STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215209	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Overlea	6116 Belair Road Baltimore, MD 21206

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 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. 31982 Based on record review and interview it was determined that the facility staff failed to immediately inform the resident representative of the residents' transfer to the hospital. This was evident for 1 (#16) of 42 residents reviewed during the complaint survey. The findings include: Resident #16's medical record was reviewed on 2/18/25 at 9:33 AM. A change in Condition progress note dated 1/21/24 at 00:15 (12:15 AM) indicated that Resident #16 was found lying on the floor. Upon assessment the resident had no apparent injuries however his/her oxygen saturation (SpO2) was 75% (Normal SpO2 is between 95%-100%). A respiratory assessment revealed diminished lung sounds and grunting-like breathing. The physician was notified and ordered oxygen administration and if there was no improvement, send to the emergency room (ER) for further evaluation. The note indicated that the resident's representative was made aware. It did not identify the time of the notification. Another progress note at 1:00 AM on 1/21/24 indicated that the resident's oxygen saturation improved to 85%, and 911 was called for ER evaluation. The note did not indicate that the resident's representative was updated. A Change in Condition/Concurrent Review note dated 1/21/24 at 6:44 AM reflected the unwitnessed fall, assessment findings, and the interventions ordered by the physician. The note indicated the resident's representative, including name, was notified on 1/21/24 at 6:00 AM. The facility Administrator was informed of these findings on 2/18/25 at 11:35 AM. He was unable to provide additional evidence that Resident #16's representative was informed immediately of his/her hospital transfer.

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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(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. 31145 Based on review of facility reported incidents and staff interview, it was determined the facility failed to provide documentation that allegations of abuse were reported timely to the appropriate agencies. This was evident for 2 (#26, #27) residents of 42 residents reviewed during a complaint survey. The findings include: 1) On 2/20/25 at 11:49 AM a review of facility reported incident MD00186485 alleged that on 12/6/22 Resident #26 alleged that a geriatric nursing assistant (GNA) had abused the resident during care early on 12/6/22. Review of the facility reported incident was blurred as to the actual time, with it either being at 3:00 AM or 8:00 AM, which was confirmed by the NHA. Review of the email confirmation that was submitted to OHCQ documented that the initial report was not filed until 12/6/22 at 5:25 PM, which was not within 2 hours of suspected abuse. There was no email confirmation as to when the final report was submitted to the Office of Healthcare Quality (OHCQ). On 2/20/25 at 12:05 PM an interview was conducted with the NHA. The NHA confirmed the report was not submitted timely to OHCQ. The NHA stated that he was not employed at the facility during that time. 31982 2) On 2/13/25, surveyor review of a facility reported incident for resident #27 revealed the resident alleged on 10/21/22 that a staff member scratched, grabbed and shoved him/her after s/he asked to be sent to the hospital. Further review of the facility report revealed that the facility submitted the initial and final reports to OHCQ. However, the facility's report indicated that local law enforcement was not contacted. The Administrator was made aware of this finding and asked to provide any additional evidence to confirm that the police were contacted. No additional information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on review of facility reported incidents and staff interview, it was determined the facility failed to provide documentation that allegations of abuse were thoroughly investigated. This was evident for 4 (#31, #7, #26, #33) residents of 19 facility reported incidents reviewed during a complaint survey. The findings include: 1) On 2/13/25 at 2:00 PM facility reported incident MD00182916 was reviewed and revealed that Resident #31 was discharged to the hospital on 7/25/22 due to abnormal blood work. On 8/26/22 the facility was made aware by a hospital social worker that Resident #31 alleged verbal abuse by nurses at the facility and physical abuse by the geriatric nursing assistants at the facility. According to the facility's documentation an investigation was initiated. Review of the investigative packet that was given to the surveyor by the Nursing Home Administrator (NHA) revealed an initial and 5 day email confirmation that an investigation was done, however there was no investigation included in the paperwork. On 2/13/25 at 2:23 PM an interview was conducted with the NHA. The NHA stated he could not find the investigative file. The NHA stated the was from the previous ownership. The surveyor explained that the investigation could not be validated. The NHA stated that he understood. 