 50 Solution15 fleet of Delfex Biofine 2.5% Dextrose1 fleet of Stay Safe Drain Set1 fleet of Under pads 1 fleet of Small vinyl gloves1 fleet of Tegaderm transparent dressing1 fleet of 4x4 Island sterile dressings1 fleet of Drain sponge15 fleet of Delfex Biofine 1.5% Dextrose1 fleet of Sterile stay safe [NAME] 09/05/25 at 12:05 PM, during an interview with the Nurse Unit Manager #6, the surveyor asked about the facility's process for storing resident's peritoneal dialysis (PD) supplies. The UM #6 explained that residents receiving PD are placed in a larger room, and their supplies are delivered and stored within the resident's room. When about the number of boxes stored in Resident #55's room, the UM #6 stated that the facility does not have sufficient space to store resident's PD supplies, which is why the supplies are kept in the resident's room. The UM #6 further explained that the facility maintains a storage room with extra PD supplies if a resident runs out, however, there is no additional designated storage area for PD supplies. 2.) On 09/05/2025, a review of Resident #17's medical record revealed that the resident was diagnosed with C. difficile infection (CDI) and placed on contact isolation precaution on 08/28/25. On 09/04/25 the surveyor observed that Resident #17 was sharing a room with another resident who receives PD. A review of Unit 1 resident censes from 08/28/25 to 09/04/25 showed that other unoccupied rooms were available, including rooms occupied by a single resident receiving PD who was not on contact isolation.On 09/05/25 at 11:41 AM, during an interview with the Assistant Director of Nursing (ADON) #1, the surveyor inquired about Resident #17, who is on contact isolation, and their roommate, who is on enhance barrier precautions (EBP). The surveyor asked why the resident on EBP were not moved to a different room. The ADON #1 stated that because the resident on EBP does not use the restroom and Resident #17 only uses a bedside commode, she believed it was acceptable for them to remain in the same room.On 09/05/25 at 12:03 PM, during an interview with the Nurse Unit Manager (UM) #6, the surveyor inquired about the shared room occupied by two residents who both received PD, one on contact isolation and the other on EBP. The UM #6 stated that she had been advised by the previous infection control staff that residents could remain in the same room as long as they were not sharing a bathroom. The surveyor requested to review the facility's infection control policy for dialysis. On 09/08/25 at 10:55 AM, the UM #6 provided the surveyor with the facility's Infection Prevention and Control Program. A review of the document failed to show evidence of a specific dialysis infection control policy. The surveyor informed the UM #6 that (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility should have infection control policies specific to dialysis, which address protocols such as the disposal of dialysis byproducts, cleaning and disinfecting dialysis equipment, procedures for spills or splashes on furnishing, as well as peritoneal catheter care and dressing changes. The UM #6 acknowledged the surveyor and reported that she would check and follow up. On 09/08/2025, the surveyor followed up with the UM #6 and Director of Nursing regarding the facility's dialysis specific infection control policy. Both stated that the facility does not have a separate dialysis infection control policy. 3.) On 09/08/2025 at 8:01 AM, a review of the care plans for Resident #17 and Resident #55 indicated that both residents required PD related to kidney failure. An intervention for each resident included checking and changing the PD catheter dressing site daily and documenting the care. A review of both resident's medical records failed to show evidence that their PD dialysis catheter sites were checked and dressing were changed daily. On 09/08/2025, during an interview with Licensed Practical Nurse (LPN) #2, the surveyor asked where staff documented the resident's daily catheter dressing change. The LPN directed the surveyor to a folder for both residents and explained the daily documentation is completed on a flow sheet. A review of the flow sheet revealed a section titled Exit Site Condition/Other Comments (Call Nurse immediately for cloudy fluid, abdominal pain or fever). A review of Resident #17's flow sheet showed that staff documented the word clear under exit site condition. On 09/04/25 and 09/07/25, this section was left blank. For Resident #55, staff documented the word clear under exit site condition. On 09/08/25, during an interview with the UM #6, the surveyor reviewed Resident #17s and Resident #55s care plan, along with the flow sheets. The UM #6 confirmed that PD catheter care is documented only on the flow sheet. When the surveyor asked where staff were documenting daily PD catheter dressing changes and catheter site assessments, the UM #6 reviewed the flow sheets and acknowledge that staff were not documenting catheter care. On 09/08/25 the surveyor informed the DON of PD catheter care concerns.