| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on review of complaint, medical record review, and staff interview, it was determined the facility failed to notify a resident's responsible party (RP) when there was a change in condition in a resident's medical status. This was evident for 1 (Resident #11) of 16 residents reviewed during a complaint survey.The findings include: Narcan (naloxone) is a life-saving nasal spray that rapidly reverses opioid overdoses. It is used for emergencies involving heroin, fentanyl, or prescription opioids and is safe to use even if no opioids are present. On 4/27/26 at 9:14 AM a review of complaint 2991540 alleged there was no communication with the RP when the medication Narcan had to be administered to Resident #11 for an alleged overdose. On 4/27/26 at 9:14 AM a review of Resident #11's medical record revealed progress notes that documented Resident #11 was admitted to the facility in March 2026 with diagnoses that included a nondisplaced zone 1 fracture of the sacrum, a nondisplaced fracture of the posterior column of the right acetabulum (the deep, cup-shaped socket on the right side of the pelvis that forms the hip joint by articulating with the femoral head), fracture of the right pubis (hip bone), and other chronic pain. Review of a 4/3/26 nurse practitioner initial evaluation note documented, pain and opioid management, patient is at high risk for poor function improvement in therapy without adequate pain management. The pain medication that was prescribed from the hospital and was to be continued on at the facility included Hydromorphone 6 mg (opioid) every 4 hours when needed (prn), Hydromorphone 4 mg every 4 hours prn, Tylenol 1 gram every 6 hours prn, Lidocaine cream to the back every 6 hours prn, Methocarbamol (muscle relaxant) 500 mg. every 6 hours prn, Celebrex 100 mg. twice per day, and Gabapentin 300 mg. three times a day. Review of a physician's note dated 4/8/26 at 12:42 PM documented, the patient reportedly had opioid overdose earlier this morning around a.m. and responded well to Narcan administration by nursing. Chronic pain, opioid overdose s/p Narcan. Further review of Resident #11's medical record failed to produce documentation that Resident #11's representative was notified of the incident. On 4/27/26 at 10:46 AM Licensed Practical Nurse (LPN) #4 (agency nurse) was interviewed and stated that Resident #11 was out of it and not responding when LPN #4 was doing rounds, so LPN #4 went to see if there was an order for Narcan. LPN #4 found the order and administered the Narcan and Resident #11 responded. On 4/27/26 at 10:55 AM an interview was conducted with the Director of Nursing (DON). The DON stated she would have expected the responsible party to be notified. On 4/27/26 at 1:09 PM LPN #19 was interviewed and stated the nurse administered the Narcan as the resident looked like the he/she was having an overdose. The physician saw the resident afterwards. LPN #19 stated, I don't think anyone was notified, but should have been. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 6 (Residents #3, #1, #9, #4, #12, #10) of 16 residents reviewed during a complaint survey.The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 4/27/26 at 12:40 PM a review of Resident #3's medical record was conducted and revealed Resident #3 had a history of cerebrovascular disease.Review of Resident #3's MDS assessment with an ARD of 3/2/26, Section J0100A pain management, received scheduled pain medication was coded, yes. Review of Resident #3's March 2026 Medication Administration Record (MAR) failed to produce documentation that Resident #3 received pain medication daily.On 4/30/26 at 12:45 PM Licensed Practical Nurse (LPN) #17, stated that she coded it that way because Resident #3 received Aspirin 81 mg. everyday.Review of Resident #3's March 2026 physician's orders revealed the Aspirin low dose 81 mg. chewable tablet was prescribed daily for prophylaxis. Aspirin is prescribed to prevent secondary cardiovascular events like heart attacks and strokes (cerebrovascular events).Review of the RAI (Resident Assessment Instrument) Manual documented, if the primary purpose of the drug is not to reduce the resident's pain, then it should not be coded here.On 4/30/26 at 2:00 PM the Nursing Home Administrator (NHA) and the Director of Nursing (DON) were informed of the error.2) On 4/28/26 at 8:05 AM a review of Resident #1's medical record revealed Resident #1 had a history of cerebral infarction, congestive heart failure, and vascular dementia.Review of Resident #1's progress notes revealed Resident #1 had a fall on 11/19/25 and 1/30/26. There were no injuries noted. Review of Resident #1's MDS assessment with an ARD of 2/4/26, Section J1900, Number of falls since admission or prior assessment, which was 11/11/25, documented the resident had 1 fall. The facility failed to capture the fact that Resident #1 had 2 falls during that time. Section J0100A, pain management, received scheduled pain medication regimen was coded no.Review of Resident #1's February 2026 MAR documented the daily use of Diclofenac topical gel for pain. The facility failed to capture the daily pain medication use.Further review of the February 2026 MAR documented the daily use of Aspirin 81 mg. every day for coronary artery disease.Review of Section N0415 (High-Risk Drug Classes) was