

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Patuxent River		STREET ADDRESS, CITY, STATE, ZIP CODE 14200 Laurel Park Drive Laurel, MD 20707	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>31145</p> <p>Based on review of a complaint, observation of resident wheelchairs, and interviews, it was determined the facility failed to provide maintenance services necessary to keep all wheelchairs in a sanitary, comfortable, and well maintained condition. This was evident on 2 of 3 nursing units observed.</p> <p>The findings include:</p> <p>On 4/15/25 at 8:30 AM a review of complaint MD00203718 alleged wheelchairs in the facility were in disrepair.</p> <p>On 4/15/25 at 8:50 AM observation was made of Resident #60 sitting in the dining area eating breakfast. The vinyl was missing on the right front wheelchair armrest approximately 1 inch. The vinyl on the left wheelchair armrest was missing vinyl and the remaining vinyl was cracked.</p> <p>On 4/15/25 at 1:15 PM Resident #59 was observed sitting in the hallway in a wheelchair. The vinyl on the left wheelchair armrest was cracked along the edge and missing 1 inch of vinyl in the front.</p> <p>On 4/18/25 at 10:49 AM Resident #56 was observed sitting in a wheelchair. The left armrest was missing vinyl. Resident #56 was interviewed and stated that the armrest had been like that for a while.</p> <p>On 4/18/25 at 10:51 AM Resident #55 was observed sitting in a wheelchair. The vinyl on the left wheelchair armrest was cracked and missing about 1 inch of vinyl in the front and along the outer edge of the armrest. The right armrest was in the same condition. Resident #55 was interviewed and stated, this is how they gave it to me. Yesterday they tightened the right armrest. The surveyor asked Resident #55 if they said anything about replacing the armrest and the resident stated, no.</p> <p>On 4/18/25 at 10:55 AM Resident #57 was observed sitting in a wheelchair. The vinyl on the right armrest was missing at the front of the armrest and in 2 other places on the armrest.</p> <p>On 4/18/25 at 11:18 AM an interview was conducted with the Director of Maintenance, Staff #25. Staff #25 stated he did audits weekly of the wheelchairs. He audited the brakes, backrests, armrests, wheels, and leg rests. At that time Staff #25 was informed of the observations.</p> <p>On 4/21/25 at 1:45 PM the Nursing Home Administrator was informed of the concern.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>34484</p> <p>Based on medical record review, documentation review and interview it was determined the facility failed to report allegations of abuse, neglect, or an injury of unknown origin within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ) (Resident #7, #8). This was evident for 2 of 24 residents reviewed for allegations of abuse, neglect or an injury of unknown origin during a complaint survey.</p> <p>The findings include:</p> <p>1. Review of Resident #7's medical record review on 4/16/25 revealed the Resident was admitted to the facility in January 2023.</p> <p>Further review of the Resident's medical record revealed a nurse's note on 3/31/23 at 2:38 PM that stated, Patient noted with swelling on right thumb. On assessment there is dark discoloration noted, which is tender and warm to the touch. Patient voiced pain on assessment on the scale of 3 out of 10.</p> <p>Review of the facility reported incident the facility staff submitted to OHCQ on 3/31/23 revealed Resident #7 had an injury of unknown origin.</p> <p>Further review of the facility's investigation documentation revealed, Staff #15 gave a statement that stated, Upon resumption of my shift on 3/30/23, I noticed some bruises on both his/her arms and I went to the nursing station with an intention to tell the nurse, but she was busy with another resident.</p> <p>Interview with the Administrator on 4/16/25 at 1:00 PM confirmed the facility staff failed to report bruising of unknown origin for Resident #7 on 3/30/23 to OHCQ.</p> <p>31145</p> <p>2. On 4/16/25 at 10:40 AM a review of facility reported incident MD00191025 alleged that Resident #8's visitor stated that Resident #8 had been inappropriately touched. The facility became aware of the alleged incident on 4/5/23 at 5:25 PM.</p> <p>Review of the facility's investigation revealed an email confirmation that documented the initial report was sent to OHCQ on 4/6/23 at 6:00 PM. The allegation of potential abuse was not reported within 2 hours of notification.</p> <p>On 4/16/25 at 11:05 AM an interview was conducted with the Nursing Home Administrator(NHA). The NHA confirmed that the incident was not reported timely. The NHA stated she was not employed at the facility at the time.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>31145</p> <p>Based on review of facility reported incidents, medical records, and staff interview, it was determined the facility failed to provide documentation that allegations of abuse were thoroughly investigated. This was evident for 3 (#10, #9, #8) of 24 residents reviewed for facility reported incidents during a complaint survey.