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interviews and administrative record reviews, it was determined that the facility staff failed to conduct annual nursing aide performance reviews. This deficient practice was evident for 2 out of 5 nursing aide annual performance reviews, reviewed during the annual survey.The findings include: On 09/08/2025 at 1:34 PM, the surveyor requested employee files from the Director of Nursing (DON) for Geriatric Nursing Assistant (GNA) #9, GNA #11, GNA #20, GNA #21, and GNA #22. The surveyor requested that each file include documentation of the employee's annual review, annual training, and immunizations.On 09/09/2025 at 7:30 AM, a review of the employee files for GNA #11, GNA #21, and GNA #22 failed to reveal nurse aide annual performance review. On 09/09/2025 at 9:00 AM, the surveyor informed the DON about the missing nurse aide annual performance reviews. On 09/9/2025 at 9:03 AM, during an interview with Human Resources (HR) #17, the surveyor asked who was responsible for maintaining nursing aide annual performance reviews. The HR #17 stated that she was responsible. When asked to explain the facility's process for annual reviews, she reported that there was no process in place. The survey asked how she determined when annual performance reviews were due. The HR #17 stated that she knew staff well enough to remember when their reviews were due. When asked how she notified supervisors of upcoming annual performance reviews, HR stated that she verbally informed them. The surveyor asked if she used any filing system to process or track annual performance reviews, and the HR acknowledged that there was no system in place to track annual performance reviews. On 09/09/25 at 10:24 AM, the surveyor interviewed the Nurse Unit Manager (UM) #6 regarding the facility's process for conducting nurse aide annual performance reviews. The UM #6 advised the surveyor to speak with the HR #17. The surveyor inquired about annual reviews for GNA #11, GNA #21 and GNA #22, the UM #16 provided documentation for GNA #22 and stated she could not provide annual performance review for GNA #11 and GNA #21.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, it was determined that staff failed to ensure that a resident did not have unnecessary medications. This was evident for 1 (#111) of 6 residents reviewed for unnecessary medications.The findings include:A pain level score of 1-10 is used to determine the resident's level of pain, 1 being the lowest amount of pain and 10 being the greatest amount of pain. A medical record review for Resident #111 on 9/9/25 at 4:30 PM revealed physician's order summary that the resident was ordered an opioid 10 mg as needed every 4 hours for a pain level of 7-10 dated 5/7/25. However, on the following dates and times facility staff administered the pain medication for no pain (as indicated by a 0): 5/9 at 1:22 PM, 5/13 at 12:09 AM, 5/17 at 1:18 PM, 5/28 at 6:00 PM, and 5/29 at 2:15 PM. On the following dates in June 2025, it was administered for no pain: 6/2 at 2:17 PM and 6/5 at 5:08 PM. During an interview with the attending physician on 9/10/25 at 1:03 PM he reported he was aware that Resident #111 had an opioid addiction and was on methadone. He stated that he would not expect staff to give the resident a pain medication when the resident reported a 0 pain score. On 9/10/25 at 12:21 PM an interview with Licensed Practical Nurse (LPN) #34, who administered the pain medication to the resident on 6/5/25 for a pain level of 0. She reported that it was possible it was an error, but she was not sure. She further reported that the resident was demanding when it came to his/her pain medication and sometimes would refuse to give a pain score. When asked if she had documented this or notified anyone she stated she had not. An interview with the DON on 9/11/25 at 10:00 AM revealed she was aware of the resident's behaviors regarding his/her pain medications. She stated that the resident would stand at the medication cart until it was time for another dose. However, she would not expect staff to administered a pain medication when it was not indicated and to call a supervisor if the resident was acting out. She acknowledged the concerns.

