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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that facility staff failed to 1.) maintain the facility's floors and resident shower room in a clean and sanitary condition and 2.) failed to ensure privacy for male and female residents who share a joint bathroom. This deficient practice was evident for multiple areas observed for cleanliness and resident privacy during the annual survey. The findings include: 1.) A review of complaint intake MD00208739 on 06/4/25 for Resident #4, reveals that the complainant reported ongoing cleanliness issues at the facility. They described the facility as filthy with trash and toilet paper scattered on the floors. The elevator was noted to be so dirty that the complainant's shoes stuck to the floor. A review of complaint intake MD00202589 on 06/4/25 for Resident #89, reveals that the complainant expressed concerns about the facility's cleanliness and is unclear when the floors were last swept or mopped, or how often the bathroom is cleaned. On 6/4/25 at 7:30AM, upon entry into the facility, the surveyor observed cigarette ashes, and a brown colored substance scattered on the floor near the resident designated smoking exit area on the first floor. The surveyor team entered the elevator on the first floor and noted that the soles of their shoes were sticking to the floor. Upon exiting the elevator, a paper straw wrapper was stuck to the bottom of the surveyor's shoe, and facility staff had to assist in removing it. On 6/4/25 at 7:47AM, an observation of the stairwell revealed trash, leaves, a used glove on the steps, along with a brown colored substance on the wall. On 6/4/25 at 7:52 AM, an observation of the resident shower room on the third floor revealed a janitor's cart with cleaning supplies, a white washcloth, toothbrush, shaving cream, and razor placed on the windowsill. Five wheelchairs were lined up against the wall, one chair was noted with an oxygen tank and reuseable bag attached to the back of the seat.On 6/4/25 at 8:03 AM, an observation of a resident's bathroom on the third floor revealed trash and toilet paper on the floor. Directly outside the resident's room, a plastic string and a paper straw wrapper were also observed.On 06/09/25 at 08:42 AM, during an interview with Environmental Services (EVS) Director #31, he stated that a set of EVS staff begin their shift at 6:00 AM and are responsible for removing trash, delivering clean linen to the units, and collecting soiled linen. He explained that a second group of employees begins at 7:00 AM and is responsible for cleaning the facility floors and stairwells. From 2:00 PM to 6:00PM, another group of staff is responsible for maintaining the cleanliness of the facility. On 6/09/25 at 8:57 AM, the surveyor reviewed images of the facility's floors, shower room, and stairwell with the EVS Director #31 and Director of Nursing (DON) from 6/4/25. Both acknowledged the surveyor's observation. 2.) During the initial tour of the third-floor unit on 6/4/25 at 7:55AM, the surveyor entered room [ROOM NUMBER] that housed four males and observed a bathroom on the right side of the room that connected directly to room [ROOM NUMBER] that housed two female residents. The bathroom doors on both sides were open, and the surveyor was able to walk directly through the bathroom from room [ROOM NUMBER] into room [ROOM NUMBER]. On 06/05/25 at 07:35 AM, the surveyor informed Administrator that bathroom doors connecting room [ROOM NUMBER] and room [ROOM NUMBER] were both open, which allowed the surveyor unsupervised access between male and female rooms. The Administrator stated that the bathroom door on the female side should remain closed, especially since the female residents are not able to access the bathroom independently. On 06/05/25 at 8:16 AM, the Administrator reported that maintenance staff placed a lock on the bathroom door on the room [ROOM NUMBER] side preventing residents from room [ROOM NUMBER] from accessing the female room through the shared bathroom. 3.) A geri-chair, also known as a geriatric chair or medical recliner, is a specialized chair designed for individuals with mobility challenges, often seniors or those with disabilities. These chairs offer comfort and support for prolonged sitting and feature adjustable components like backrests, footrests, and armrests, as well as reclining capabilities.On 6/4/2025 at 8:12 AM, the 4th floor shower room was observed to have used wash cloths laying on the floor next to the soiled linen bin. Two geri-chairs were observed being stored in front of 1 of 2 shower stalls. A wound dressing with date and time on it was observed hanging over shower stall handle in the 4th floor shower room on 6/10/2025 at 8:27 AM. The shower room floor was visibly soiled, and a geri-chair was observed being stored in the 2nd shower room stall. A soiled clothing item was observed to be laying on the air-conditioning unit.On 6/10/2025 at 8:37 AM, the 3rd floor shower room was observed by surveyor. A geri-chair with two pillows and a foam fall mat on top of it was observed being stored in the shower room. Two janitor carts with mop buckets full of dirty water were also being stored in the 3rd floor shower room. A geri-chair and a wheelchair were observed being