</p> <p>The findings include:</p> <p>1) On 4/15/25 at 9:38 AM a review of facility reported incident MD00194205 alleged that on 7/7/23 in the evening, 3 staff members held Resident #10 down while the resident fought them off.</p> <p>Review of the facility's investigation revealed that 7 residents were interviewed, however there were no staff interviews conducted.</p> <p>On 4/17/25 at 11:44 AM the Nursing Home Administrator (NHA) was interviewed and stated that it was prior to her time at the facility. The NHA was informed of the findings of an incomplete investigation. The NHA stated that the investigations that she does are more thorough.</p> <p>2) On 4/16/25 at 1:55 PM facility reported incident MD00192876 was reviewed and alleged that Resident #9 was noted on 5/29/23 to have swelling and discoloration of the face under the right eye. Resident #9's mother stated to the shift nurse that she believed someone punched Resident #9.</p> <p>Resident 9's medical record was reviewed and revealed the resident suffered from a traumatic subarachnoid hemorrhage, was a quadriplegic, and had contractures of both hands. Resident #9 was totally dependent on staff for all aspects of daily living.</p> <p>Review of the facility's investigation revealed the discoloration was found on 5/29/23 at around 11:48 AM while family was visiting. Other residents on the unit were interviewed along with 3 staff members which included the RN shift supervisor, the charge nurse, and the geriatric nursing assistant (GNA) that worked 7:00 AM to 3:00 PM.</p> <p>The investigation was incomplete as the GNA that took care of the resident overnight and other staff from previous shifts that took care of the resident were not interviewed.</p> <p>On 4/17/25 at 11:44 AM the Nursing Home Administrator stated that she was not employed at the facility during that time period, and she confirmed the surveyor's findings.</p> <p>3) On 4/16/25 at 10:40 AM a review of facility reported incident MD00191025 alleged that Resident #8's visitor stated that Resident #8 had been inappropriately touched. The facility became aware of the alleged incident on 4/5/23 at 5:25 PM.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation revealed a typed statement from the Assistant Director of Nursing (ADON). The statement documented that she was notified by a staff member that the resident had reported to his/her loved one that he/she had been sexually abused by a staff member. The statement documented that she interviewed Resident #8 who alleged there was a person that would always come in the room at night while the resident was sleeping and sat and looked at the resident. The resident alleged that when he/she opened his/her eyes that the person would quickly run out of the room. When asked if he/she was ever touched, the resident stated no but felt uncomfortable of the way the resident was looked at while sleeping.</p> <p>There were no staff interviews or any other resident interviews on the unit. The investigation was incomplete.</p> <p>On 4/16/25 at 11:05 AM an interview was conducted with the NHA. The NHA confirmed that the incident was not investigated completely. The NHA stated she was not employed at the facility at the time and that her investigations are complete and thorough.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>31145</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on complaint, record review, and interview, it was determined the facility failed to have documentation that residents were offered and/or received a shower on the resident's assigned shower day. This was evident for 1 (#20) of 25 residents reviewed for complaints during a complaint survey.</p> <p>The findings include:</p> <p>On 4/17/25 at 1:47 PM a review of complaint MD00203718 alleged unacceptable means of personal cleanliness for Resident #20.</p> <p>Review of Resident #20's medical record revealed the resident was admitted to the facility at the end of November 2023 from an acute care hospital for rehabilitation following a wedge compression fracture of the lumbar vertebra. Review of a 11/28/23 nurse's note documented that the resident had intermittent confusion and required extensive assistance with activities of daily living (ADL) needs.</p> <p>Review of geriatric nursing assistant (GNA) ADL documentation for bathing documented the resident did not receive any bathing on 11/30/23 and 12/1/23. From 12/2/23 to 12/16/23 Resident #20 received a bed bath.</p> <p>There was no documentation that Resident #20 was offered a shower and/or refused a shower.