STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215195	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bridgepark	4017 Liberty Heights Avenue Baltimore, MD 21207

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to provide reasonable accommodations of preferences by not honoring a resident's request for female only caregivers. This was found to be evident for Resident #105 during investigation of facility reported incident MD00186826. The findings include: On 06/11/2025 at 11:00 AM, facility reported incident MD00186826 was reviewed by surveyor. In the report, Resident #105 alleged that a male caregiver had sexually assaulted them while applying barrier cream during incontinence care on 12/15/2022. The facility initiated an investigation and found the alleged incident to be unsubstantiated. Further record review revealed that Resident #105 was admitted to the facility on [DATE] and transferred to another nursing facility on 2/17/2023. Additional review of facility reported incident MD00186826 on 06/11/2025 revealed that the facility had stated on the Comprehensive & Extended Care Facilities Self-Report Form that the resident, is to receive ADL care from females only going forward. Included in the facility investigation packet was an interview conducted by the Nursing Home Administrator (NHA) with Resident #105 on 12/19/2022, where it was documented that the resident, explained that they did not want any males to work with them. On 06/12/2025 at 10:13 AM, review of Resident #105's electronic health record (EHR) revealed a nurse progress note dated 12/17/2022 that stated, Resident is alert and stable, able to make her needs known. No complaints, cooperated with GNA and RN, due meds and treatment provided as ordered and well tolerated. Supervisor made RN aware that patient cannot have Male care giver. Resident #105's treatment administration record (TAR) for barrier cream application during incontinence care was reviewed on 6/12/2025 at 11:35 AM. It revealed that on dates 1/5/2023, 1/10/2023, 1/15/2023, 1/16/2023, 1/17/2023, 1/24/2023, 1/27/2023, 1/28/2023, 1/29/2023, and 2/7/2023, two presumed male staff members performed the care. Additionally, review of Resident #105's care plan did not show a revision that included their preference for female caregivers. The NHA was interviewed on 06/13/2025 at 9:20 AM and presented a copy of the January and February 2023 TAR. The NHA confirmed that a check mark with initials on the TAR means that staff member performed the care and confirmed that the two presumed male staff members were indeed male. The NHA further stated that the care plan should have been updated to reflect the resident's wishes for only female caregivers and acknowledged surveyor concerns.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record reviews and interviews it was determined that facility staff failed to notify a resident's representative of a change in the resident's medical condition and failed to inform the resident's representative of the resident's transfer to the hospital. This deficient practice was evident for one (#89) resident reviewed for notification of changes during the annual survey. The term resident representative means the following: An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications. The findings include: Resident #89 was admitted to the facility August 2023 with medical history that includes aphasia (language disorder that can affect a person's ability to speak, understand, read or write) among other conditions. A review of complaint intake MD00202589 on 06/10/25 at 7:33 AM reveals that the complainant reported not being notified by the facility about a change in Resident #89's medical condition. The complainant stated that they learned of the resident's hospitalization on 2/10/24; one day after the admission occurred. On 6/11/25 at 6:50 AM, a review of Resident #89's admission record revealed that the complainant is listed as the resident's representative. Further review of the baseline care plan confirmed that the complainant was listed as the resident representative. On 2/9/24, a facility staff documented on a change of condition template that Resident #89 became short of breath. Under Section L1, it was noted that the Certified Registered Nurse Practitioner was notified on 2/9/24 and recommended stat diagnostic testing and medication. Under section M which addresses resident representative notification, staff documented that the resident was their own representative and that the resident was notified on 2/9/24. Resident #89 was transported to the hospital on the same day. There was no documentation indicating that the resident's designated representative was notified of the change in the resident's medical condition or the hospital transfer. On 06/11/25 at 7:33 AM, during an interview with the Director of Nursing (DON) with the Administrator present, the surveyor asked about the facility's expectation for notifying resident representative when a resident is transferred to the hospital. The DON stated that staff are expected to notify the residents' representatives. The surveyor informed the DON of the concerns mentioned in intake MD00202589. The DON stated that if the resident can make their own decisions, staff are not required to notify the representative.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, it was determined that the facility failed to ensure that a resident remained free of abuse. This deficient practice was evident for one (#11) of five residents reviewed for abuse during the annual survey. The findings include: Review of the facility's investigation file related to the facility reported incident MD00208357 and compliant intake MD00208362 on 6/4/25 at 2:45 PM, revealed that the facility substantiated allegations of sexual abuse based on a witness account provided by Geriatric Nursing Assistant (GNA) #18. GNA #18 reported that while walking into room [ROOM NUMBER] on 8/2/24 as part of her initial shift rounding, GNA #18 witnessed Resident #27 who is cognitively impaired on their knees next to Resident #11's bed and was touching the resident's genital area. The GNA immediately intervened and redirected Resident #27 out of the room. The GNA reported the incident to her floor nurse as they attended to Resident #11. Resident #11 who is cognitively impaired, did not appear to have any injuries but did note that the resident's incontinence brief had been pulled to the side. Review of the investigation file revealed that the incident occurred on 8/2/24, at 2:54 PM. The Director of Nursing (DON) became aware of the incident at 3:15 PM and notified the Administrator at the same time. Further review indicated that the Baltimore City Police Department was notified at 3:57 PM, and the report was submitted to the state agency at 4:57 PM on the same day. On 06/05/25 at 11:39 AM, during an interview, the Administrator stated that she recalled the incident that occurred on 8/2/24. After the incident, Resident #11 was transported to the hospital for further evaluation and returned to the facility with no physical injuries. Upon returning, Resident #11 was placed on a different unit. Resident #27 was evaluated and placed on one-to-one supervision until medication adjustments were effective.