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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 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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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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, record reviews, and interviews, it was determined that facility staff failed to ensure a resident wore an arm splint as ordered by the physician. This deficient practice was evident for one (# 11) resident reviewed for position and mobility and 1 (Resident #58) of 2 residents reviewed for range of motion during the annual survey. The findings include: A contracture is an abnormal shortening of muscle tissue causing the muscle to be resistant to stretching. Failure to protect the palm of the hand when the hand is contracted can result in injury to the palm of the hand caused by the pressure of fingers/fingernails pressing into the palm of the hand.1.) On 06/04/25 at 10:21AM, the surveyor observed Resident #11 in bed with bilateral upper extremity contractures. No arm splints were observed on the resident or noted anywhere in the resident's room. On 06/04/25 at 02:00 PM, the surveyor made a second observation of Resident #11. No arm splints were observed on the resident or noted anywhere in the resident's room.A review of Resident #11's Treatment Administration Record (TAR) on 6/5/25 at 8:26 AM indicated a physician order for the resident to wear a right arm splint daily for 6 hours, from 10AM-4PM. Further review of the medical records failed to indicate a reason why the arm splint was not applied. 06/05/25 at 10:45 AM, the surveyor made a third observation of Resident #11. No arm splints were observed on the resident or noted anywhere in the resident's room.During an interview with the Director of Nursing on 06/05/25 at 12:09 PM, the surveyor reviewed Resident #11's TAR for June 2025. The DON confirmed that the resident has an order for right arm splint to be worn daily for 6 hours per day from 10:00 AM-4:00 PM as tolerated. The surveyor informed the DON of the observations. The DON stated that she expects nursing staff to follow the physician's orders. 2.) On 06/04/25 at 10:38 AM, Resident #58 was observed without any splint after morning care.On 06/04/25 at 01:30 PM, a record review of Resident #58's orders was conducted. The review revealed an order that the resident should wear a rolled cloth on the left hand for 10 hours or as tolerated after morning care. Additionally, there was a care plan intervention for usage of splint on the left hand to prevent contractures.On 06/04/25 at 02:17 PM, during an afternoon observation on the unit, the surveyor observed Resident #58 without a splint on the left hand. On 06/06/25 at 03:11 PM, Resident #58 was observed lying on the bed without a splint. This observation was confirmed by Staff #28 who was asked to come to Resident #58's room. When asked if the resident should have a splint on, Staff #28 responded yes. On 06/09/25 at 11:11 AM, the Director of Nursing (DON) was notified of the findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on record reviews and interviews, it was determined that facility staff failed to ensure a treatment order was in place for a resident with a suprapubic catheter, and 2.) failed to change a resident for extended periods following episodes of incontinence. This deficient practice was evident for two (#4, #47) of two residents reviewed for bowel and bladder incontinence during the annual survey. The findings include: 1.) On 6/4/25 at 11:00PM, during an interview with Resident #4's representative, they expressed concerns regarding the resident's catheter, questioning how often it should be replaced. On 6/6/25 at 8:43AM, a review of Resident #4's treatment administration record revealed a physician's order to change the suprapubic catheter every 28 days and as needed. This order was discontinued on 5/20/25. Further review of the medical record indicated that the resident was discharged to the hospital on 5/19/25 and returned to the facility on 5/22/25. There were no physician orders in place for the suprapubic catheter, although the hospital discharge summary noted the presence of the catheter and recommended it be changed in one month. During an interview with the Director of Nursing (DON) on 6/6/25 at 1:48 PM, the DON stated that it is the responsibility of the admitting nurse to ensure all orders are entered at the time of admission. The surveyor informed the DON that Resident #4 returned from the hospital with a suprapubic catheter, however, there were no orders in place for the catheter. After reviewing the medical records, the DON acknowledged that there were no current orders for the suprapubic catheter. 2.) On 6/4/25 at 8:00 AM, a review of complaint intake MD00210014 revealed the complainant reported that Resident #47 is being left soiled for extended periods of time. On 6/04/25 at 9:18 AM, during an interview with Resident #47, the surveyor discussed allegations noted in intake MD00210012. The resident confirmed that they are often left unchanged for extended periods following episodes of incontinence. The resident also stated that they were last changed on the night of 6/3/25 and as of this morning 6/4/25 they have not been changed. On 6/5/25 the surveyor requested Resident #47's bladder continence Kardex (a quick reference tool used to outline a resident's toileting schedule and incontinence care) for the past 30 days from the Director of Nursing (DON). On 6/6/25 at 6:39 AM, the DON provided the surveyor with Resident #47's bladder continence Kardex from 5/8/25 to 6/5/25. Review of the Kardex for 6/4/25 indicated that the resident had an incontinent episode at 3:34 AM and was changed. The next entry was not documented until 12:14 PM. Further review of the Kardex indicated that the resident experienced extended periods without being changed on the following dates: 5/12/25, 5/17/25, 5/19/25, 5/22/25, 5/23/25, 5/24/25, and 6/3/25. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 6/6/25 at 7:34 AM, she explained that incontinence care should be completed prior to the change of shift, and that the geriatric nursing assistants are expected to round on residents every two hours and provide care as needed. The surveyor reviewed Resident #47's bladder continence Kardex with the DON and informed her of dates where the resident had gone extended periods of time with being changed. The DON acknowledged that on the dates mentioned, the resident was not changed in a timely manner.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on surveyor observations, review of the medical record, and interview with facility staff, it was determined the facility staff failed to provide residents with respiratory care consistent with professional standards by failing to 1) properly date label oxygen tubing when changed and 2) Change the water in the humidifier. This was evident for 1 resident (Resident #10) out of 9 residents on oxygen reviewed during the Medicare/Medicaid recertification survey. The findings include: On 06/04/25 08:07 AM, during the initial tour of the facility, Resident #10 was seen in bed with nasal cannula and oxygen running at around 2 liters. The oxygen humidifier bottle was dated 04/21/2025 and the nasal cannula tubing had no dates. On 06/04/2025 at 8:10 AM, Licensed Practical Nurse LPN#4 was invited for a dual observation, and she confirmed that the nasal tubing was not dated, and the oxygen humidifier bottle was dated 04/21/2025. When she was asked what the process was after changing nasal tubing, she stated that the normal process should have been to date it. When asked how often the water in the humidifier should be changed, she stated that she did not know and added that the water should not have been left unchanged for that long period of time. 06/04/25 01:39 PM, The DON was informed about these concerns, and she stated that the oxygen humidifier bottle would be changed immediately, and the nasal tubing would also be changed and dated because the last time that it was changed was not known because it was not dated.