</p> <p>On 4/21/25 at 12:11 PM an interview was conducted with the Director of Nursing (DON). The DON stated Resident #20 received bed baths. The DON was asked what days Resident #20 was assigned to receive showers. The DON stated Tuesday and Friday evenings was the resident's assigned shower days. The DON stated, on those days, showers are offered. They have an option to change the days. They can prefer a bed bath. The DON was asked if there was any documentation that the resident was offered a shower and she stated, no. The DON was asked if there was any documentation that the resident refused a shower, and she stated no.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>40141</p> <p>Based on interview, record review, and facility document and policy review, the facility failed to ensure neurological evaluations were comprehensively conducted per facility policy/procedure after falls for 1 (Resident #30) of 2 sampled residents reviewed for falls.</p> <p>Findings included:</p> <p>A facility policy titled, Neurological Evaluation, dated 10/2024, indicated, Assess resident following a known, suspected, or verbalized head injury. The assessment shall include, at a minimum: a. Vital signs and c. Neurological evaluation for changes in:</p> <ul style="list-style-type: none"> i. Physical functioning ii. Behavior ii. Cognition iv. Level of consciousness v. Dizziness vi. Nausea vii. Irritability viii. Slurred speech or slow to answer questions. <p>The policy also indicated, Perform neuro [neurological] checks as indicated or as specified by the physician. Neuro checks:</p> <ul style="list-style-type: none"> -q [every] 15 minutes x [for] 1 hour -q 30 minutes x 1 hour -q 1 hour x 4 hours -q 4 hours x 24 hours -q shift until 72 hours. <p>An Admission Record revealed the facility originally admitted Resident #30 on 08/10/2022 and readmitted the resident on 08/31/2024. According to the Admission Record, the resident had a medical history that included diagnoses of nondisplaced cervical fracture, heart failure, left bundle branch block, hypertension, difficulty walking, Alzheimer's disease, muscle weakness, age-related physical debility, and the presence of a cardiac pacemaker.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/04/2024, revealed Resident #30 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident was dependent on staff for rolling left and right in bed, sitting to lying, lying to sitting, and transferring from chair/bed. Per the MDS, Resident #30 did not walk during the assessment look-back period. The MDS also indicated the resident had sustained a fall in the last month and in the prior two to six months.</p> <p>Resident #30's Care Plan Report included a focus area, initiated 08/19/2022, that indicated the resident was at risk for falls related to an unsteady gait, shortness of breath, and dementia. Interventions directed staff to monitor and report any changes in gait/status (initiated 08/19/2022). Resident #30's Care Plan Report also included a focus area, initiated 09/18/2023, that indicated the resident had sustained a fall with no injury on 07/02/2024 and a fall with injury on 08/28/2024 at 3:10 PM and was sent for a computed tomography (CT) scan.</p> <p>A Change in Condition note, dated 07/02/2024 at 2:12 PM and signed by Staff #34, a Licensed Practical Nurse (LPN), indicated Resident #30 was found on the floor next to their bed. Per the note, the resident stated they were trying to reach a cupcake. The form indicated neurological checks were in progress and vital signs were obtained on 07/02/2024 at 2:41 PM.</p> <p>There was no documented evidence that another neurological check was completed until 4:23 PM on 07/02/2024, approximately two hours after the resident was found on the floor. A Neuro Checks form, with an effective date of 07/02/2024 at 4:23 PM, revealed Staff #34 documented that a neurological check was completed.</p> <p>Resident #30's Neuro Checks form, with an effective date of 07/02/2024 at 11:43 PM, revealed that the most recent vital signs documented under an A. Vital Signs section were obtained at 2:41 PM on 07/02/2024, approximately nine hours before the second neurological check was documented.</p> <p>Resident #30's Neuro Checks forms, with effective dates of 07/03/2024 at 1:13 AM, 07/03/2024 at 2:13 AM, 07/03/2024 at 3:13 AM, 07/03/2024 at 4:13 AM, 07/03/2024 at 5:13 PM, and 07/04/2024 at 3:13 PM revealed that vital signs obtained on 07/03/2024 at 12:31 AM were documented as the most recent vital signs for the neurological checks in question, even though the vital signs were taken hours or days before the neurological checks were documented as completed.</p> <p>During an interview on 04/17/2025 at 3:15 PM, Staff #34, an LPN, stated neurological checks, when required, were initiated immediately. Staff #34 stated neurological checks were completed every 15 minutes for an hour and then, if the resident in question was not sent to an emergency room in that timeframe, neurological checks continued every 30 minutes for an hour, every hour for four hours, and then every eight hours for 72 hours. She stated that anytime staff conducted a neurological check, staff were also to obtain vital signs. Staff #34 stated she did not remember Resident #30. Staff #34 reviewed Resident #30's 07/2024 neurological checks and stated she typically wrote a resident's vital signs on a piece of paper, then entered them into the computer. Staff #34 stated she did not see documentation that neurological checks were conducted for Resident #30 every 15 minutes, but asserted that she completed the required checks.