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility reported incident investigation, review of record and interviews, it was determined the facility failed to 1) report an allegation of abuse in a timely manner to the state agency, immediately, but not later than two hours after the allegation was made, and 2) report an injury of an unknown source to the state agency as required. This was evident for 1 resident (Resident #106) of 17 residents reviewed for timely reporting an alleged violation, and 1 resident (#94) of 3 residents reviewed for an injury of unknown origin during an annual survey. The findings include:1) On 06/10/2025 at 8:41 AM, review of the investigation report of Facility Reported Incident (FRI), MD#00190620 revealed that on 03/28/2023 at 09:15 AM, Resident #110 reported to the administrator that Resident #106 might have been choked by Geriatric Nursing Assistant (GNA #21) on 03/27/2023 during the evening shift. On 06/10/2025 at 8:57 AM, further review of the investigation packet showed that on 03/27/2023, Certified Medicine Aide (CMA #32)'s in her statement stated that on that day at around 6:00PM to 6:30 PM, a resident informed her that Resident #106 had been hit and on the same day Resident #106's roommate had given her a note about Resident #106 being hit. On 06/10/2025 at 12:53 PM, in an interview with the Nursing Home Administrator (NHA), when she was asked about the reporting time of an alleged abuse violation, she stated that she typically reports such incidents within two hours or less. When she was informed that the alleged violation was not reported in a timely manner, she responded that she learned about the incident from another resident as she was arriving at the facility and added that this failure to report to the supervisor was a major factor in the termination of CMA #32's employment, noting that CMA #32 was aware of the incident but failed to notify a supervisor who would have informed her(NHA). She was informed that delay in reporting was a concern that would be brought to our office, and she acknowledged understanding of the concern. 2) Review of complaints #MD00210615 and #MD00210588 on 6/4/25 at 10:21 AM, revealed an allegation that Resident #94 sustained an ankle fracture of unknown origin on or about 10/5/24. The Resident's medical record revealed that Resident #94 was non-verbal, and was completely dependent on staff for all care and ADL (Activities of Daily Living) including but not limited to bed mobility, turning and repositioning, toileting, and hygiene; and that s/he had severe contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). A Change in Condition/Concurrent Review dated 10/4/24 12:53 (12:53 PM) noted that the resident's left lower extremity was swollen, and left ankle was red and warm to touch; the Physician was contacted and ordered a STAT (immediate) x-ray to rule out a fracture and an ultrasound to rule out a Deep Vein Thrombosis (blood clot). The X-ray report dated 10/5/24 revealed the resident had fractures of the distal metaphysis of the left tibia and fibula (ankle area) in satisfactory position and alignment. S/he also had severe deformities of the left foot. No documentation was found in Resident #94's record of an accident, incident or trauma associated with the injury.On 06/4/25 at 11:30 AM the Administrator was asked if the facility reported the injury of unknown origin related to Resident #94's fractured ankle to the State Agency. She initially indicated no but then indicated that she would look because there may be something in her office. At 1:10 PM on 06/4/25 the DON (Director of Nursing) and the Administrator confirmed that the facility did not report the resident's injury to the State Agency. The DON provided the surveyor with an investigation that was completed by the facility on 10/7/24 and indicated the injury was not reported because the medical director determined that it was a pathological fracture. The DON confirmed that the medical director's determination was made on 10/7/24, 2 days after the initial injury was identified. She also confirmed that Resident #94 was incapable of moving independently. Cross reference F 628 and F 842.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of a facility reported incident it was determined the facility failed to 1) ensure the thorough investigation of an allegation of abuse, and 2) provide residents with psychological evaluations and physician assessments following a substantiated incident of resident to resident sexual abuse. This was evident for 1 (Resident #106) out of 17 residents reviewed for allegations of abuse, and 1 (MD#00193881) of 17 Facility Reported Incidents (FRI) reviewed during the annual survey.The findings include:1) On 06/10/2025 at 8:41 AM, review of the investigation report of Facility Reported Incident (FRI), MD#00190620 revealed that on 03/28/2023 at 09:15 AM, Resident #110 reported to the administrator that Resident #106 might have been choked by Geriatric Nursing Assistant (GNA #21) on 03/27/2023 during the evening shift. On 06/10/2025 at 11:12 AM, when the surveyor requested copies of employee files/trainings for GNA #21 from the Nursing Home Administrator (NHA), she informed this surveyor that GNA #21 was from a nursing agency and added that the facility did not have his employee file and training. When asked how the facility ensured that nursing agency staff received the required training, she explained that the facility had a contract with the agency stipulating that all staff would be properly trained before being assigned to the facility. On 06/10/2025 at 11:24 AM, She was asked to provide a copy of the contract with the nursing agency.On 06/10/2025 at 1:52 PM, The NHA and Director of Nursing (DON) informed the surveyor that they do not have the contract from the nursing agency do not have any documentation of GNA #21's training. She stated that it seemed the agency did not exist any longer. When they were informed that the inability to maintain an employee training/file record was a concern, the NHA and DON verbalized understanding of it and the DON stated that they should have ensured that GNA #21 had the required training which should have been made available on request. 2) Based on record review and interview with staff, it was determined that the facility failed to provide residents with psychological evaluations and physician assessments following a substantiated incident of resident to resident sexual abuse. On 06/05/2025 at 9:24 AM, the surveyor reviewed an investigation into an incident of resident to resident sexual abuse that took place on 06/29/2023 at 9:23 AM. In the investigation documentation, the facility made several claims that the residents had been seen by psychiatric services and the facility physician for assessment and evaluation following the substantiated incident. On 06/05/2025 at 10:01 AM, a review of Resident #27's medical records failed to reveal that the resident was seen for a psychiatric evaluation following the incident regarding the sexual abuse.On 06/06/2025 at 10:18 AM, a review of Resident #85's medical records failed to reveal that the resident was seen by the facility physician in regards to the sexual abuse. On 06/12/2025 at 2:13 PM, during an interview with the Director Of Nursing (DON), she stated that it was normal practice following any allegation of resident to resident abuse that both residents would be seen by psychiatric services and