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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, record review and interviews, it was determined that the facility failed to serve residents meals based on their meal tickets. This was evidence for 3 residents (Resident #6, #40, and #14) out of 8 residents observed during dining.The findings include:A Magic Cup is a fortified nutritional supplement. It is designed to add calories and protein to the diets of individuals experiencing malnutrition or involuntary weight loss. Each serving of magic cup provides a significant amount of calories and protein, along with essential vitamins and minerals. On 9/04/2025 at 8:24 AM Resident #6 was served breakfast while the surveyor was at the bedside, the breakfast included a pureed meal but there was no magic cup. The resident reported the facility often failed to serve them magic cups during breakfast. The meal ticket that was on the resident's food tray stated Resident #6 should have a magic cup with all meals.On 9/04/2025 at 9:45 AM a review of Resident #6's medical record was conducted. The review revealed an order entered on 7/21/25 that stated the resident should have a magic cup with all meals for malnutrition. Additionally, there was a dietary progress note dated 7/21/25 that stated Resident #6's nutrition interventions which included magic cups three times with meals. On 9/04/2025 at 11:58 AM another dining observation was conducted on the second-floor unit. On 9/04/2025 at 12:21 PM Resident # 40 was observed removing 2 slices of bread from their plate. Review of the meal ticket indicated no bread. On 9/04/2025 at 12:27 PM a brief interview with Resident #40 was conducted. When asked why they removed the served bread, the resident stated that they dislike bread and that they have asked the facility several times not to serve them bread because of their diagnoses, but the facility constantly served them bread with meals. On 9/04/2025 at 12:29 PM Resident #14 was served their plate which had lasagna but did not have bread. A review of the meal ticket placed next to their plate indicated that the resident was supposed to be served a slice of bread. On 9/04/2025 at 12:34 PM an interview with the dietary manager, Staff #7, was conducted. When asked if she was aware of Resident #40's preferences and dislike for bread, Staff #7 stated that she was aware. She also reported that it was the facility's protocol to ensure that residents were served what is written on the meal ticket.The surveyor and Staff #7 then proceeded to inspect the meal tickets and the meals that were served to Resident #40 and #14. She acknowledged that the residents' meal tickets did not match what residents were served. On 9/05/2025 at 7:22 AM the Director of Nursing (DON) and Facility Administrator were notified of the findings.

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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. Based on record review and staff interviews, it was determined the facility failed to 1) maintain medical records on residents that are complete and accurately documented and 2) validate the signature on a bed hold policy form and included conflicting information regarding the resident's ability to sign the document. This was evident for 1 resident (Resident #3) out of 2 residents reviewed for hospitalization and 1 (Resident #111) of 6 residents reviewed for unnecessary medications during the facility's recertification survey.The findings include:1a) On 09/04/2025 at 11:33 AM, review of Resident #3's electronic health record revealed that his/her quarterly BIMS score on 07/03/2025 was 15 which showed that the resident was cognitively intact. The health record also showed a progress note dated 06/21/2025 at 8:20 PM documenting that the resident was found unresponsive. Vital signs were within normal limits; blood glucose was 157 mg/dL; the resident was administered oxygen via non-rebreather mask, and oxygen saturation was 100%. Emergency medical services were called, and the resident was transferred to the hospital. A follow-up note on 06/22/2025 at On 09/05/2025 at 12:31 PM, the surveyor requested the transfer notification and a copy of Resident #3's bed hold policy from the Director of Nursing (DON). On 09/08/2025 at 7:27 AM, the DON provided the document for Resident #3's change in condition on 06/21/2025 and upon review, the surveyor discovered that there was no bed hold policy and the Responsible Party's (RP) name documented as the person notified at the time of the incident was not the same name as noted on the face sheet. The surveyor requested the bed hold policy from the DON for the second time. On 09/08/2025 at 7:55 AM, in an interview with the DON, when she was asked who was the Responsible Party (RP) for Resident #3, she stated that the resident was his/her own RP and when she was asked who else would be notified in case of emergency, she stated that Resident #3's