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility incident report for Resident #30, dated 08/28/2024 and completed by Staff #41, an LPN, indicated staff found Resident #30 on the floor at 3:10 PM that day. The report revealed Resident #30 stated, 'I wanted to get out of the bed. The report revealed the resident stated they hit their head, and the resident had two reddened areas noted to the left side of the head. Per the report, an assessment revealed the resident was alert and verbally responding, which was within normal limits for the resident.</p> <p>Resident #30's emergency medical services (EMS) report for 08/28/2024 revealed a 911 call was placed and an ambulance was dispatched to the facility at 4:17 PM. Per the report, at 4:23 PM, EMS was at the facility assessing Resident #30.</p> <p>There was no documented evidence that the facility completed neurological checks for Resident #30 every 15 minutes after the resident was found on the floor at 3:10 PM until EMS arrived at approximately 4:23 PM.</p> <p>A hospital summary, dated 08/28/2024, revealed Resident #30 had an accidental fall from bed at the facility that resulted in a fracture of the second cervical vertebra.</p> <p>Resident #30's nursing Progress Notes, dated 08/31/2024 at 5:30 AM, revealed the resident was readmitted to the facility from the hospital.</p> <p>Resident #30's Neuro Checks forms, with effective dates of 08/31/2024 at 11:16 AM, 08/31/2024 at 1:02 PM, 08/31/2024 at 10:30 PM, 09/01/2024 at 10:43 PM, 09/02/2024 at 3:52 PM, 09/02/2024 at 9:37 PM, and 09/03/2024 at 3:12 AM revealed the most recent vital signs documented in the forms were obtained on 08/31/2024 at 5:30 AM, approximately six hours before the first neurological check on 08/31/2024 at 11:16 AM was conducted and three days before the last neurological check on 09/03/2024 at 3:12 AM was conducted.</p> <p>During an interview on 04/17/2025 at 3:39 PM, Staff #41, an LPN, stated neurological checks were a risk management requirement, noting a risk management form (incident report) and change in condition notes were completed with each fall. Per Staff #41, she wrote vital signs (corresponding with neurological checks) on a piece of paper, then input the numbers into the computer later, though she noted she sometimes forgot to change the time of the vital signs.</p> <p>During an interview on 04/17/2025 at 1:01 PM, Staff #17, an LPN, stated vital signs were a part of neurological checks and vital signs previously obtained should not be used.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/17/2025 at 4:36 PM, Staff #2, the Director of Nursing, stated if a resident had an unwitnessed fall, neurological checks were conducted. Staff #2 reviewed Resident #30's neurological checks after the fall in 07/2024 and stated the neurological checks were not completed correctly. Staff #2 also reviewed Resident #30's neurological checks after the fall in 08/28/2024 and stated that the Change in Condition note addressed the resident's neurological status; however, Staff #2 stated she did not see any other neurological checks documented until 08/31/2024. Staff #2 stated staff used the same vital sign measurements for multiple neurological checks, which was not appropriate. Staff #2 stated the importance of performing neurological checks was to determine if the resident had a change in neurological status. Staff #2 stated she expected neurological checks to be completed according to the ordered frequency and documented at the time the check was completed. Staff #2 stated all requirements for neurological check assessments were to be completed and documented and, if anything abnormal was identified, staff should notify the provider.</p> <p>During an interview on 04/17/2025 at 6:26 PM, Staff #1, the Administrator, reviewed Resident #30's neurological checks for the 07/02/2024 and 08/28/2024 falls and stated it was not appropriate for vital signs from previous assessments to be used for a current assessment. Staff #1 stated she expected vital signs to be obtained with each neurological check, and that neurological checks were to be done timely.</p> <p>During a telephone interview on 04/18/2025 at 3:39 PM, Staff #40, a Doctor of Nursing Practice (DNP), stated the protocol was to conduct neurological checks if a resident's head was involved in a fall. Staff #40 stated neurological checks should be completed at least every 15 minutes for the first hour for a fall with head involvement/injury. She also stated that vital signs should be a part of neurological checks. She stated she expected nurses to follow protocol and conduct proper assessments for acute situations.