STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215141	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Patuxent River	14200 Laurel Park Drive Laurel, MD 20707

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to maintain the dignity of 2 of 3 residents (Residents #7 and #50) reviewed for dignity. The findings include: 1. Observation of Resident #7's room, on 07/30/25 at 8:42 a.m., revealed a brown clothing bin with the top missing and two drawers underneath the missing top. Clothing was observed under an empty milk carton. Also observed were a black plastic bowl with old food stuck in it and a clear plastic bag containing used disposable dinnerware.On 08/01/25 at 11:30 a.m., during a follow-up observation, the resident was not in bed. The clothing bin was covered with a clean towel; however, the empty milk carton, the black plastic bowl with old food stuck in it, and the clear plastic bag with used disposable dinnerware remained on top of the resident's clothing. On 08/01/2025 at 12:15 PM, Geriatric Nursing assistant Staff 18 # (GNA) stated the clothing bin has been like that for a while and that she was unsure who was responsible for putting the items there.On 08/01/2025 at 12:30 PM, the Unit Manager (staff #15) stated staff should ensure residents' rooms remain clean and organized, and that personal items should be stored appropriately to maintain dignity. The Unit Manager confirmed the items should have been removed after the initial observation.2. Observation of Resident #50, on 07/30/25 at 9:00 a.m., revealed the resident's Foley catheter bag was observed to contain approximately 600 cc of cloudy yellow urine and was resting directly on the floor. The Unit Manager (staff #15) was notified, she removed the bag from the floor, and emptied it.On 08/01/25 at 11:00 a.m., the Foley bag was observed lying on the bedside table with approximately 100 cc of urine. When asked if the Foley had been discontinued, the resident pulled back the covers and revealed a urinary leg Foley, which was nearly full.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure: 1.) Residents' or family representative's request to implement an Advance Directive was addressed; 2.) Resident's advanced directive was obtained and followed; and 3.) Information regarding advance directives was offered. This was evident for 3 (#10, #117, #106) residents out of 66 residents investigated during the survey.The findings include: 1. On 07/30/2025 12:40 PM during resident medical record review, it revealed an 'Advanced Directive Admission' facility evaluation form completed on 05/26/25 at 11:03 AM indicating that Resident #10 answered 'a. Yes' to the question: 'I am interested in meeting with a member of the Social Work team to discuss steps to implement an Advance Directive.' This surveyor was unable to locate an Advance Directive for Resident #10 that was requested to be formulated. On 07/30/2025 at 12:58 PM during staff interview with Director of Social Work #6 discussed that Resident #10 requested to implement an Advance Directive and unable to locate Advance Directive on chart; Staff #6 stated he/she was unable to locate an Advance Directive on the chart and would determine if an Advance Directive was ever created with and for Resident #10. On 08/01/25 at 1:31 PM during follow-up staff interview with Director of Social Work #6, surveyor was given a completed copy of the Maryland Advance Directive: Planning For Future Health Care Decisions form for Resident #10 dated for 07/30/25. Staff #6 stated this was completed after surveyor intervention regarding Resident #10 request to implement an Advance Directive. 2. On 7/31/25 at 8:53AM the surveyor observed and reviewed the medical record of Resident #117 which revealed they were admitted to the facility in March 2025, and one physician certification of incapacity was present within their medical record signed as completed by Physician #5 dated 6/17/25 in which the section titled: Part 1: Identifying information; Patient: I am certifying information about: failed to include the resident's name. Review of the resident's Maryland Orders for Life Sustaining Treatment (MOLST) Form indicated the resident had a surrogate in place for decision making dated 4/1/25. Review of the advanced directive present in the resident's medical record revealed a power of attorney for a person with a different first name and was not Resident #117's advanced directive. On 8/4/25 at 10:18AM the surveyor conducted an interview with the facility's Administrator who confirmed with the surveyor that Resident #117 was incapable of medical decision making. At this time, the surveyor shared the concern and conducted a dual observation of Resident #117's medical record with the facility Administrator who observed the certification of incapacity, MOLST form, and the power of attorney advanced directive located in the medical record of Resident #117 which was not Resident #117's. On 8/4/25 at 11:00AM the surveyor conducted a review of the medical record of Resident #117 which revealed the following care plan focus dated as initiated on 4/5/25: See MOLST form, (Resident #117) has an advanced directive, and the following