daughter, whose name was on the face sheet would be notified. When asked who was the person that was notified at the time of hospital transfer, she stated that she did not know the name and that she would follow up and inform the surveyor about her findings. On 09/08/2025 8:14 AM, in an interview with Resident #3, when asked who would be contacted in an emergency, the resident named his/her daughter. When asked if she recognized the name of the contacted person at the time of his/her hospital transfer on 06/21/2025, the resident stated that he/she did not recognize the name and did not know the person. On 09/08/2025 at 8:22 AM, the DON admitted that she had mistakenly entered the wrong name as the resident's representative in Resident #3's record. She also stated that an agency nurse had worked with the resident that day and that she was only trying to assist the agency nurse. When the DON was informed that the issue with the wrong name in the resident's record was a concern, she agreed and stated that she should have checked the name of the right emergency contact and entered it accurately. 1b) A pain level score of 1-10 is used to determine the resident's level of pain, 1 being the lowest amount of pain and 10 being the greatest amount of pain. A medical record review for Resident #111 on 9/9/25 at 4:30 PM revealed physician's order summary that the resident was ordered an opioid 5 mg as needed every 4 hours for a pain level of 4-6 and opioid (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 mg as needed every 4 hours for a pain level of 7-10 dated 5/7/25. On 9/10/25 at 1:00 PM a review of the resident's May 2025 medication administration record (MAR) and the controlled substance sign out sheets revealed that the resident had 16 additional doses signed out on the controlled substance sheet than documented on the MAR. The dates and times were as follows: 5/9/25 at 9:00 PM, 5/10/25 at 8:00 PM, 5/11/25 at 1:00 PM, 9:00 PM, 5/12/25 at 1:00 PM, 5/13/25 at 8:00 PM, 5/15/25 at 3:00 PM, 5/16/25 at 2:30 PM and 8:00 PM, 5/19/25 at 8:00 PM, 5/21/25 at 10:10 PM, 5/22/25 at 10:05 AM, 5/25/25 at 2:00 PM, 5/26/25 at 1:00 PM, 5/30/25 at 10:15 AM and 2:15 PM. The failure of staff to document in the medical record all the doses administered does not allow the physician to track the resident's pain management to determine the effectiveness. An interview with Licensed Practical Nurse (LPN) #34 on 9/10/25 12:21 P revealed that staff were expected to sign off the controlled substance log and then sign off on the MAR and document the pain level of the resident. On 9/11/25 at 10:00 AM the findings were reviewed with the Director of Nursing and the Regional Director of Nursing. The concerns were acknowledged. 2) On 09/05/2025 at 12:31 PM, the surveyor requested the transfer notification and a copy of Resident #3's bed hold policy from the Director of Nursing (DON). On 09/08/2025 at 7:27 AM, the surveyor requested the bed hold policy from the DON for the second time. On 09/08/2025 at 8:01 AM, the DON provided the surveyor with a bed hold policy signed and dated 06/21/2025. On 09/08/2025 8:14 AM, in an interview with Resident #3, when he/she was shown the bed hold policy form from 06/21/2025 and asked if she had signed it prior to his/her transfer to the hospital, Resident #3 stated that he/she did not recognize the signature and did not recall signing it. On 09/08/2025 at 8:32 AM, during an interview with the Director of Nursing (DON), when asked if Resident #3 was responsive and alert at the time of the hospital transfer on 06/21/2025, she stated that she was not sure. When asked if there was any documentation verifying that the resident was alert and capable of signing the bed hold policy form, the DON stated that she did not have any supporting documentation. When asked how the form was completed if the resident had been documented as unresponsive at the time of transfer, the DON stated that the agency nurse must have filled out the form on behalf of the resident as part of the hospital transfer process. When informed that completing a legal document on behalf of an unresponsive resident was a concern, the DON acknowledged the issue and stated that it would have been more appropriate to leave the form blank until the resident or responsible party could complete it. She further stated that the agency nurse should not have completed the form and that this practice would not reoccur.