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>34484</p> <p>Based on medical record review and interview, the facility staff failed to ensure a resident received podiatry services as ordered (Resident #12). This was evident for 1 of 3 residents reviewed for podiatry care during a complaint survey.</p> <p>The findings include:</p> <p>Review of Resident #12's medical record on 4/15/25 revealed the Resident was admitted to the facility in 2010.</p> <p>Further review of the Resident's medical record for podiatry care revealed the last time the Resident was seen by the Podiatrist was 1/10/24. A podiatrist is a medical doctor devoted to the treatment of disorders of the foot, ankle, and related structures of the leg.</p> <p>During interview with the Unit Manager (Staff #19) on 4/15/25 at 11:33 AM, the Surveyor advised Staff #19 the Surveyor can not find any documentation the Resident was seen by the Podiatrist since 1/10/24. At that time the Surveyor accompanied Staff #19 to medical records. At that time Staff #30 pulled up a list of all residents that were seen the last time podiatry was in the facility on 4/8/25. Staff #30, Staff #19 and the Surveyor reviewed the list together and Resident #12 was not on the list.</p> <p>On 4/15/25 at 1:56 PM the Administrator provided the Surveyor documentation the Resident was last seen by the Podiatrist on 2/4/25.</p> <p>Review of the Podiatrist's Evaluation Form from 2/4/25 revealed the Podiatrist documented the Resident's medical necessity for routine foot care is Patient presents with significant atherosclerosis. Professional foot/nail care is needed to prevent infection or ulceration given the patient's compromised vascular status. Follow-up date 4/8/25 for at risk foot care.</p> <p>Interview with the Administrator on 4/16/25 at 8:14 AM confirmed Resident #12 was not seen by the Podiatrist on 4/8/25.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145</p> <p>Based on observation, interview, and facility documentation review, it was determined that facility staff failed to keep a medication cart locked when unattended. This was evident on 1 of 4 nursing units observed during a complaint survey.</p> <p>The findings include:</p> <p>On 4/17/25 at 2:31 PM observation was made of an unlocked and unattended medication cart sitting in the hallway outside of room [ROOM NUMBER]. The surveyor was able to open all of the drawers and visualize all the medications in the medication cart. Unit Manager #24 walked up to the surveyor on 4/17/25 at 2:36 PM and asked if she could help the surveyor. At that time the surveyor informed her of the unlocked and unattended medication cart. At 2:37 PM Agency LPN #25 walked up and asked if someone had pulled on the drawers to unlock the cart. The surveyor informed LPN #25 that the silver lock button was extended out away from the cart prior to opening the drawers. LPN #25 then proceeded to unlock the treatment cart which was sitting next to the medication cart and said, well I don't know who unlocked it.</p> <p>On 4/18/25 at 10:04 AM a review of the medication storage policy, that was given to the surveyor from the Director of Nursing, documented under general guidelines that A) all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. B) documented, only authorized personnel will have access to the keys to locked compartments.</p> <p>On 4/18/25 at 10:04 AM the surveyor informed the Director of Nursing (DON) of the observation. The DON confirmed that she had heard from the unit manager.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/21/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Patuxent River		STREET ADDRESS, CITY, STATE, ZIP CODE 14200 Laurel Park Drive Laurel, MD 20707	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>31145</p> <p>Based on review of complaints, tray tickets, observation, and interview, it was determined the facility failed to serve residents food that was palatable and appealing and failed to follow the selections residents had chosen. This was evident for 13 (#10, #65, #63, #61, #68, #67, #66, #58, #70, #64, #62, #17, #71) of 73 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>Review of complaints MD00202967, MD00206399, and MD00201718 alleged, inferior quality of food that was tasteless, cold, and often old. Badly cooked food without any nutrition or nourishment. Food was cooked raw with blood in it. I have been forced to order food regularly for my mother. They give patients a food menu and it's not what they have on their tray.</p> <p>1) On 4/15/25 at 8:30 AM Resident #10 was observed sitting in the dining room. Resident #10 was asked how the food was, and the reply was, it is ok, but I don't like biscuits and that is what they sent me instead of toast.