intervention: Will review MOLST with resident/POA quarterly and as needed. The surveyor noted that there was no advanced directive of Resident #117 in their medical record. (continued on next page)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/25 at 11:22AM the surveyor conducted an interview with Social Worker (SW) #6 who confirmed with the surveyor that the power of attorney paperwork in the medical record of Resident #117 was not theirs and further stated this was an oversight. SW #6 confirmed with the surveyor that in response to the surveyor having shared concerns, the resident's family member was contacted by them, and they were able to confirm that Resident #117 has a power of attorney which the family member will bring a copy of to the facility the next day. When surveyors inquired as to who the resident's power of attorney currently was, SW #6 stated: I do not know yet who that POA names. SW #6 informed surveyors that the resident has a husband, however, surveyors noted that the facility had a person other than the resident's husband named as the current surrogate who was the person named in the power of attorney which was another person's. SW# 6 reported to surveyors they had made an attempt to call the resident's husband, however, no supporting documentation could be found in the resident's medical record. On 8/4/25 at 11:51AM SW #6 provided the survey team with a second certification of incapacity form for Resident #117 which was observed to have a different person's first name and the same last name as the resident written on it as the person that information was being certified about instead of the resident. On 8/4/25 at 11:53AM the surveyor shared concerns with the facility's Administrator who observed, confirmed, and acknowledged understanding of the concerns. On 8/6/25 at 2:30PM the surveyor reviewed the medical record which revealed the following information: 1.) An advanced directive admission assessment dated [DATE] in which questions regarding advanced directives was blank, 2.) A social service assessment dated [DATE] completed by SW #6 which indicated the resident was married and identified the person's name and under section E of the form titled Health Care Decision Making: 1.) Advanced Directives document: the answer of yes was checked indicating that the resident had an advanced directive. On 8/6/25 at approximately 3:30PM concerns were shared during the facility's exit conference with the facility Administrator, Director of Nursing, and Corporate Compliance Nurse. 3. On 07/31/2025 at 10:44 AM, during review of Resident #106's hard chart and electronic medical record, the surveyor found that a physician had documented the resident was capable of making their own medical decisions. No documented advance directive or evidence that advance directive information had been provided was found. On 08/01/2025 at 10:20 AM, the surveyor requested the documentation from the Director of Nursing (DON). At 11:30 AM, the DON stated that no advance directive or record of an offer being made could be located. At 11:48 AM, the facility's social worker confirmed there was no advance directive on file and no documentation that the resident had been offered information. At 12:57 PM, the surveyor requested documentation showing that advance directive information had been offered that day. At that time, the resident had still not been offered the information. At 1:31 PM, the DON and the social worker again confirmed that the resident had not been offered information regarding advance directives.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview it was determined the facility failed to ensure the care plan for Resident #117 was comprehensive. This was evident for 1 out of 4 residents reviewed for urinary catheters during the facility's recertification survey. The findings include: Review of the medical record by the surveyor on 8/4/25 at 10:51AM revealed Resident #117 had an active medical order for an indwelling urinary catheter which was dated as beginning on 3/31/25, and diagnoses listed which included urinary tract infection as well as an active medical order dated as beginning on 6/15/25 for contact precautions. On 8/4/25 at 11:00AM the surveyor reviewed the medical record of Resident #117 which revealed their care plan had no documentation of the resident's urinary catheter. Additionally, the enhanced barrier precautions focus on the resident's care plan did not include a catheter as one of the indications that were listed for the precautions, and the care plan did not reflect the active medical order in place dated as beginning on 6/15/25 for contact precautions. Review of Resident #117's baseline care plan by the surveyor on 8/4/25 at 11:16AM revealed the resident was documented as having an indwelling catheter present on 3/31/25 upon their admission to the facility. On 8/4/25 at approximately 12:00PM the surveyor observed Resident #117 had a foley catheter in place. On 8/4/25 at 1:01PM the surveyor shared the concern and conducted an interview with the Director of Nursing (DON) who acknowledged the surveyor's concern and confirmed with the surveyor that the resident's catheter was not