2) On 2/18/25 at 3:15 PM facility reported incident MD00182384 was reviewed. On 2/13/22 Resident #7 alleged that Resident #34 attempted to touch Resident #7 inappropriately and Resident #7 hit Resident #34 with a reacher causing an injury. On 2/18/25 at 2:15 PM the surveyor had requested to review the investigation that had not been provided upon entrance on 2/13/25. An interview was conducted with the NHA who stated the building was owned by another corporation at that time and he can not find the investigation even though he has torn the office apart. 3) On 2/20/25 at 11:49 AM a review of facility reported incident MD00186485 alleged that on 12/6/22 Resident #26 alleged that a geriatric nursing assistant (GNA) had abused the resident during care early on 12/6/22. Review of the facility reported incident was blurred as to the actual time, with it either being at 3:00 AM or 8:00 AM, which was confirmed by the NHA. Review of the facility's investigation, that was given to the surveyor from the NHA, revealed documentation of a skin assessment, 1 resident interview and the staffing schedule. There was no investigation provided, no other resident interviews, and no staff interviews. On 2/20/25 at 12:05 PM an interview was conducted with the NHA. The NHA confirmed the investigation was incomplete and that was all he could find. The NHA stated that he was not employed at the facility during that time. 31982 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Upon entrance to the facility on [DATE] the Administrator was provided with a list of facility reported incidents (FRI's) that would be reviewed during the survey and asked to provide the facility's investigation pertaining to each, to the survey team for review. On 2/18/25 at 3:00 PM the Administrator confirmed he was unable to locate the investigation pertaining to Resident #33. He indicated that the abuse allegation occurred during the facility's prior ownership. He indicated that he reached out to the prior administration to inquire on the possible location of the investigation, and they indicated that it should be in the facility. He stated, we've looked everywhere and could not find it.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31145 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 2 (#10, #14) of 42 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 2/14/25 at 12:25 PM Resident #10's medical record was reviewed and revealed Resident #10 was admitted to Hospice services on 11/9/24. Review of the quarterly MDS with an assessment reference date of 2/10/25, Section O, failed to capture that the resident received Hospice services. On 2/20/25 at 12:55 PM an interview was conducted with the MDS coordinator who confirmed the findings. 2) On 2/19/25 at 7:57 AM Resident #14's medical record was reviewed and revealed a progress note written on 7/18/24 at 8:33AM that documented, Resident verbally aggressive with staff yelling and cursing at them, as well as getting in their face screaming. Not able to be redirected. Psych aware and consult requested. A 7/18/24 at 10:27 AM note documented, Resident making false accusations towards staff. Psych made aware to follow up. MD aware of behaviors. CP updated and ongoing. Review of Resident #14's MDS with an assessment reference date of 7/22/24, Section E, behaviors, Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) was coded, no behaviors. Review of Resident #14's annual MDS with an assessment reference date of 1/3/25, Section N, Medications, documented the resident received a hypnotic medication. Review of Resident #14's January 2025 Medication Administration Record (MAR) failed to reveal a hypnotic medication. On 2/19/25 at 9:57 AM an interview was conducted with the MDS coordinator who stated that the resident received Lorazepam (an antianxiety medication) and that it was also a hypnotic as it had a dual classification. Informed the MDS coordinator the drug had to be coded in the classification that it was intended for according to the physician's order. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2025 physician's order documented the medication Lorazepam to be given twice per day for anxiety. On 2/20/25 at 12:49 PM the MDS Coordinator confirmed the errors.