the physician to be assessed and evaluated. She stated that both residents involved in this incident had not been seen by psych services or the facility physician regarding the sexual abuse. The DON was made aware of the concern on 06/12/2025 and again during the exit conference on 06/13/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review and interviews it was determined the facility staff failed to ensure that the required minimum information was provided to the receiving provider upon transfer from the facility. This was evident for 1 (#94) of 3 residents reviewed for an injury of unknown origin. The findings include: A review of Resident #94's medical record on 6/4/25 at 10:21 AM revealed a Change in Condition/Concurrent Review dated 10/4/24 12:53 (12:53 PM) which noted that the resident's left lower extremity was swollen, and left ankle was red and warm to touch. The Physician was contacted and ordered a STAT x-ray to rule out a fracture and an ultrasound to rule out a Deep Vein Thrombosis (blood clot). The Change in Condition form contained a section to document specific information in the event of a hospital transfer. The section was blank. The X-ray report dated 10/5/24 confirmed the resident had fractures of the ankle. A Nursing Note dated 10/6/24 03:13 (3:13 AM) noted that the on-call physician was notified of the results and ordered that the resident be sent to the hospital for evaluation. Another Nurses Note at 03:33 (3:33 AM) on 10/6/24 indicated the resident was sent to the hospital at that time. No documentation was found to indicate that the required information was provided to the receiving provider at the time of the transfer. During an interview on 6/4/25 at 11:30 AM the Administrator was made aware of this finding and indicated the required information should be documented in the Change in Condition form. She reviewed the form and confirmed it did not contain the required information. She indicated that she would check with the DON (Director of Nursing). At 1:10 PM on 6/4/24 the Administrator and DON confirmed that there was no documentation to indicate that the required hospital transfer information was sent to the receiving facility. Cross reference F 609 and F 842.

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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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, it was determined the facility failed to ensure comprehensive care plans were developed and implemented. This was evident for 1 resident (Resident#104) out of 17 facility reported investigations, and 2 (Resident #58 and Resident #92) out of 6 residents reviewed for care plans. The findings include:1) A care plan is an outline of nursing care showing all the residents' needs and the ways of meeting the needs. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the individual's specific needs. It is a dynamic document initiated at admission and subject to continuous reassessment and change by the nursing staff caring for the resident. The care plan typically includes nursing and medical diagnoses, nursing interventions, and outcomes to ensure consistency of care.On 06/11/2025 6:33 AM, the surveyor reviewed the facility's reported incident investigation packet for intake MD#00181243 in which the facility reported an unexpected death of Resident #104 to the state agency.On 06/11/2025 at 8:44 AM, further review of the investigation packet revealed the resident's death certificate which was signed by the certifying physician and dated 07/22/2022 was seen which revealed the following as the cause of deathA)Septic shock with approximate interval between onset and death described as days.B)Necrotizing Fasciitis with approximate interval between onset and death described as weeks.C)History IV drug abuse with approximate interval between onset and death described as years.D)Polysubstance abuse with approximate interval between onset and death described as years.On 06/11/2025 9:04 AM, review of the resident's electronic health record (EHR) showed that Resident #104 had diagnosis of osteomyelitis and history of substance abuse amongst other diagnosis. On 06/12/2025 at 7:31 AM, review of the resident's care plans failed to reveal a plan to address the history of substance abuse and there was no documentation found regarding what intervention would be facilitated by staff to prevent such while the resident was at the facility. On 06/12/2025 at 8:13 AM, in an interview with the Nursing Home Administration (NHA), When asked if there was a care plan in place for Resident #104 which addressed the history of substance abuse, she stated that the facility did not put a care plan in place for history of substance abuse. When asked if there should have been a care plan in place for the history of substance abuse, she stated that there should have been one in place which would have helped to identify that she had the potential for illicit substance use and interventions would have been in place. She also added that she did not know if a post mortem was done or not. 2a) On 06/06/25 at 07:52 AM, a review of Resident #58's medical records was conducted. This review revealed that the resident was dependent on staff for personal hygiene and toileting. Further review of the resident's care plan indicated that Resident #58 needed 2-persons assist during the provision of personal care. On 06/06/25 at 08:00 AM, a review of the resident's Minimum Data Set (MDS) revealed that the resident was coded as dependent on staff. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. MDS defines dependent as when the caregiver does all of the effort, or, the assistance of 2 or more helpers is required for the resident to complete the activity.On 06/06/25 at 01:50 PM, a review of Resident #58's personal hygiene record for March and April 2025 revealed that the resident received only 1 person assist during various shifts every day in March and April 2025.On 06/06/25 at 02:00 PM, further review of the record revealed a nurse note dated 06/01/2025 that indicated the resident rolled out of the bed and was caught by the aide who assisted the resident to the floor.On 06/06/25 at 02:25 PM, an interview with the Director of Nursing (DON) was conducted. The DON confirmed that according to the facility's provided documentation, Resident #58's care was provided by 1 person instead of 2-persons as care planned. 2b) On 06/11/2025 at 09:06 AM, review of confidential complaints reported to the state agency revealed complaint #MD00206301 which was received on 6/4/2024. This complaint alleged that Resident #92 did not receive tracheostomy care.A tracheostomy is a surgical procedure that creates an opening in the neck, called a stoma, through which a tube is inserted into the trachea (windpipe) to provide an airway and facilitate breathing.On 06/11/2025 at 10:00 AM, further review of Resident #92's medical record was conducted. The review revealed that Resident #92 was admitted into the facility with a tracheostomy on 4/3/24 and was discharged to a hospital on 5/31/24. A review of the resident's care plan did not include tracheostomy care.On 06/11/2025 at 10:30 AM, an interview with the DON was conducted. During the interview, the surveyor and the DON reviewed Resident #92's care plan and the DON confirmed that the resident was never care planned for tracheostomy care.