</p> <p>Observation of Resident #10's breakfast plate revealed a hard-boiled egg yolk sitting on the plate along with a biscuit. Review of Resident #10's tray ticket documented the resident was supposed to get white toast 1 slice. The resident stated he/she did not receive toast. The tray ticket also said apple juice, but the resident stated they served orange juice.</p> <p>2) On 4/15/25 at 8:40 AM Resident #65's breakfast tray ticket did not match what was on the tray. Resident #65's tray ticket stated banana and 2% milk. Observation of the breakfast tray revealed whole milk instead of 2% milk and there was no banana.</p> <p>3) On 4/15/25 at 8:43 AM Resident #63's tray ticket documented hard cooked egg. Review of the breakfast tray had scrambled eggs. There was no bread, however the tray ticket said 1 slice of bread. There was no coffee or hot tea, no assorted yogurt cup, and no house shake. According to the cook there was a certain person on the line that made the error.</p> <p>4) On 4/15/25 at 8:50 AM Resident #61's tray ticket and breakfast tray were observed. Resident #61 stated, they gave me oatmeal and I don't eat oatmeal. There was milk on the tray and the resident stated he/she doesn't drink milk. The tray ticket indicated 2 eggs, however the resident only received 1 egg. The tray ticket said banana; however, the resident did not receive a banana. Resident #61 stated he/she got a muffin and that it wasn't on the ticket and jelly was on the ticket but did not get jelly.</p> <p>5) On 4/15/25 at 12:20 PM Resident #66's tray ticket stated coffee or hot tea. Observation of the lunch tray revealed no hot beverage. Resident #66 stated, it would be good to have it.</p> <p>6) On 4/15/25 at 12:22 PM Resident #58's ticket said coffee or tea. Resident #58 did not receive coffee or tea. The resident was served cranberry juice, and he/she said it tasted watered down. Resident #58 was interviewed about food and stated that there were many times when the tray ticket did not match what was served. Resident #58 complained that he/she was served bread with mold.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7) On 4/15/25 at 12:23 PM Resident #67's tray ticket stated house shake and frozen nutritional treat. There was no house shake or frozen nutritional treat on Resident #67's lunch tray.</p> <p>8) On 4/15/25 at 12:24 PM Resident #61 stated they gave him/her a salad with no egg. There was no hot tea and no cookie.</p> <p>9) On 4/15/25 at 12:26 PM Resident #70's lunch ticket stated chopped sliced peaches, but the resident received mandarin oranges. The ticket stated 1 slice of bread and LPN #33 confirmed that the resident did not receive bread</p> <p>10) On 4/15/25 at 12:28 PM Resident #68's tray ticket for lunch said house shake, however there was no house shake and no coffee.</p> <p>11) On 4/15/25 at 12:28 PM Resident #64 had ground peaches on the tray ticket but received applesauce. Resident #64 stated, I wanted the peaches. I get applesauce almost every day and it tastes sour.</p> <p>12) On 4/15/25 at 12:30 PM Resident #62 did not have coffee or hot tea or 2% milk on the tray even though it was on the ticket. Resident #62 stated there were times that he/she did not get what he/she asked for.</p> <p>13) On 4/16/25 at 12:31 PM Resident #70's tray ticket stated 5/14/25 instead of 4/16/25. The ticket stated open-faced roast pork sandwich. Resident #70 complained that the meat was thick, and they did not send a knife. Resident #70 kept a knife from yesterday because that happened frequently. Resident #70's tray ticket stated Frozen Nutritional Treat, Chocolate. The resident was served vanilla. Resident #70 stated, they do it all the time. I prefer chocolate.</p> <p>On 4/18/25 at 8:58 AM Staff #48, cook and Staff #4, dietary manager were interviewed and stated, we get food delivery on Tuesday and typically it is not until the afternoon. We run out of the house shakes or they are on back order. We probably only had a few of the house shakes. We normally have them but it's Tuesday and that is when the truck comes so it may have been an oops. Staff #48 stated that this happens with the bananas too. When asked if the geriatric nursing assistants (GNAs) look at the tray ticket and see what isn't on the tray, what happens. The cook stated, if they come and tell us we can make sure they get it. There is a lot of miscommunications around here.</p> <p>The surveyor went through each tray ticket with Staff #4 and Staff #48. Staff #48 stated that the person that was on the food line that day was excused off the line due to the amount of mistakes she was making. They also stated that they are not responsible for the juices and the hot drinks. They stated they send a cart out with the beverages on the cart and the GNAs are responsible to make sure the residents receive the drinks.