care planned and stated to the surveyor: No, it is not on there. The DON further confirmed with the surveyor that the resident currently had a foley catheter in place. At this time, the surveyor offered an opportunity for the facility to provide any and all documentation of the foley catheter having been care planned. On 8/4/25 at 1:20PM the surveyor reviewed the kardex document that the Geriatric Nursing Assistants of the facility utilize to know the care required for the resident, which revealed there was no mention of the resident's urinary catheter on that document. On 8/4/25 at 1:49PM the surveyor provided another opportunity to the DON for any and all further documentation regarding the concern to be provided to the surveyor for review. On 8/4/25 at 1:54PM the DON informed the surveyor that nothing is on the care plan for the resident's catheter. On 8/4/25 at 12:48PM the surveyor conducted an interview with the DON and inquired as to if any action was taken by the facility in response to this surveyor having shared the concern. At this time, the DON reported to the surveyor: We should have that on the care plan now, I'll bring you a copy. On 8/06/2025 at 12:50PM during the surveyor's review of the medical record, the care plan of Resident #117 was observed with the following care plan documentation dated as initiated on 8/5/25: (Resident #117) has an indwelling urinary catheter. Additionally goals and interventions for the care of the catheter and a goal related to urinary infection were now observed by the surveyor to be present on the resident's care plan. On 8/06/2025 at 1:44PM the facility's Administrator and DON provided the surveyor with a copy of the updated care plan.

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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 reviews and interviews, it was determined that the facility failed to clarify residents pain medication orders and ensure residents' medications were administered and physician's orders were followed in accordance with professional standards. This was evident for 2 (#14 and #24) residents out of 66 residents investigated during the survey.The findings include: 1. On 07/31/25 at 12:00 PM during Resident #24's medical record review revealed a doctor's order dated 11/06/2024 for oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl) *Controlled Drug* Give 10 mg by mouth every 6 hours as needed for Pain (5-10). Take 10 mg by mouth every 4 hours as needed for Pain (5-10). The orders had two administration frequencies for the same pain level within the order. On 07/31/25 at 12:06 PM during medical record review, it revealed the Medication Administration Record(MAR) dated 7/1/2025 - 7/31/2025, that the medication oxycodne HCl was given to Resident #24 for 17 days of 31 days, on July 1, 2, 3, 4, 5, 6, 10, 11, 12, 14, 15, 16, 17, 18, 20, 23, and 26. On 08/01/25 at 11:00 AM the surveyor conducted an interview with the facility's Nursing Home Administrator (NHA), Staff #01 and Director of Nursing (DON), Staff #02 and shared the concern for the two administration frequencies for the same pain level within a single medication order that was not clarified and subsequently administered to Resident #24 on 17 different days of 31 days for the month of July 2025. When surveyor inquired about the expectation of clarifying medication orders, the NHA #01 and DON #02 stated the expectation is for nursing staff to have had the order clarified. On 08/04/25 at 12:00 PM during interview with NHA #01 and DON #02, they informed the survey team that the above order was discontinued on 08/01/25 after surveyor intervention and discussion. During follow-up medical record review of Resident #24, a facility Order Audit Report revealed the oxycodone HCl medication order was discontinued on 08/01/25 at 17:14 PM. 2. On 07/31/25 at 10:00 AM during medical record review of Resident #14's facility Medication Admin Audit Report for Schedule Date of 07/29/25-07/31/25, it revealed concerns late medication administration and inconsistent daily weight measurement times. Resident #14 had a significant medical history of ?essential primary hypertension, chronic combined systolic (congestive) and diastolic (congestive) heart failure, and lyphemdema'. Review of physician orders revealed Weights Daily - Weigh at same time every day and call MD if increases more than 2 lbs/day or 5 lbs/week every day shift every Mon, Wed, Fri for CHF; The resident was also prescribed cardiac medications such as Losartan, Carvedilol, and Lasix. Continued record review revealed:Weights scheduled for 07:00 AM were done on 07/29/25 at 13:56 PM and then on 07/30/25 at 10:14 AM.Medications were administered as follows:Scheduled on 07/29/25 at 08:00 AM, were documented as given at 13:54 PMScheduled on 07/29/25 at 12:00 PM, were documented as given at 13:56 PMScheduled on 07/30/25 at 08:00 AM, were documented as given at 10:14 AMScheduled on 07/30/25 at 12:00 PM, were documented as given at 13:05 PMScheduled on 07/31/25 at 08:00 AM, were documented as given at 10:06 AMScheduled on 07/31/25 at 12:00 PM, were documented as given at 15:18 PM On 08/01/25 at 11:10 AM the surveyor conducted an interview with the facility's Nursing Home Administrator (NHA), staff #01 and Director of Nursing (DON), staff #02 and shared the concern of late medication administration and inconsistent weight monitoring on Resident #14 with significant CHF history. NHA #1 and DON #2 acknowledged and agreed that the medications and weight monitoring were administered late; and stated, this is not the expectation of medication administration and weight monitoring for residents.