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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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews, it was determined that the facility failed to revise care plans for residents. This was evident for 1 (MD#00207171) out of 17 facility reported investigations, 2 (Resident #100, #27) out of 5 residents reviewed for care plans reviewed during an annual survey.The findings include:1) On 06/09/2025 at 9:48 AM, the surveyor reviewed the facility's reported investigation packet for intake MD#00207171 in which the facility had stated that on 06/28/2024, Resident #64 was seen naked with another resident.On 06/09/2025 at 10:30 AM, further review of the investigative packets showed that the facility stated in the final report sent to the state agency that the corrective action to be taken would be to update Resident #64's care plan to reflect his/her wish for companionship with other residents but that his/her interactions would be supervised by staff, that no sexual interactions would take place due to resident's cognitive deficits and provide assistance with resolution as needed.On 06/09/2025 at 10:51 AM, review of the resident's care plan in the electronic health record dated 07/02/2024 showed inappropriate exposure behaviors with another resident which care-planned underneath behaviors care plan and there was no goal or intervention for the care plan focus. The surveyor did not see a care plan update that addressed Resident #64's desire for companionship with other residents or care plan intervention for staff to supervise him/her so that there would not be sexual interactions.On 06/09/2025 at 12:04 PM, in an interview with the Director of Nursing (DON), when she was asked what measures were put in place after the incident. She stated that she had just started working at the facility 2 days after the incident and that the Nursing Home Administrator would know more about it.On 06/09/2025 at 12:11 PM, in an interview with the Nursing Home Administration (NHA), when asked what measures were put in place after the incident, she stated that the facility had planned to update Resident #64's care plan to reflect the desire for companionship and that he/she would be supervised by staff so that there would be no sexual interaction. When she was asked for the documentation of the care plans, she stated that she would provide it to the surveyor.On 06/09/2025 at 12:16 PM, the NHA informed the surveyor that she had checked the resident's electronic health record but did not find any care plan that addressed Resident #64's desire for companionship with other residents or care plan intervention for staff to supervise him/her so that there would be no sexual interaction. When she was informed that this was a concern that would be taken to the office, she stated that the care plan should have been specific just as it was noted in the final report sent to the state agency. 2) On 06/11/25 at 9:00 AM, a review of Complaint #MD00212923 was conducted. The complaint expressed concerns with how Resident #100 fell and the process after the fall. On 06/12/25 at 9:30 AM, Resident #100's Change of Condition documentation was reviewed. On 12/6/2024, the change of condition documentation stated the resident was found on the floor during rounds.On 06/12/25 at 10:12 AM, a review of Resident #100's care plan and orders was conducted. A care plan of Potential for falls was created on 11/9/24. No revisions made to the care plan's Focus, Goal, or Interventions after the fall on 12/6/24. There was no additional Fall care plan created after the fall on 12/6/24. A review of Resident #100's orders revealed that no orders for interventions were created after fall on 12/6/24.On 06/12/2025 at 12:30 PM, an Interview with the Director of Nursing (DON). The DON noted that there was no Care plan, orders, or interventions created or revised after Resident #100's fall on 12/6/2025. 3.) Monitoring and Modification-Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks.A review of the facility's investigation file related to the facility reported incident MD00208357 and complaint intake MD00208362 on 6/4/25 at 2:45 PM, revealed that the facility substantiated allegations of sexual abuse. The investigation indicates that Resident #27 sexually assaulted Resident #11 on 8/2/24.Further review of the investigation file revealed that the facility's corrective action for the incident included updating Resident #27 care plan to reflect the incident from 8/2/24, monitoring sexually inappropriate behaviors, and assessing the effects of medication changes. On 6/5/25 at 12:26 PM, a review Resident #27 care plan indicates that the facility failed to update care plan interventions to address monitoring and supervision in response to the resident's inappropriate sexual behaviors. 06/05/25 11:39 AM during an interview with the Administrator, the surveyor discussed the facility's investigation file and corrective action plan. The surveyor asked if Resident #27 inappropriate sexual behavior was monitored and supervised, since there was no indication of such on the care plan. The Administrator stated that the resident was receiving psychotropic medication behavioral monitoring, but no additional monitoring or supervision was in place for the inappropriate sexual behavior.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that facility staff failed to 1.) ensure that a tube feeding container was labeled 2.) follow professional standards when caring for a resident who had a change in condition. This deficient practice was evident for one resident (Resident #53) out of 9 residents reviewed for tube feedings during the annual survey and one (#87) resident reviewed for nursing standards during the annual survey.The findings include: 1.)Gastrostomy tube (G-tube) is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications. The most common type is a percutaneous endoscopic gastrostomy (PEG) tube.On 06/04/25 at 07:54 AM, during the initial tour of the facility, Resident #53 was seen sleeping, in bed, with a bottle of enteral feed running at 70 milliliters per hour(mL/hr). The surveyor observed that the enteral feed did not have a name or date on it. The surveyor also observed that the water flush that was up did not have a name or date as well.On 06/04/2025 at 8:12 AM, Registered Nurse #3 was invited for dual observation and confirmed that it was not dated or labeled. When she was asked if the enteral feed and the water flush should have had a name and a date, she stated that it should have been named and dated appropriately. She also added that it would be dated immediately.On 06/04/2025 at 1:15 PM, the surveyor went to observed Resident #53 and discovered that both the enteral feed and the water flush had been labeled.2.) According to the American Nurses Association, nursing documentation must be accurate, timely, and reflect the patient’s condition and care provided. A failure to document an assessment following a change in condition during a nursing shift is inconsistent with these professional standards. A review of complaint intake MD00186830 reveals that a family member reported finding Resident #87 unresponsive during a visit and called 911. The family member reported that staff told them the resident was like that all day. The