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on record review and interviews, it was determined that the facility failed to comply with State Regulations when the facility failed to provide nursing staff with a minimum of 2 hours of training on cognitive impairment annually. This was evident for 5 (Staff #13, Staff #14, Staff #15, Staff #16, and Staff #17,) of 5 nursing staff evaluated for cognitive impairment training and has the potential to affect all residents. The findings include: Maryland state regulations at 10.07.02.10 D. states, Ongoing training in cognitive impairment and mental illness shall be provided annually and consist of, at a minimum of 2 hours for employees who are licensed, certified, or registered under the Health Occupations Article, Annotated Code of Maryland, or who assist residents with activities of daily living. 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 employee files for Staff #13, Staff #14, Staff #15, Staff #16, and Staff #17. Review of these files failed to reveal that nursing staff received a minimum of 2 hours of cognitive impairment training annually. On 06/10/25 at 11:57 AM, an interview with the DON was conducted. The DON confirmed that Staff #13, Staff #14, Staff #15, Staff #16, and Staff #17 did not have the required hours of cognitive impairment training.

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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)

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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

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interviews, it was determined that the facility failed to provide 12 hours of in-service training to nurse aides yearly. This finding was evident for 2 Geriatric Nursing Assistants (GNA #15 and GNA #16) of 2 nurse aide employee files reviewed during the recertification survey. The findings include: On 06/09/25 at 08:08 AM, as part of the sufficient and competent nurse staffing task, the surveyor reviewed two Geriatric Nursing Assistants (GNA) employee files (GNA #15 and GNA #16). The review of these records failed to show that the two GNAs had 12 hours of in-service education for the year 2024. On 06/09/25 at 09:50 AM, the facility administrator was asked to provide any documentation that indicated that GNA #15 and GNA #16 received in-service education. On 06/10/25 at 11:57 AM, an interview with the DON was conducted. The DON confirmed that GNA #15 and GNA #16 did not have 12 hours of in-service training, and that she had identified the lack of staffing education as a concern in the facility.