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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. 31145 Based on record review, observation and staff interview, it was determined the facility staff failed to revise a resident's care plan. This was evident for 1 (#10) of 42 residents reviewed during a complaint survey. The findings include: On 2/14/25 at 12:25 PM facility reported incident MD00209375 was reviewed and revealed Resident #10 alleged that on 9/1/24 GNA #23 hurt Resident #10's arm. Review of the facility investigation documented that Resident #10 had a history of banging his/her arm on the side rail. The investigation documented that padding had been placed on the side rail to prevent further injury and that the issue had been care planned. On 2/19/25 at 11:30 AM observation was made of Resident #10 lying in bed having a dressing change by hospice staff. There was a quarter bed rail up on the right side of the bed with a yellow foam noodle on the top of the bed rail. Review of the care plan, has potential for skin tear, failed to have the intervention of padding the side rail. Review of the care plan, has skin tears to right lower arm and has a behavior problem r/t banging the phone, the remote and hand on the side rails of the bed and yelling, failed to have the intervention of padding on the side rail. On 2/20/25 at 2:00 PM an interview was conducted with the Director of Nursing (DON). The care plan was reviewed with the DON. The DON confirmed that the padding was not added to the care plan.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on record review and interview with facility staff, it was determined that the facility failed to ensure that a recapitulation of the resident's stay was completed following a resident's discharge from the facility. This was evident for 1 (Resident #23) of 42 residents reviewed during a complaint survey. The findings include: On 2/14/25 at 10:42 AM a record review was conducted for Resident #23. Resident #23 was admitted to the facility in July 2017 for physical and occupational therapy following an amputation of the right leg above the knee. On 1/20/23 a care plan note documented, Family and patient in agreement that they desire the matter of social work addressing alternative nursing home locations. Patient will look to pursue further the Alf [assisted living facility] after that patient is located within another nursing home facility. On 4/28/23 social services documented a Maryland Discharge Instructs for Resident #23 for a discharge of 5/1/23 to an assisted living facility. It was completed by the social worker. Continued review of Resident #23's medical record failed to produce a physician's discharge summary. There was no documentation of what medications Resident #23 should take once discharged and there was no summary for the receiving facility. Further review of Resident #23's medical record revealed the last note documented about the resident was dated 5/13/23. There were no notes after 5/13/23. The last evaluation in the medical record was dated 5/15/23. Review of the census tab in the electronic medical record revealed Resident #23 was discharged on [DATE]. There was no nursing documentation in the medical record that Resident #23 had left the building to be discharged to an assisted living facility. There was no documentation as to the condition of the resident, how the resident left the building and with whom, and what the resident took when he/she left and what documentation was given to the resident prior to discharge and to the receiving facility. On 2/14/25 at 12:45 PM the Director of Nursing (DON) was interviewed and stated she could not find a discharge summary. The DON stated she looked through the paper chart and electronic chart and she could not find one. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 1:40 PM the Nursing Home Administrator (NHA) brought the discharge summary dated 5/1/23 and gave it to the surveyor. The NHA stated that what he remembered was that Resident #23 wanted to discharge to assisted living (ALF) but ALF needed the resident to be there by the first of the month in order to collect payment so the resident did not discharge from the facility until 6/1/23. The NHA confirmed that there were no nursing notes to reflect when the resident was discharged . The NHA acknowledged that there was no physician's discharge summary.