resident was transported to the hospital for further evaluation. Review of medical records reveals that the resident was admitted to the facility on [DATE]. A baseline care plan was completed and indicated that the resident is alert, cognitively intact, and can make needs and preference know to staff. A review of the nurse’s progress note dated 12/12/22 at 5:31 PM indicated that the resident was alert and responsive to care. Another nurse’s progress note dated 12/13/22 at 12:23 AM also documented that the resident was alert and responsive. Further review of the nursing progress note reveals that the day shift nurse on 12/13/22 failed to document a nursing assessment of the resident. A Physician (MD) #35 progress note dated 12/13/22 at 1:36 PM stated that the resident was seen earlier that day lying on the bed with their feet dangling down and was noted to be confused and disoriented. Laboratory tests were reviewed, and the physician ordered repeat labs in two weeks. A review of the nursing progress note dated 12/13/22 at 3:30 PM indicated that the evening shift nurse entered Resident #87’s room and observed that the resident was unresponsive. The resident’s family who was at the bedside requested that the resident to be transferred to the hospital. The doctor was notified, however, the family member called 911 and the resident was transported to the hospital by paramedics. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 9:58 AM, during an interview with MD #35 the surveyor asked about the process for assessing new admission. The MD #35 stated that he reviews the resident's hospital discharge summary and receives a report from the nursing staff. He explained that he completes a physical examination and documents his findings and orders laboratory test and treatment as needed. The surveyor discussed Resident #87 and mentioned that at the time of admission, the resident was documented as alert and cognitively intact. On 06/23/2025 at 5:32 PM, a review of hospital admission notes dated 12/13/22 reveals that at the time of arrival, the resident was noted with altered mental status and was diagnosed with a urinary tract infection and tested positive COVID.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interviews, it was determined that the facility staff failed to provide a resident (Resident #92) with oral care. This was evident for 1 (MD#00206301) of 46 intakes reviewed during the recertification survey. The findings include: On 06/10/2025 at 10:00 AM, a review of confidential complaints reported to the state agency revealed complaint #MD00206301. This complaint alleged that Resident #92 did not receive oral care during their stay at the facility. On 06/10/2025 at 10:20 AM, a review of Resident #92's medical record was conducted. The review revealed that Resident #92 was admitted into the facility with a tracheostomy on 4/3/24 and was discharged to a hospital on 5/31/24. A tracheostomy is a surgical procedure that creates an opening in the neck, called a stoma, through which a tube is inserted into the trachea (windpipe) to provide an airway and facilitate breathing. The review of the care plan failed to mention any intervention for tracheostomy care or oral care. On 06/11/2025 at 9:49 AM, an interview with the Director of Respiratory Therapy (Staff #19) was conducted. When asked whose responsibility it was to provide dependent residents with oral care, Staff #19 stated that Respiratory Therapists (RTs) were responsible and that tracheostomy care also included oral care. Additionally, Staff #19 reported that RTs were required to document oral care provided under progress notes. On 06/11/2025 at 10:00 AM, a review of the respiratory therapist progress notes was conducted. The review of these notes revealed that some respiratory therapists had documented oral care provision while others had not. On 06/11/2025 at 10:20 AM, the Director of Nursing (DON) was asked to provide the facility's tracheostomy care policy. On 06/11/2025 at 11:30 AM, the facility's tracheostomy care policy was received. Review of this policy only revealed the care of the tracheostomy and did not include oral care. On 06/11/2025 at 12:00 PM, the DON was notified of the investigation findings and concerns with the lack of oral care provision to a dependent resident.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observation, and interviews, it was determined that the facility failed to have documented evidence to support that the facility provided an ongoing program to support residents in their choice of activities. This was evident for 1 (Resident #73) of 3 resident reviewed for activities during the Medicare/Medicaid recertification survey. The findings include: On 06/04/2025 at 10:12 AM, during a family interview with Resident #73's Responsible Party (RP), when she was asked about the resident's activities, she stated that Resident #73 liked listening to music, but the facility was not offering him/her any activity. On 06/04/25 01:59 PM, this surveyor reviewed Resident #73's care plan goal which showed that he/she would accept/participate in one-on-one visits at least 2 times per week and the care plan intervention showed that the facility would provide one-on-one visits 2-3 time a week gospel music, daily bread, television. On 06/05/25 at 07:32 AM, in an interview with the Activities Director (Staff #8), when she was asked about the activity process for the residents, she stated that she would have assessed the residents upon admission to know their interests. She added that she provided activities to all the residents in the facility and that a one-on-one visit was made for residents that cannot go out of their rooms. When asked how activities were carried out, she stated that activity was usually done for residents who do not get out of their room according to the residents' care plans. On the same day at 07:38 AM, when the Activities Director was asked for the type of activities done with Resident #73, she stated that she plays lots of gospel music for him/her. When asked how often the music was played, she stated that it was played about 2 to 3 times a week and the timing depends on how staff were assigned to the residents on the floor and added that each session was about 15 minutes long. On 06/05/25 at 07:46 AM, the surveyor asked Staff #8 to provide an activity assessment and a copy of the residents' activity log. The required documents were provided at 08:40 AM and upon review, it showed that the resident had only logs for May 2025, this surveyor did not see the activity logs from admission on [DATE]. When Staff 19 was asked about the other logs from the time of admission, she stated that her former assistant had spilled drinks on the logs and had trashed them instead of leaving them out to dry. On the same day at 08:49 AM, further review of May 2025 activity log showed that Resident #73 had only 5 visits in May of 2025 (7th, 15th and 27th) and two times in June (3rd and 5th) so far. When she was asked the reason for the inconsistency, she stated that it was due to her not having enough support staff. On 06/06/25 at 01:46 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were informed of the concerns and the NHA stated that the documents should have been kept even if they were soiled instead of trashing the activity logs.