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, it was determined that the facility failed to provide and document individualized activities to support the physical, mental, and psychosocial well-being of 1 (Resident #6) of 1 resident reviewed for activities.The findings include:On 07/30/2025 at 9:08 AM, Resident #6 was observed lying in bed with no activities occurring in the room or any evidence of engagement in individualized activity.On 08/01/2025 at 9:04 AM, the resident was again observed lying in bed with no materials or indications of participation in any activity.At 9:10 AM, the surveyor requested documentation of activities provided for Resident #6 for the last 30 days from Staff #4. Staff #4 checked the electronic medical record and stated there were no recorded activities for the last 30 days. At 9:22 AM, Staff #4 reported that he was unable to locate any documentation for Resident #6 in the activity department's logbook. Staff #4 stated that musical encounters, involving a musician (typically a guitarist) visiting residents' rooms, occur approximately twice a month. However, there was no documentation to confirm Resident #6's participation in these or any other activities.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interview it was determined the facility failed to ensure a resident's care was reviewed by the physician. This was evident for 1 out of 10 residents reviewed for advanced directives during the facility's recertification survey. The findings include:On 8/4/25 at 11:51AM SW #6 provided the survey team with a second certification of incapacity form dated 6/19/25 for Resident #117. This form was observed to have a different person's first name and the same last name as the resident written on it at the top as the person that information was being certified about instead of the resident. The surveyor reviewed documentation provided by the facility and observed an additional copy of the certification of incapacity form which had the resident's name at the top of the form. Part 1 of both of the physician certifications related to medical condition, substitute decision making, and treatment limitations forms was observed to be left blank which was missing the following information: 1.) Patient: I am certifying information about . 2.) Certifying practitioner (check all that apply), and 3.)Time frame: The following certifications are or are not made within 2 hours of examining the individual, however, both forms were observed to be dated 6/19/25 and signed by Physician #8.On 8/4/25 at 11:53AM the surveyor shared concerns with the facility's Administrator who observed, confirmed, and acknowledged understanding of the concerns.On 8/6/25 at 1:17PM the surveyor conducted an interview with the facility Administrator and Director of Nursing at which time Physician #8 was interviewed via phone at 1:25PM. Physician #8 reported to surveyors that the facility social worker asked them to come into the facility to sign forms left at the desk for them which they did on 8/4/25. On 8/6/25 at 1:30PM the surveyor again shared concerns with the Administrator and Director of Nursing who acknowledged understanding of the concerns. On 8/6/25 at approximately 3:30PM concerns were shared during the facility's exit conference with the facility Administrator, Director of Nursing, and Corporate Compliance Nurse.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on record reviews and interviews the facility failed to ensure that a resident must be seen by a physician at least once every 60 days after the first 90 days after admission. This was evident for 1 (#24) resident out of 8 residents investigated during the facility's annual survey.The findings include:On 07/31/25 at 12:00 PM during medical record review of Resident #24, it revealed an MD General Note for date of service of 01/10/2025 at 21:15 PM created by Physician #08; and no other MD General Notes for any subsequent dates of services during this review.On 08/01/25 at 11:30 AM the surveyor conducted an interview with the facility's Nursing Home Administrator (NHA), staff #01 and Director of Nursing (DON), staff #02 and shared the concern for lack of physician visit at least once every 60 days after the first 90 days after admission.On 08/06/25 at 14:10 PM during follow-up interview after surveyor discussion and intervention, NHA #1 and DON #02 provided the surveyor with a Late Entry MD General Note for date of service 05/14/25 at 18:32 PM created by Physician #08 on 08/04/25 14:34 PM. The 05/14/25 physician visit was 124 days from last physician visit on 01/10/25. When NHA #01 and DON #02 asked did they agree this timeframe was outside of the regulation, both stated yes, the physician visit was late.