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interviews and administrative record reviews, it was determined that the facility failed to provide the required Quality Assurance and Performance Improvement (QAPI) training to staff. This deficient practice was evident in 5 of 5 employee files reviewed during the annual survey. The findings include: On 09/08/2025 at 1:34 PM, the surveyor requested employee files from the Director of Nursing (DON) for Geriatric Nursing Assistant (GNA) #9, GNA #11, GNA #20, GNA #21, and GNA #22. The surveyor requested that each file include documentation of the employee's annual review, annual training, and immunizations.On 09/09/2025 at 7:30 AM, a review of the employee files for GNA #9, GNA #11, GNA #20, GNA#21, and GNA #22 failed to reveal QAPI training. On 09/09/2025 at 9:00 AM, the surveyor informed the DON and the Assistant Director of Nursing (ADON) #1 about missing QAPI training. The DON explained that the facility's previous nurse educator had been responsible for maintaining nursing staff education record. Since the educator's departure, she is having difficulty locating employee education records. When asked who is currently responsible for maintaining the education records, the DON stated human resources is now responsible. On 09/9/2025 at 9:03 AM, during an interview with Human Resources (HR) #17 regarding employee annual performance reviews and annual training, the Administrator entered the HR office and stated he overheard the surveyor's interview. He asked if he could provide the surveyor with the facility's annual education requirements. The surveyor accompanied the Administrator to his office, where he reviewed the annual training on his computer and explained that the facility uses an educational platform called Carefeed that was updated June 2025 to include all required annual staff training. The surveyor informed the Administrator that QAPI training for 2024 and 2025 was missing from the GNA employee files. The Administrator then directed the surveyor back to HR #17 to obtain the missing QAPI training.A review of QAPI training records in Carefeed with HR #17 for GNA #9, GNA #11, GNA #21, GNA #20, and GNA #22 failed to show evidence of QAPI training for 2024. Further review revealed that the facility assigned QAPI training through Carefeed on 09/08/25 at 3:35 PM, after the surveyor had requested employee files earlier that same day. The surveyor again asked HR #17 if they could provide documentation of any QAPI training for the requested GNA employee files from 2024. HR #17 stated they had rechecked but were unable to locate any prior QAPI training for the GNA's. On 09/09/25 at 10:01 AM, the ADON #1 provided the surveyor with documentation for in-service training conducted on 01/17/25 and 01/27/25. A review of the training topics failed to show evidence of QAPI training. The surveyor informed the ADON #1 that the files provided did not include QAPI training. The ADON #1 acknowledged the missing training and stated that this was all the education she was able to find.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interviews and administrative record reviews, it was determined that the facility failed to provide the required Infection Control training to staff. This deficient practice was evident in 3 of 5 employee files reviewed during the annual survey. The findings include: On 09/08/2025 at 1:34 PM, the surveyor requested employee files from the Director of Nursing (DON) for Geriatric Nursing Assistant (GNA) #9, GNA #11, GNA #20, GNA #21, and GNA #22. The surveyor requested that each file include documentation of the employee's annual review, annual training, and immunizations.On 09/09/2025 at 7:30 AM, a review of the employee files for GNA #11, GNA #21, and GNA #22 failed to reveal infection control training. On 09/09/2025 at 9:00 AM, the surveyor informed the DON and the Assistant Director of Nursing (ADON) #1 about missing infection control training. The DON explained that the facility's previous nurse educator had been responsible for maintaining nursing staff education record. Since the educator's departure, she is having difficulty locating employee education records. When asked who is currently responsible for maintaining the education records, the DON stated human resources is now responsible. On 09/9/2025 at 9:03 AM, during an interview with Human Resources (HR) #17 regarding employee annual performance reviews and annual training, the Administrator entered the HR office and stated he overheard the surveyor's interview. He asked if he could provide the surveyor with the facility's annual education requirements. The surveyor accompanied the Administrator to his office, where he reviewed the annual training on his computer and explained that the facility uses an educational platform called Carefeed which was updated June 2025 to include all required annual staff training. The surveyor informed the Administrator that infection control training for 2024 and 2025 was missing from the GNA employee files. The Administrator then directed the surveyor back to HR #17 to obtain the missing training.A review of infection control training records in Carefeed with HR #17 for GNA #11, GNA #21, and GNA #22 failed to show evidence of infection control training for 2024. Further review revealed that the facility assigned infection control training through Carefeed on 09/08/25 at 3:35 PM, after the surveyor had requested employee files