not coded for an anti-platelet medication. The facility failed to capture the use of Aspirin as an anti-platelet medication. On 4/29/26 at 10:12 AM an interview was conducted with LPN #14. LPN #14 confirmed that she missed the second fall, and she confirmed the Aspirin error.3) On 4/28/26 at 11:35 AM a review of Resident #9's medical record was conducted. Review of Resident #9's MDS assessment with an ARD of 8/26/25, Section N0415 (High-Risk Drug Classes) documented the use of a hypnotic medication.Review of Resident #9's August 2025 MAR failed to produce documentation that a hypnotic medication was administered.Review of Resident #9's MDS assessment with an ARD of 11/26/25, Section N0415 (High-Risk Drug Classes) coded that a hypnotic medication was administered. There was no documentation that an antidepressant medication was administered.Review of Resident #9's November 2025 MAR failed to produce documentation that a hypnotic medication was administered, however, there was documentation that Sertraline (antidepressant) 50 mg. was administered every evening. The facility failed to capture the use of the antidepressant. The facility inaccurately coded that a hypnotic medication was given.Review of Resident #9's MDS assessment with an ARD of 12/17/25, Section N0415 (High-Risk Drug Classes) coded that a hypnotic medication was administered.Review of Resident #9's December 2025 MAR failed to produce documentation that a hypnotic medication was administered.On 4/29/26 at 10:19 AM LPN #11 was interviewed and stated that she was coding the medication Clonazepam (antianxiety<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | medication) for the dual use of anxiety and hypnotic. LPN #11 stated they were using the USP Medicare Model Guidelines V6.0 when coding medications.Review of the USP Medicare Model Guidelines V6.0 failed to indicate that Clonazepam was a hypnotic medication.On 4/29/26 at 12:30 PM LPN #11 confirmed the errors.4) On 4/28/26 at 12:15 PM a review of Resident #4's medical record was conducted.Review of Resident #4's MDS assessment with an ARD of 1/8/26, Section J0100A pain management, received prn (when necessary) pain medication was coded, yes. Review of Resident #4's January 2026 Medication Administration Record (MAR) failed to produce documentation that Resident #4 received prn pain medication.Review of Resident #4's MDS assessment with an ARD of 4/10/26, Section N0415 (High-Risk Drug Classes) documented the use of an anti-anxiety medication.Review of Resident #4's April 2026 MAR failed to reveal that an anti-anxiety medication was administered.On 4/29/26 at 9:59 AM Licensed Practical Nurse (LPN) #12 confirmed the errors.5) On 4/29/26 at 7:38 AM a review of Resident #12's medical record was conducted and revealed Resident #12 had a history of traumatic subarachnoid hemorrhage, type 2 diabetes mellitus with diabetic neuropathy, atrial fibrillation, and atherosclerotic heart disease.Review of Resident #12's MDS assessment with an ARD of 2/3/26, Section J0100A pain management, received scheduled pain medication was coded, yes. For received prn (when needed) pain management, it was code, no.Review of Resident #12's February 2026 MAR failed to produce documentation where a pain medication was given every day. The pain reliever Tylenol was administered when needed for pain on 2/1/26 at 12:19 PM and 20:21 (8:21 PM), 1/31/26 at 10:13 AM, 1/30 at 20:36 and 1/29 at 20:10. The MAR also documented that Resident #12 received Aspirin 81 mg. every day for heart failure. The facility failed to capture the prn pain medication administration and inaccurately coded that pain medication was given daily.Continued review of the 2/3/26 MDS assessment, Section N0415 (High-Risk Drug Classes), documented that hypoglycemic medication was not administered during the look back period, however review of the February 2026 MAR documented that Resident #12 received Rybelus every day for diabetes mellitus.On 4/30/26 at 12:45 PM LPN #17 stated that she coded that way because Resident #12 received Aspirin 81 mg. everyday. The Aspirin should not have been coded as pain medication as that was not the intent for the medication. LPN #17 confirmed that she inaccurately coded the hypoglycemic medication.On 4/30/26 at 2:00 PM the Nursing Home Administrator and the Director of Nursing were informed of the MDS coding concerns.6) On 4/29/26 at 12:45 PM a review of Resident #10's medical record was conducted and revealed Resident #10 had a history of cerebral infarction (stroke) with hemiplegia and hemiparesis affecting the right dominant side.Review of Resident #10's MDS assessment with an ARD of 2/7/26 and 2/18/26, Section J0100A pain management, received scheduled pain medication was coded, yes. Review of Resident #10's February 2026 Medication Administration Record (MAR) failed to produce documentation that Resident #10 received pain medication daily.On 4/30/26 at 12:45 PM LPN) #17 stated that she coded that way because Resident #10 received Aspirin 81 mg. every day as a prophylactic. The Aspirin should not have been coded as pain medication as that was not the intent for the medication.On 4/30/26 at 2:00 PM the Nursing Home Administrator and the Director of Nursing were informed of the MDS coding concerns. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on medical record review and interview, it was determined the facility staff failed to provide treatment and care in accordance with professional standards of practice for residents. This was evident for 2 (Resident #13 and #11) of 16 residents reviewed during a complaint survey.The findings include:<br><br>1) The facility staff failed to administer treatment per the Wound Doctor's orders for Resident #13.<br><br>Review of Resident #13's medical record on 4/27/26 revealed the Resident was admitted to the facility in February 2026 following a hospitalization with discharge diagnoses to include acute systolic heart failure and peripheral edema.<br><br>Further review of Resident #13's medical record on 4/28/26 revealed the Resident was first assessed by the Wound Doctor on 3/12/26 for a venous wound of the right shin, left medial foot and left second toe. At the time the Wound Doctor ordered oil emulsion daily for all 3 wounds.<br><br>Further review of Resident #13's medical record revealed the Wound Doctor reassessed the Resident's wounds on 3/19/26. At the time the Wound Doctor reassessed the right shin, left medial foot and left second toe. The Wound Doctor also assessed the Resident to have a new arterial wound of the left plantar foot.<br><br>Review of the 3/19/26 Wound Doctor's orders revealed the Wound Doctor changed the treatment to the left medial foot from oil emulsion to skin prep daily and added skin prep daily to the left plantar foot wound.<br><br>Review of Resident #13's March 2026 Medication and Treatment Administration Records revealed the facility staff failed to 1) Discontinue the oil emulsion and administer the skin prep as ordered for the Resident's left medial foot wound and 2) Administer skin prep to the Resident's left plantar foot wound from 3/19/26 until 3/26/26.<br><br>The Resident was sent out to the hospital on 3/26/26 after assessment by the Wound Doctor.<br><br>Interview with the Director of Nursing on 4/30/26 at 2:00 PM confirmed the facility staff failed to administer treatments to Resident #13's left medial foot and left plantar foot wounds per the 3/19/26 Wound Doctor's orders from 3/19/26 until 3/26/26 when the Resident was discharged .<br><br>2) On 4/27/26 at 9:14 AM a review of complaint 2991540 alleged that Resident #11 was given Narcan for an alleged overdose.<br><br>Narcan (naloxone) is a life-saving nasal spray that rapidly reverses opioid overdoses. It is used for emergencies involving heroin, fentanyl, or prescription opioids and is safe to use even if no opioids are present.<br><br>On 4/27/26 at 9:14 AM a review of Resident #11's medical record revealed progress notes that documented Resident #11 was admitted to the facility in March 2026 with diagnoses that included a nondisplaced zone 1 fracture of the sacrum, a nondisplaced fracture of the posterior column of the right acetabulum (the deep, cup-shaped socket on the right side of the pelvis that forms the hip joint by articulating with the femoral head), fracture of the right pubis (hip bone), and other chronic pain.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a 4/3/26 nurse practitioner initial evaluation note documented, pain and opioid management, patient is at high risk for poor function improvement in therapy without adequate pain management. The pain medication that was prescribed from the hospital and was to be continued on at the facility included Hydromorphone 6 mg (opioid) every 4 hours when needed (prn), Hydromorphone 4 mg every 4 hours prn, Tylenol 1 gram every 6 hours prn, Lidocaine cream to the back every 6 hours prn, Methocarbamol (muscle relaxant) 500 mg. every 6 hours prn, Celebrex 100 mg. twice per day, and Gabapentin 300 mg. three times a day.<br><br>Review of a physician's note dated 4/8/26 at 12:42 PM documented, the patient reportedly had opioid overdose earlier this morning around a.m. and responded well to Narcan administration by nursing. Chronic pain, opioid overdose s/p Narcan.<br><br>Further review of Resident #11's medical record failed to produce a nursing assessment of the resident. There was no nursing documentation of what the resident's condition was and what the vital signs were at the time. There was no documentation that the Narcan was administered and what the resident's response was after the Narcan was administered.<br><br>On 4/27/26 at 10:46 AM Licensed Practical Nurse (LPN) #4 (agency nurse) was interviewed and stated that Resident #11 was out of it and not responding when LPN #4 was doing rounds. LPN #4 stated that she knew Resident #11 was on little pills real heavy and the roommate told me that [he/she] was acting crazy the previous night and couldn't get any rest. The vitals were fine, so I went to see if there was an order for Narcan. LPN #4 found the order and administered the Narcan and Resident #11 responded and was his/her normal self. LPN #4 stated they monitored the resident and they knew the doctor was on the way and when the doctor got there all of the pain meds were discontinued and he/she just had 2 pain meds.<br><br>LPN #4 was asked by the surveyor if she did a change in condition after the Narcan was administered. LPN #4 stated, I don't know if a change a condition, what the P and P (policy and procedure) is because this is the first time I had to give the Narcan. I don't know since the order was there. I didn't document it.