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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 observation, interview and record review it was determined the facility failed to ensure the accuracy and completeness of Resident #117's medical record. This was evident for 1 out of 10 residents reviewed for advanced directives; and failed to ensure accuracy of room numbers on resident medical records This was evident for 5 out of 32 residents located on the lighthouse nursing unit during the facility's recertification survey.The findings include:1.) On 7/31/25 at 8:53AM the surveyor observed and reviewed the medical record of Resident #117 which revealed one physician's certification of incapacity present within their medical record completed by Physician #5 dated 6/17/25. The surveyor noted that on the certification of incapacity form signed as completed by Physician #5 titled Part 1: Identifying information; Patient: I am certifying information about: this section failed to include the resident's name. On 8/4/25 at 10:18AM the surveyor conducted an interview with the facility's Administrator who confirmed with the surveyor that Resident #117 was incapable of medical decision making. When the surveyor inquired to the Administrator as to how the resident is deemed incapable they stated the following information: Two certifications for incapacity are required for that. At this time, the surveyor shared the concern and conducted a dual observation of Resident #117's medical record with the facility Administrator who observed and confirmed that only one certification of incapacity was present and the power of attorney advanced directive located in the medical record of Resident #117 which was not Resident #117's. When the surveyor inquired to the Administrator as to if there was any other certification of incapacity of the resident they reported the following information: The social worker has further information in her office in case documentation is misplaced or sent to the hospital or something by accident. On 8/4/25 at 11:00AM the surveyor conducted a review of the medical record of Resident #117 which revealed the following care plan focus dated as initiated on 4/5/25: See MOLST form, (Resident #117) has an advanced directive, and the following intervention: Will review MOLST with resident/POA quarterly and as needed. The surveyor noted that there was no second certification of incapacity and no advanced directive of Resident #117 in their medical record.On 8/4/25 at 11:22AM the surveyor conducted an interview with Social Worker (SW) #6. SW #6 confirmed with the surveyor that the power of attorney paperwork in the medical record of Resident #117 was not theirs and further stated this was an oversight. SW #6 confirmed with the surveyor that in response to the surveyor having shared concerns, the resident's family member was contacted by them, and they were able to confirm that Resident #117 has a power of attorney which the family member will bring a copy of to the facility the next day.On 8/4/25 at 11:38AM the surveyor observed the hard copy medical record of Resident #117 in which a second certification of incapacity form dated 6/19/25 was present which had a different person's first name instead of the resident's name on it, indicating incapacitation was being certified for a person other than the resident.On 8/4/25 at 11:51AM SW #6 provided the survey team with the second certification of incapacity form dated 6/19/25 for Resident #117 which was again, observed to have a different person's first name written on it as the person that information was being certified about instead of the resident. The surveyor reviewed documentation provided by the facility and observed an additional copy of the certification of incapacity form which had the resident's name at the top of the form. Part 1 of both of the physician certifications related to medical condition, substitute decision making, and treatment limitations forms was observed to be left blank which was missing the following information: 1.) Patient: I am certifying information about . 2.) Certifying practitioner (check all that apply), and 3.)Time frame: The following certifications are or are not made within 2 hours of examining the individual, however, both forms were observed to be dated 6/19/25 and signed by Physician #8.On 8/4/25 at 11:53AM the surveyor shared concerns with the facility's Administrator who observed, confirmed, and acknowledged understanding of the concerns.On 8/6/25 at approximately 3:30PM concerns were shared during the facility's exit conference with the facility (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator, Director of Nursing, and Corporate Compliance Nurse.2.) On 8/4/2025 at 10:17AM the surveyor observed the hard copy medical records located at the nursing station on the lighthouse unit which had room numbers labeled on the spine of the records which did not match the room number of the rooms in which the residents were located in, and did not match the room number labeling of the areas they were located in.On 8/4/25 at 10:36AM the surveyor performed a dual observation and shared the concern with the facility Administrator who observed, acknowledged and confirmed understanding