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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 0689 Level of Harm - 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 record reviews, and interviews, it was determined that facility staff failed to 1.) provide adequate supervision of a resident identified with inappropriate sexual behavior towards residents and staff resulting in actual harm to Resident #11, and 2.) ensure two-person assistance was provided while providing care to a resident in bed, as required by the resident's care plan. This deficient practice was evident for 2 of 5 residents (#11 and #98) reviewed for accidents during the annual survey.The findings include: 1) On 6/4/25, the surveyor reviewed facility incident reports and medical records for Residents #27 and #11. Resident #27 was admitted to the facility on [DATE] with diagnoses including schizophrenia and cognitive impairment. The nursing assessment for Resident #27 dated 6/19/24 documented a Brief Interview of Mental Status (BIMS) score of 6, indicating severe cognitive impairment. A review of the facility reported incident (FRI) MD00193881 revealed that the facility substantiated that Resident #27 inappropriately touched Resident #85 on 6/29/23. The resident’s care plan was revised on 6/30/23, to address sexually inappropriate behaviors toward residents and staff. Interventions included administering psychotropic medications as ordered, monitoring side effects, establishing limits for inappropriate behaviors, and explaining unacceptable behavior to the resident. There was no documentation indicating that the facility revised the care plan to include increased supervision to ensure safety for all residents. Following the incident from 6/29/23, a review of a psychiatric evaluation conducted on 1/30/24 indicated that Resident #27 has a history of inappropriate sexual behavior towards staff. Another psychiatric evaluation was completed on 2/5/24 to assess the resident for Gradual Dose Reduction (GDR) of Zyprexa. It was documented that the resident previously failed a GDR attempt, but a second attempt was made. A progress note from the psychiatrist indicates that Resident #27 continued to display inappropriate behavior. Resident #11 was admitted to the facility on [DATE] with diagnoses including dementia. The nursing assessment for Resident #11 dated 7/22/24 documented a BIMS score of 0 indicating severe cognitive impairment. A review of FRI MD00208357 revealed that Resident #27 inappropriately touched Resident # 11 on 8/2/24. The facility substantiated allegations of sexual abuse based on a witness account provided by Geriatric Nursing Assistant (GNA) #18. According to the investigation, on 8/2/24 at 2:54 PM, GNA #18 reports walking into room [ROOM NUMBER] at 2:54 PM and noticed Resident #27 on his/her knees next to bed A. Resident #27 appeared to be touching Resident #11 in the genital area. The GNA saw that one side of Resident #11 brief was wide open, and she could see his/her genital area exposed. The GNA immediately told Resident #27 to leave the room, and she redressed Resident #11, observing that the non-verbal resident was “tearful and kicking their legs urgently.” (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The surveyor conducted an interview with GNA #18 regarding FRI MD00208357. The surveyor asked if she recalled the incident involving Resident #11 and Resident #27. GNA #18 stated that she did remember and witnessed tears streaming down Resident #11’s face, explaining that the resident typically does not cry. When asked whether she believed the resident understood what had happened, the GNA stated “yes”. Although the resident is nonverbal, she appears to understand at times. Following the incident on 8/2/24, the facility requested a psychiatric evaluation which was conducted on 8/5/24. A psychiatrist's progress notes documented that the resident was evaluated at the nurse’s station and is now under close supervision by staff. A review of Resident #27s care plan revealed that the care plan was revised on 8/7/24, to address inappropriate touching of others. Previous care plan updates were made on 2/25/24, 2/26/24, 5/29/24 & 8/7/24 including behavioral monitoring, redirecting, and maintaining the resident’s dignity and right to sexual expression. However, the intervention failed to include increased supervision to ensure the safety of other residents. On 6/5/2025 at 7:35 AM, during an interview with the Administrator regarding FRI MD00208357. The surveyor asked whether the incident had been reviewed during the facility’s Quality Assurance and Performance Improvement (QAPI) meeting and if a corrective plan had been developed. The Administrator stated that the incident was reviewed during the facility’s risk management meeting, but no plan was implemented following the incident on 8/2/24. The Administrator confirmed that no additional supervision was initiated for Resident #27 beyond general monitoring and staff rounding. Both the surveyor and the Administrator reviewed Resident #27 care plan and acknowledged that the care plan should have included supervision interventions following the 8/2/24 incident. She also stated that no additional incidents of sexually inappropriate behavior towards another resident occurred between June 2023 and August 2024, she did not believe higher supervision was necessary. On 6/5/25 at 3:49 PM, both the Administrator and Director on Nursing (DON) were informed that the facility’s failure to revise Resident #27 care plan interventions to include more supervision led to the harm that occurred on 8/2/24. Both the Administrator and DON acknowledged that information. Although Resident #11 did not have any documented emotional distress, behaviors, or other negative outcomes from the incident on 8/2/24, the resident was known to be unable to respond normally to situations, to communicate effectively with staff, or to express their feelings clearly. In situations where a resident is unable to express their feelings such as this, the Reasonable Person Concept can be used to approximate how a reasonable person in the resident's situation would have reacted for the purpose of determining the outcome of a deficient practice. Using this concept, it was determined that a reasonable person would have experienced humiliation, anger, shame, and intimidation in response to the actions of Resident #27. Therefore, it was determined that psychosocial harm occurred to Resident #11. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2.) On 06/11/2025 at 11:00 AM, a review of complaint MD#00212331 revealed a concern regarding an incident that occurred in March of 2024 when only one staff member was providing care for Resident #98 which resulted in the resident rolling out of bed and hitting their head on the floor sustaining a cut over their right eye. Review of Resident #98's medical records on 06/12/2025 at 9:14 AM, revealed a baseline care plan for the resident that was completed on 03/12/2024. In this baseline care plan, under section 2B titled, Functional Abilities and Goals- Mobility, Bed Mobility: support provided, the resident was designated as a Two+ persons physical assist.On 06/12/2025 at 11:21, Resident #98's care documentation was reviewed for bed mobility in March of 2024. There were a total of 52 documented tasks performed for bed mobility. Of those 52, there were 30 documented as using a one person physical assist. On March 14, 2024 at 2:00 PM, just prior to the fall, the bed mobility task was documented as using a one person physical assist. Review of a change in condition dated 03/14/2024 revealed that the Resident rolled/fell out of bed during care by the assigned aid at 4:45 PM, thus sustaining a 1.0 cm laceration over the right eyebrow. On 06/12/2025 at 12:49 PM, during an interview with the Director of Nursing (DON), she stated that if a resident is designated as a Two+ persons physical assist for bed mobility then it is expected that the aid or nurse ensures that there are two people present during care.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interviews, it was determined that the facility failed to ensure nursing staff were competent with their skills set. This was evident for 3 (Staff #14, Staff #29, and Staff # 30) of 5 nursing staff evaluated for competency and has the potential to affect all residents. The findings include: 1a) Nursing competence is defined by the American Nurses Association as an expected level of performance that integrates knowledge, skills, abilities, and judgment. On 06/09/25 at 08:08 AM, as part of the sufficient and competent nurse staffing task, the surveyor asked the Director of Nursing (DON) to provide employee files of 5 randomly selected nursing staff. On 06/09/25 at 09:10 AM, the DON provided for Staff #14's employee file, one of the facility's contracted/agency Registered Nurse. On 06/09/25 at 09:15 AM, a review of Staff #14's employee file did not reveal any nursing competencies. The DON reported that she had contacted the staffing agency to request Staff #14 nursing competencies completed. On 06/10/25 at 11:57 AM, an interview with the DON was conducted. The DON reported that the agency could not provide Staff #14 nursing competencies or skill tests. Additionally, the DON acknowledged that she had identified the lack of staff education as a concern. 1b) On 06/10/2025 at 10:00 AM, a review of confidential complaints reported to the state agency revealed complaint #MD00206301. On 06/11/2025 at 12:10 PM, an interview with the complainant was conducted. S/He alleged that nurses who cared for Resident #92 were not skilled in taking care of a tracheostomy. On 06/11/2025 at 2:00 PM, a review of Resident #92's medical record was conducted. The review revealed that Resident #92 became unresponsive and was sent to the hospital on 5/31/24. On 06/11/2025 at 3:00 PM, the facility administrator was asked to provide: (1) the names of the nursing staff that worked on 5/31/24, and (2) their tracheostomy care competencies. On 06/11/2025 at 3:40 PM, the facility provided the names of the nursing staff who worked on 5/31/24, Staff #29 and Staff #30. However, the administrator acknowledged Staff #29 and Staff #30 had no tracheostomy care competencies. On 06/11/2025 at 3:50 PM, the lack of nursing competencies concern was discussed with the facility administrator and the DON.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on record review and interviews, it was determined that the facility failed to provide adequate physical therapy services to a resident (Resident #92). This was evident for 1 (MD#00206301) of 46 intakes reviewed during the recertification survey. The findings include: On 06/10/2025 at 10:00 AM, a review of confidential complaints reported to the state agency revealed complaint #MD00206301. On 06/11/2025 at 12:10 PM, the complainant was called. S/He alleged that Resident #92 did not receive physical therapy as ordered and as needed. On 06/11/2025 at 01:00 PM, a review of Resident #92's medical record was conducted. The review revealed that the resident had an order to receive physical therapy services 5 to 7 times a week for the recertification period of 4/4/24 to 5/2/24. On 06/11/2025 at 01:10 PM, the Director of Nursing (DON) was asked to provide physical therapy notes for the month of April 2024. On 06/11/2025 at 02:00 PM, the facility provided physical therapy notes. These documents were reviewed with a physical therapist (Staff #26), and revealed that Resident #92 did not receive adequate physical therapy sessions. The resident received 3 sessions of physical therapy the Week of 4/14/24 to 4/20/24; 4 sessions the week of 4/21/24 to 4/27/24 and only one session the week of 4/28/24 to 5/2/24. On 06/11/2025 at 03:40 PM, the DON was notified of these 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 interviews it was determined the facility staff failed to maintain medical records on each resident that are complete and accurately documented. This was evident for 1) 1 (#94) of 3 residents reviewed for an injury of unknown origin, 2) 1 (Resident #86) out of 2 resident's reviewed for death in the facility, 3) 2 (Resident #33 and #60) of 5 residents reviewed for pressure ulcers, 4) 1 (Resident #30) of 3 residents reviewed for activities, and 5) 1 resident (Resident#104) out of 17 facility reported investigations reviewed during an annual survey.The findings include:1) Review of Resident #94's medical record on 6/4/25 at 10:21 AM revealed that the resident sustained an injury to his/her left ankle on 10/4/24. An x-ray confirmed a fracture, and the resident was sent to the hospital for further evaluation. During an interview on 6/4/25 at 1:10 PM the DON (Director of Nursing) indicated that the Medical Director determined that the fracture was pathological after the hospital confirmed the fracture on 10/7/24. Further review of Resident #94's medical record on 6/4/25 at 1:41 PM failed to reveal physician documentation related to the resident's ankle fracture. The Administrator and DON were made aware at that time and provided the surveyor with the Medical Directors review of the clinical case which concluded that in his medical opinion it appeared to be a pathological fracture secondary due to underlying osteopenia and disuse atrophy in the setting of having contractures. They confirmed that neither the finding nor the report were documented in the resident's medical record. Cross reference F 609 and F 628. 