<br><br>On 4/27/26 at 10:55 AM an interview was conducted with the Director of Nursing (DON). The DON stated she would have expected to see a change in condition in the resident's medical record along with an assessment and vital signs.<br><br>On 4/27/26 at 1:09 PM LPN #19 was interviewed and stated she was the unit manager. LPN #19 stated the nurse administered the Narcan as the resident looked like the he/she was having an overdose. The physician saw the resident afterwards. LPN #19 stated, The nurse should have done an assessment and taken vital signs of the resident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on complaint, observation and staff interview it was determined the facility failed to keep the environment free from accident hazards. This was evident for 1 of 6 nursing units observed during a complaint survey.The findings include:On 4/29/26 at 7:25 AM a review of complaint 2723364 alleged the concern about cleaning supplies not being in a locked area on the dementia unit and the potential for residents to use cleaning wipes for personal use.On 4/30/26 at 8:10 AM observation was made in the dining room of the Seagull Unit, which is the locked dementia unit. Observation was made of disinfectant wipes sitting on a wire shelf. The wording on the containers stated, store in original container in areas inaccessible to children. The back of the contained stated, do not use as a diaper wipe or for personal cleansing. This is not a baby wipe.At the time of the observation Geriatric Nursing Assistant (GNA) #18 was in the dining room with the residents while they were waiting for breakfast. The unit manager, Licensed Practical Nurse (LPN) #13 was with the surveyor during the observation. The surveyor expressed concern about the wipes in a public area where residents with cognitive impairment were located. LPN #13 immediately removed the wipes from the dining room. LPN #13 came back to the room and stated she had never seen any residents use the wipes or attempt to use the wipes. LPN #13 stated that staff use the wipes to wipe down the tables before and after meals.On 4/30/26 at 8:15 AM an interview was conducted with GNA #18 who stated that she was always in the dining room when the residents are in the dining room and that the residents are never left alone. GNA #18 was asked if the doors to the dining room were always kept open during the day and she stated they were. GNA #18 also stated she never saw a resident use a wipe.On 4/30/26 at 8:21 AM an interview was conducted with the Infection Control Nurse (ICP) #10. She stated she was not aware that the disinfectant wipes were a concern in the dining room because no residents had ever gone near them. ICP #10 stated, they are for staff use to wipe down the tables.On 4/30/26 at 9:45 AM an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). They stated that they were never made aware of the concern with the wipes. The DON stated that she understood the concern. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on medical record review and interview it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (Resident #11) of 16 residents reviewed during a complaint survey.The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.On 4/27/26 at 9:14 AM a review of Resident #11's medical record revealed the April 2026 Medication Administration Record (MAR) which documented the day, time, and nurse's initials of when medication was administered. At the same time the Controlled Drug Administration Record was reviewed to determine if it matched the April 2026 MAR. The Controlled Drug Administration Record documents when a narcotic such as Hydromorphone is given. Review of both records revealed that Resident #11's April 2026 MAR was blank on the following days when the Hydromorphone was signed out by a licensed nurse on the Controlled Drug Administration Record for Resident #11. On 4/9/26 not signed off on MAR but on narcotic sheet the medication was signed out as given at 8:00 AM, 1:00 PM, 5:00 PM, and 10:00 PMOn 4/10/26 not signed off on MAR but on narcotic sheet the medication was signed out as given at 8:00 AM and 1:30 PM.On 4/11/26 not signed off on MAR but on narcotic sheet the medication was signed out as given at 11:37 PM.On 4/12/26 not signed off on MAR but on narcotic sheet the medication was signed out as given at 8:00 PM.On 4/13/26 not signed off on MAR but on narcotic sheet it was signed out as given at 6:30 PM.On 4/15/26 not signed off on MAR but on narcotic sheet it was signed out as given at 12:00 AM.On 4/27/26 at 10:46 AM an interview was conducted with Licensed Practical Nurse #4 who stated, I sign out on the narcotic sheet, but I do not document it on the MAR.On 4/27/26 at 10:55 AM the Director of Nursing (DON) was interviewed and stated, I am aware the nurses are signing off on the Narcotic sheet but not the MAR and I am going to have to educate them that they have to sign off on the MAR that the medication was administered.On 4/27/26 at 1:09 PM LPN #19, the unit manager stated, I am not aware that the nurses were not signing off on the MAR when they are also signing off on the narcotic sheet. They need to document on the MAR and the narcotic sheet.On 4/30/26 at 9:45 AM an interview was conducted with the Nursing Home Administrator (NHA) and the DON. They stated that they were not aware of the concern until the surveyor pointed it out and that they both agreed with the findings. |