of the concern. The surveyor conducted an interview with the Administrator at this time who confirmed that staff refer directly to the hard copy medical records to follow the MOLST in the event of emergencies.On 8/6/25 at 1:44PM the surveyor conducted review of the resident census which revealed 5 hard copy medical records in which the room numbers documented on the spine of the hard chart did not match the room the residents were located in, and the surveyor noted the hard copy of medical records were located in areas labeled with conflicting room numbers.On 8/6/25 at approximately 3:30PM concerns were shared during the facility's exit conference with the facility Administrator, Director of Nursing, and Corporate Compliance Nurse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215141	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Patuxent River	14200 Laurel Park Drive Laurel, MD 20707

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and interviews, it was determined that the facility failed to: 1.) maintain infection prevention designed to prevent the development and transmission of communicable diseases and infections. This was evident for 1 (Resident #1) of 2 residents reviewed for Trach Care; 2.) maintain proper infection control practices to prevent cross-contamination with Foley catheters. This was evident for 1 (Resident #7) of 3 residents reviewed for Foley Care; and 3.) ensure infection control precautions were followed. This was evident for 2 residents (Resident #117, and Resident #125) of 2 residents reviewed for infection control precautions during the survey.The findings include: 1. On 07/30/25 at 7:57 AM the surveyor observed Resident #1 supine in bed with Trach Collar intact to neck and Trach Collar Oxygen mask, dated 07/23/25 laying lateral to the left side of the resident bed on the floor. On 07/30/25 at 8:16 AM during follow-up observation rounds of Resident #1 with LPN Unit Manager staff #03, the resident remained supine in bed with Trach Collar intact and Trach Collar Oxygen mask, dated 07/23/25, again observed on the floor lateral to the left side of the resident bed. On 07/30/25 at 8:18 AM the surveyor conducted an interview with Unit Manager #03 who confirmed with the surveyor that Resident #1 Trach Collar Oxygen mask was found on floor. The surveyor shared the concern for the importance of maintaining infection prevention to prevent the development and transmission of potential infections. After surveyor discussion and intervention, Unit Manager #03 stated that the Trach Collar Oxygen mask would be replaced. The surveyor observed Unit Manager #03 remove the Trach Collar Oxygen mask from the floor. 2. On 8/1/25 at 11am, during a follow-up observation of Resident #7's room, a used Foley catheter with visible urine in the drainage tubing and collection bag was observed placed directly on the bedside table next to personal care items. The Foley catheter was not contained in a biohazard bag or other appropriate receptacle for contaminated medical waste. An interview was conducted at the time of the observation with the Registered Nurse (RN) staff #17 who stated, I meant to come back and throw it away after I finished with the resident, but I forgot. Staff #17 acknowledged that placing a contaminated Foley catheter on a bedside table was against infection control policy and could expose the resident and others to harmful pathogens. A review of the facility’s Infection Prevention and Control Program Policy, updated last 2019, revealed staff are to immediately discard used medical equipment, including Foley catheters, into appropriate biohazard receptacles after use to prevent contamination of the resident’s environment. In an interview on 8/6/25 at 1pm, the Infection Preventionist (IP) and the DON (Director of nursing) confirmed that used Foley catheters should never be left on bedside tables and should be discarded immediately following use. The IP stated that leaving the contaminated catheter in the resident's environment was a direct violation of infection control protocols and posed a risk of infection spread. 3. On 7/30/25 at 9:02AM the surveyor observed the following signage on the door to the room of Resident #117: Stop, Contact Precautions, Everyone must: Clean their hands, including before entering and when leaving the room, Providers and staff must also: put on gloves before room entry, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discard gloves before room exit, put on gown before room entry, discard gown before room exit, do not wear the same gown and gloves for the care of more than one person, use dedicated or disposable equipment, clean and disinfect reusable equipment before use on another person. The trach tubing connected to Resident #117 was observed by the surveyor to be laying directly on the facility floor surface. On 7/30/25 at 9:02AM the surveyor observed Geriatric Nursing Assistant (GNA) #9 walk past the contact precautions signage on the door to the room of Resident #117 and enter the room with no hand hygiene performed and no personal protective equipment (PPE) donned, and they proceeded to walk over to the resident's bed and pick a towel up off of the floor from underneath the bed with their bare hands, and