earlier that same day. The surveyor again asked HR #17 if they could provide documentation of any infection control training for the requested GNA employee files from 2024. HR #17 stated they had rechecked but were unable to locate any prior infection control training for the GNA's. On 09/09/25 at 10:01 AM, the ADON #1 provided the surveyor with documentation for in-service training conducted on 01/17/25 and 01/27/25. A review of the training failed to show evidence of infection control training for GNA #11, GNA #21, and GNA #22. The surveyor informed the ADON that the files provided did not include infection control training for GNA #11, GNA #21, and GNA #22. The ADON acknowledged the missing training and stated that this was all the education she was able to find.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215090	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Loch Raven	8720 Emge Road Baltimore, MD 21234

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on interviews and administrative record reviews, it was determined that the facility failed to provide the required Compliance and Ethics training to staff. This deficient practice was evident in 3 of 5 employee files reviewed during the annual survey. The findings include: On 09/08/2025 at 1:34 PM, the surveyor requested employee files from the Director of Nursing (DON) for Geriatric Nursing Assistant (GNA) #9, GNA #11, GNA #20, GNA #21, and GNA #22. The surveyor requested that each file include documentation of the employee's annual review, annual training, and immunizations.On 09/09/2025 at 7:30 AM, a review of the employee files for GNA #11, GNA#21, and GNA #22 failed to reveal compliance and ethics training. On 09/09/2025 at 9:00 AM, the surveyor informed the DON and the Assistant Director of Nursing (ADON) #1 about missing compliance and ethics training. The DON explained that the facility's previous nurse educator had been responsible for maintaining nursing staff education record. Since the educator's departure, she is having difficulty locating employee education records. When asked who is currently responsible for maintaining the education records, the DON stated human resources is now responsible. On 09/9/2025 at 9:03 AM, during an interview with Human Resources (HR) #17 regarding employee annual performance reviews and annual training, the Administrator entered the HR office and stated he overheard the surveyor's interview. He asked if he could provide the surveyor with the facility's annual education requirements. The surveyor accompanied the Administrator to his office, where he reviewed the annual training on his computer and explained that the facility uses an educational platform called Carefeed that was updated June 2025 to include all required annual staff training. The surveyor informed the Administrator that compliance and ethics training for 2024 and 2025 were missing from the GNA employee files. The Administrator then directed the surveyor back to HR #17 to obtain the missing training.A review of compliance and ethics training records in Carefeed with HR #17 for GNA #11, GNA #21, and GNA #22 failed to show evidence of compliance and ethics training for 2024. Further review revealed that the facility assigned compliance and ethics training through Carefeed on 09/08/25 at 3:35 PM, after the surveyor requested employee files earlier that same day. The surveyor again asked HR #17 if they could provide documentation of any compliance and ethics training for the requested GNA employee files from 2024. HR #17 stated they had rechecked but were unable to locate any prior compliance and ethics training for the GNA's. On 09/09/25 at 10:01 AM, the ADON #1 provided the surveyor with documentation for in-service training conducted on 01/17/25 and 01/27/25. A review of the training failed to show evidence of compliance and ethics training for GNA #11, GNA #21, and GNA #22. The surveyor informed the ADON #1 that the files provided did not include compliance and ethics training for GNA #11, GNA #21, and GNA #22. The ADON #1 acknowledged the missing training and stated that this was all the education she was able to find.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interviews and administrative record reviews, it was determined that the facility failed to provide geriatric nursing assistants (GNA) with the required minimum of 12 hours of annual in-service training. This deficient practice was evident in 5 out of 5 GNA employee files reviewed during the annual survey.The findings include: On 09/08/2025 at 1:34 PM, the surveyor requested employee files from the Director of Nursing (DON) for Geriatric Nursing Assistant (GNA) #9, GNA #11, GNA #20, GNA #21, and GNA #22. The surveyor requested that each file include documentation of the employee's annual review, annual training, and immunizations.On 09/09/2025 at 7:30 AM, a review of the employee files for GNA #9, GNA #11, GNA #20, GNA #21, and