2) On 6/11/25 at 8:29 AM, a review of Complaint #MD00181498 was conducted. A complaint was made regarding the quality of care provided to Resident #86 at the time of their death.On 6/11/25 at 8:40 AM, an interview with the Director of Nursing (DON) was conducted. This surveyor asked the DON to provide a copy of Resident #86's Death Certificate. The DON stated they do not have the Death certificate in the resident's record but will request it from funeral home. On 6/11/25 at 10:03 AM, an interview with DON was conducted. The DON stated they contacted the funeral home to provide Death certificate. This surveyor expressed concern regarding maintaining complete resident records. The DON agreed that the Death certificate should have been maintained in the resident's record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215195	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bridgepark	4017 Liberty Heights Avenue Baltimore, MD 21207

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3a) On 06/06/25 at 12:59 PM, a review of Resident #33's medical record revealed he/she had multiple areas of wounds with active wound care orders that indicated:Left elbow- clean with medication Right elbow- clean with medicationLeft knee- clean with medicationLeft head- clean with medicationBack- clean with medicationLeft ear- clean with medicationLeft buttock- clean with medicationRight buttock- clean with medicationLower back- clean with medicationAt the same time, review of the Treatment Administration Record (TAR) for May 2025 revealed that the areas of wounds with active wound care orders for each day shift, failed to be documented on the following dates:Left elbow- clean with medication: 5/12/25, 5/16/25, 5/23/25, and 5/30/25Right elbow- clean with medication: 5/2/25, 5/5/25, 5/12/25, 5/16/25, 5/23/25, and 5/30/25Left knee- clean with medication: 5/2/25, 5/5/25, 5/12/25, 5/16/25, 5/23/25, and 5/30/25Left head- clean with medication: 5/12/25, 5/16/25, 5/23/25, and 5/30/25Back- clean with medication: 5/2/25, 5/5/25, 5/12/25, 5/16/25, 5/23/25, and 5/30/25Left ear- clean with medication: 5/2/25, 5/5/25, 5/12/25, 5/16/25, and 5/23/25Left buttock- clean with medication: 5/2/25, 5/5/25, 5/16/25, 5/23/25, and 5/30/35Right buttock- clean with medication: 5/2/25, 5/5/25, 5/16/25, 5/23/25, and 5/30/25Lower back- clean with medication: 5/2/25, 5/5/25, 5/16/25 5/23/25, and 5/30/253b) On 06/06/25 at 08:27 AM, review of Resident #30's medical record revealed he/she had a wound on their left heel and an active order that indicated for left heel wound care each day shift.At the same time, review of the Treatment Administration Record (TAR) in May 2025 revealed that the active order for their heel wound care failed to be documented on the following dates: 5/5/25, 5/8/25, 5/16/25, 5/23/25, and 5/30/25On 06/10/25 at 07:28 AM, an interview with the Director of Nursing revealed that the expectation of staff was to document based on orders, whether the care was completed or refused. The surveyor reviewed the concern.4) On 06/05/25 at 11:45 AM, a review of complaint #MD00203753 revealed that the complainant had general concerns regarding the care provided to Resident #30.On 06/05/25 at 11:45 AM, an interview with the complainant revealed she/he had a concern regarding the facility providing activities for the resident.On 06/06/25 at 8:45 AM, an interview with the Activities Director (Staff #8) revealed that when residents are visited by an activities team member or an activity was provided, that the staff would document it. The surveyor requested to see the activity log for Resident #30.On 06/06/25 at 1:34 PM, the surveyor was provided Resident #30's activity log sheet for April-June 2025. Review of the activity log revealed that Activities Assistant (Staff #32) signed off all of the activities provided for the resident between April-June 2025.On 06/06/25 at 1:43 PM, the surveyor requested documentation that would reflect when Staff #32 was in the facility for each date signed off as an activity or visit completed on Resident #30's activity log between April-June 2025.On 06/10/25 at 07:43 AM, review of the documentation provided by the facility that indicated when Staff #32 was in the facility from April-June 2025 revealed 13 days (4/1/25, 4/5/25, 4/6/25, 4/10/25, 4/11/25, 4/16/25, 4/20/25, 4/24/25, 5/2/25, 5/7/25, 5/14/25, 5/21/25, 6/1/25) when an activity was signed off by Staff #32 on the Resident's activity log, but the staff member was not at the facility that day.On 06/10/25 at 08:03 AM, the surveyor reviewed the concern with the Nursing Home Administrator. She acknowledged the concern. 5) PERRLA is an acronym for pupils are equal, round and reactive to light and accommodation. Healthcare providers use the PERRLA eye test to check if the pupils look and function as they should.On 06/11/2025 6:33 AM, the surveyor reviewed the facility's reported incident investigation packet for intake MD#00181243 in which the facility reported an unexpected death of Resident #104 to the state agency.On 06/11/2025 at 9:04 AM, surveyor's review of the resident's electronic health record (EHR) showed a change in condition notes for Resident #104 in which the nurse stated in a brief synopsis of the change that: During routine medication pass, the resident was observed to be extremely lethargic. A neurological assessment revealed the following: PERRLA; speech was intermittently slurred; and the resident responded to their name. When spoken to, Resident #104 briefly opened his/her eyes before closing them again. The attending physician was notified and provided a one-time order for Narcan administration. Hospice was also informed. A 4 mg dose of Narcan was administered. Following administration, Resident #104 made some vocalizations and then returned to sleep. The Responsible Party (RP) was notified and expressed an understanding of the situation.On 06/11/2025 at 09:31 AM, surveyor reviewed the statement in the investigation packets, and it showed a statement from Licensed Practical Nurse LPN #20 dated 07/25/2022 that where she stated that on 07/22/2022, she did not administer 9:00 AM meds due to suspected opioid overdose and Narcan was administered at 1:00 PM. In another statement from the same staff on 07/27/2022, LPN#20 noted that the unit manager had administered Narcan to Resident #104 On