then carried it out of the room with no hand hygiene or ppe and retrieved a trash bag and placed the towel into the trash bag. At this time, the surveyor conducted an interview with GNA #9 and Registered Nurse Supervisor (RN) #10. GNA #9 and RN #10 visualized the contact precaution signage on the door and the trach tubing laying on the floor with the surveyor and confirmed that the resident was to be on contact precautions. GNA #9 stated to the surveyor during the interview that PPE should be worn when in the resident's room. At this time, the surveyor shared their concern and GNA #9 acknowledged understanding of the concern. RN #10 acknowledged and confirmed understanding of the surveyor's concern and stated to the surveyor that Gown and gloves have to be worn for contact precautions. RN #10 further stated to the surveyor that they did not know why Resident #117 was on contact precautions. On 7/30/2025 at 9:03AM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #11 who was assigned care of the resident who stated to the surveyor that the resident was to be on contact precautions and confirmed there was an active medical order for contact precautions for Resident #117. The surveyor shared their concerns with LPN #11, and after surveyor intervention, they responded, performed hand hygiene, donned ppe, and addressed the resident's trach tubing. On 7/30/2025 at 11:20AM the surveyor shared the concerns with the facility Administrator who acknowledged and confirmed understanding of the concerns. On 8/6/25 at 11:50AM the surveyor conducted an interview with the Director of Nursing (DON) and Infection Preventionist (IP) #12. During the interview, the DON reported their expectation of staff for adhering to contact precautions was for them to perform hand hygiene and gather items needed items before going into the room, to gown and glove prior to entering the room, and if they are on contact precautions then they need to use that PPE. The DON and IP #12 confirmed with the surveyor that Resident #117 required contact precautions. At this time, all infection control concerns were shared by the surveyor and both the DON and IP #12 acknowledged the surveyor's concerns. 4. On 8/5/25 at 9:17AM the surveyor observed following signage on the door to the room of Resident #125: Stop, Contact Precautions, Everyone must: Clean their hands, including before entering and when leaving the room, Providers and staff must also: put on gloves before room entry, discard gloves before room exit, put on gown before room entry, discard gown before room exit, do not wear the same gown and gloves for the care of more than one person, use dedicated or disposable equipment, clean and disinfect reusable equipment before use on another person. During the surveyor's review of medication administration, Licensed Practical Nurse (LPN) #13 was observed walking past the contact precautions signage posted on the door to the room of Resident #125 and entered the room to pass medications with no personal protective equipment (PPE) donned and was standing against the side of the bed with their clothing touching the resident's bed linens as they passed medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/25 at 9:21AM Geriatric Nursing Assistant (GNA) #14 was observed walking past the contact precautions signage on the door to the room of Resident #125 and entered the room without performing hand hygiene or donning PPE, performed a task in the resident's bathroom and then re-entered the resident's room before exiting the room. At this time, the surveyor conducted an interview and shared the concern with GNA #14 who reported the following information to the surveyor: Yes, I have to have PPE on when providing care. On 8/5/25 at 9:26AM the surveyor conducted an interview with LPN #13 who observed the contact precautions signage on the resident's door with the surveyor and stated to the surveyor that PPE only needed to be worn when providing care. When the surveyor further inquired as to what contact precautions meant, LPN #13 further stated: I wear PPE if I am changing a dressing for a wound. When the surveyor asked LPN #13 what reason the resident had been placed on contact precautions for, they reported they did not know what the reason was for the contact precautions in place for Resident #125. Review of the medical record with LPN #13 revealed the resident required contact precautions for more than one multi drug resistant organism. On 8/5/25 at 9:31AM the surveyor conducted an interview and shared concerns with Registered Nurse Supervisor, Unit Manager (RN UM) #15 who confirmed that Resident #125 was to be on contact precautions and acknowledged understanding of the surveyor's concerns. When the surveyor inquired as to what their expectation was for staff when caring for a resident on contact isolation they reported their expectation was that the signage was there on the room so the staff can follow it and use the PPE that is there in the cart. After surveyor intervention, RN UM #15 stated the following to the surveyor: I am going to do an in-service right away. On 8/6/25 at 11:50AM all infection control concerns were shared by the surveyor with both the DON and IP #12 who acknowledged the surveyor's concerns.