GNA #22 failed to reveal 12 hours of nurse aide in-service training. On 09/09/2025 at 9:00 AM, the surveyor informed the DON and the Assistant Director of Nursing (ADON) #1 about missing nurse aide in-service training. The DON explained that the facility's previous nurse educator had been responsible for maintaining nursing staff education record. Since the educator's departure, she is having difficulty locating employee education records. When asked who is currently responsible for maintaining the education records, the DON stated human resources is now responsible. On 09/9/2025 at 9:03 AM, review of nurse aide training records in Carefeed with HR #17 for GNA #9, GNA #11, GNA #20, GNA #21, and GNA #22 failed to show evidence of the required 12 hours of nurse aide training for 2024 and 2025. Further review revealed the facility assigned the required mandatory in-service training through Carefeed on 09/08/25 at 3:35 PM, after the surveyor requested employee files earlier that same day. The surveyor again asked HR #17 if they could provide documentation of any nursing aide training for the requested GNA employee files from 2024 and 2025. HR #17 stated they had rechecked but were unable to locate any prior nurse aide training for the GNA's. On 09/09/25 at 10:01 AM, the ADON #1provided the surveyor with documentation for in-service training conducted on 01/17/25 and 01/27/25. A review of the training failed to show evidence that GNA #9, GNA #11, GNA #20, GNA #21, and GNA #22 completed 12 hours of nurse aide training in 2024 and 2025. The surveyor informed the ADON #1 that the files provided did not include the minimum 12 hours of in-service training for GNA #9, GNA #11, GNA #20, GNA #21, and GNA #22. The ADON #1 acknowledged the lack of training and stated that this was all the education she was able to find.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interviews and administrative record reviews, it was determined that the facility failed to provide the required Dementia training to staff. This deficient practice was evident in 4 of 5 employee files reviewed during the annual survey. The findings include: On 09/08/2025 at 1:34 PM, the surveyor requested employee files from the Director of Nursing (DON) for Geriatric Nursing Assistant (GNA) #9, GNA #11, GNA #20, GNA #21, and GNA #22. The surveyor requested that each file include documentation of the employee's annual review, annual training, and immunizations.On 09/09/2025 at 7:30 AM, a review of the employee files for GNA #11, GNA #20, GNA #21, and GNA #22 failed to reveal dementia training. On 09/09/2025 at 9:00 AM, the surveyor informed the DON and the Assistant Director of Nursing (ADON) #1 about missing dementia training. The DON explained that the facility's previous nurse educator had been responsible for maintaining nursing staff education record. Since the educator's departure, she is having difficulty locating employee education records. When asked who is currently responsible for maintaining the education records, the DON stated human resources is now responsible. On 09/9/2025 at 9:03 AM, during an interview with Human Resources (HR) #17 regarding employee annual performance reviews and annual training, the Administrator entered the HR office and stated he overheard the surveyor's interview. He asked if he could provide the surveyor with the facility's annual education requirements. The surveyor accompanied the Administrator to his office, where he reviewed the annual training on his computer and explained the facility uses an educational platform called Carefeed that was updated June 2025 to include all required annual staff training. The surveyor informed the Administrator that dementia training for 2024 and 2025 was missing from the GNA employee files. The Administrator then directed the surveyor back to HR #17 to obtain the missing training.A review of dementia training records in Carefeed with HR #17 for GNA #11, GNA #20, GNA #21, and GNA #22 failed to show evidence of dementia training for 2024. Further review revealed that the facility assigned dementia training through Carefeed on 09/08/25 at 3:35 PM, after the surveyor requested employee files earlier that same day. The surveyor again asked HR #17 if they could provide documentation of any dementia training for the requested GNA employee files from 2024. HR #17 stated they had rechecked, but were unable to locate any prior compliance and ethics training for the GNA's. On 09/09/25 at 10:01 AM, the ADON #1provided the surveyor with documentation for in-service training conducted on 01/17/25 and 01/27/25. A review of the training failed to show evidence of dementia training for GNA #11, GNA #20, GNA #21, and GNA #22. The surveyor informed the ADON #1 that the files provided did not include dementia training for GNA #11, GNA #20, GNA #21, and GNA #22. The ADON acknowledged the missing training and stated that this was all the education she was able to find.