</p> <p>Staff #4 was told about the vanilla and chocolate frozen nutritional treat situation. He stated, most people don't like chocolate, so we don't order it as much. We just give them the vanilla. The surveyor stated, even though they requested chocolate. Staff #4 shook his head.</p> <p>Both Staff #4 and Staff #48 were told about the numerous tray tickets that did not match what was sent to the residents. They both stated that they had problems with a few staff and have since removed them from the tray line.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>14) On 4/18/25 at 12:45 PM the lunch tray was served to Resident #17. The resident looked at the salad and said, I don't like romaine lettuce. It is supposed to be iceberg lettuce. The resident then looked at the 1 small piece of broccoli and then looked at the surveyor and wrinkled up her nose. The broccoli was mushy and surrounded by some white object that was mushy. The presentation of the plate was a piece of bread cut in half, mushy broccoli, and half of a shriveled up baked potato. The resident also complained about the food and said the other day he/she got syrup but no pancake and received rice and mashed potatoes for lunch with no meat. Resident #17 stated he/she told someone, and they were going to get him/her something else but never did.</p> <p>At that time the surveyor went to get the Nursing Home Administrator (NHA) to view the lunch tray. The NHA came to the resident's room and confirmed that the chef's salad was made with Romaine lettuce and the tray ticket said iceberg lettuce in bold print. The NHA confirmed that it was half a potato but stated that it may be due to portion size. (Note: the resident was prescribed a regular diet). The tray ticket said regular diet. The resident complained the ice cream was melted so the NHA took that and said she would get another one. The NHA confirmed that the lunch did not look appealing.</p> <p>The surveyor and NHA then went to the roommate, Resident #71 and with his/her permission took off the lid off the plate. There was half of a small baked potato that had 2 small scoops out of it. The resident stated, why didn't I get a whole potato. The baked chicken breast was half eaten as the resident stated it was rubbery, and the bread was half eaten and the tossed salad was not touched. Again, the NHA admitted the meal did not look appealing.</p> <p>The surveyor discussed with the NHA that even after having a conversation with Staff #4 earlier in the day, the tray tickets still did not match what was sent to the residents.</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>34484</p> <p>Based on medical record review and interview, the facility staff failed to obtain outside services for residents in a timely manner (Resident #6). This was evident for 1 of 73 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>Review of Resident #6's medical record on 4/15/25 the Resident was admitted to the facility in October 2022 with a diagnosis to include tracheostomy. Tracheostomy is a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck.</p> <p>Further review of the Resident's medical record revealed on 1/26/23 the Resident went to the ENT (ear, nose and throat doctor). Review of the ENT's Report of Consultation revealed the Resident's trach was changed and ordered to see the Resident was scheduled to see a specialist in head and neck surgery on 2/14/23.</p> <p>Further review of the Resident's medical record revealed the Resident did not go to the appointment on 2/14/23.</p> <p>Interview with the Administrator on 4/16/25 at 11:01 AM confirmed the facility staff failed to ensure Resident #6 went to a scheduled appointment on 2/14/23.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>34484</p> <p>Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards (Resident #12). This was evident for 1 of 73 residents reviewed during a complaint survey.</p> <p>The findings include.</p> <p>A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.</p> <p>Review of Resident #12's medical record on 4/15/25 revealed the Resident was admitted to the facility in 2010.</p> <p>Further review of the Resident's medical record for podiatry care revealed the last time the Resident was seen by the Podiatrist was 1/10/24.</p> <p>During interview with the Unit Manager (Staff #19) on 4/15/25 at 11:33 AM, the Surveyor advised Staff #19 the Surveyor can not find any documentation the Resident was seen by the Podiatrist since 1/10/24.</p> <p>On 4/16/25 at 8:14 AM the Administrator provided the Surveyor the Evaluation forms from the Podiatry visits on 3/12/24, 5/14/24, 7/15/24, 10/1/24, 12/3/24 and 2/4/25. The Administrator at that time stated they had a change in medical records staff and there was some confusion on uploading podiatry visits into the medical record.</p> <p>Interview with the Administrator on 4/16/25 at 8:14 AM confirmed Resident #12's medical record did not include Podiatry visits from 1/10/24 until current until Surveyor intervention.</p>