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, it was determined the facility staff failed to provide showers twice weekly to a resident (Resident #17). This was evident for 1 of 42 residents reviewed during a complaint survey. The findings include: Review of Resident #17's medical record on 2/14/25 for a concern related not receiving showers from October 2023 until January 2024 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include dementia. Dementia is a general term for a decline in mental abilities that impacts a person's daily life. It's caused by brain damage that destroys nerve cells. Further review of Resident #17's medical record revealed the facility staff assessed the Resident on 11/7/23 to need supervision and/or touching assistance for showering and bathing. Review of Resident #17's care plans revealed a care plan entitled: Resident has an ADL (Activities of Daily Living) Self Care Performance Deficit related to dementia initiated on 10/26/23 that included an intervention of Resident requires 1 staff participation with bathing. Review of Resident #17's documented showers on Documentation Survey Report and Shower Sheet Assessment Tool for October 2023, November 2023, December 2023 and January 2024 revealed the facility staff documented the Resident received no showers for the 5 days in October 2023, one shower in November 2023, 2 showers in December 2023 and 4 showers in January 2024. Review of the Resident's nursing notes from admission through January 2024 did not reveal any documented refusal of showers by the Resident. During interview with the Director of Nursing (DON) on 2/19/25 at 9:10 AM, the DON stated the expectation is a Resident is to receive 2 showers a week. The DON confirmed the Resident #17 did not receive 2 showers a week from October 2023 until January 2024.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to provide treatment/services to prevent/heal pressures ulcers for a resident (Resident #1). This is evident for 1 of 3 residents reviewed for pressure ulcers during a complaint survey. The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). Review of Resident #1's medical record on 2/14/25 revealed the Resident was admitted to the facility on [DATE] and on 8/15/24 the Resident was assessed by the Wound Care physician for pressure ulcers to bilateral heels. Resident #1 continued to be seen weekly by the Wound Care physician until discharge on [DATE]. Further review of Resident #1's medical record revealed a nurse's note on 8/19/24 at 9:48 PM that stated Resident noted with open areas to sacrum and right buttocks. Review of the 8/19/24 Change of Condition Staff #19 documented doctor notified on 8/19/24 at 10:30 PM and doctor recommendations to apply dry dressing and do wound consult. Review of the Wound Care physician notes on 8/22, 8/29 and 9/6/24 reveal no assessment of the sacral and right buttock wounds to include measurements or changes in the wound's status. Further review of the Wound Care physician notes reveal Resident #1 sacral pressure wound was not assessed until 9/12/24, 24 days after it was discovered. Interview with the Director of Nursing on 2/18/25 at 3:10 PM confirmed Resident #1 sacral pressure ulcer was not assessed by the Wound Care physician until 9/12/24.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility failed to ensure a resident's drug regimen was free from an unnecessary drug (Resident #6 and #15). This was evident for 2 of 42 residents reviewed during a complaint survey. The findings include: 1. Review of Resident #15's medical record on 2/14/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include hypertension. Hypertension, also known as high blood pressure, is a condition where the blood pressure in the arteries is consistently elevated above normal levels. Review of Resident #15's physician orders revealed on 4/1/24 the Resident was ordered Metoprolol 25 mg one time a day for high blood pressure, hold if blood pressure is less than 110 or heart rate less than 60. Review of Resident #15 April 2024 Medication Administration Record revealed from 4/1 through 4/14/24 the Resident was administered Metoprolol 2 times outside of the parameters: a) on 4/8/24 at 6:00 PM when the Resident's heart rate was 59 and b) on 4/13/24 at 6:00 PM the Resident's blood pressure was 100/60. Interview with the Director of Nursing on 2/19/25 at 8:19 AM confirmed Resident #15 was administered Metoprolol on 4/8 and 4/13/24 outside of physician ordered parameters. 2. Review of Resident #6's medical record on 2/19/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include hypertension. Hypertension, also known as high blood pressure, is a condition where the blood pressure in the arteries is consistently elevated above normal levels. Review of Resident #6's physician orders revealed on 1/14/25 the Resident was ordered Metoprolol 50 mg one time a day for high blood pressure, hold if blood pressure is less than 110 or heart rate less than 60. Review of Resident #6's February 2025 Medication Administration Record revealed on 2/16/25 the Resident was administered Metoprolol 50 mg outside of the parameters when the Resident's blood pressure was 107/73. Interview with the Director of Nursing on 2/20/25 at 11:05 AM confirmed Resident #6 was administered Metoprolol on 2/16/25 outside of physician ordered parameters.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on medical record review and interview, the facility staff failed to schedule a follow up appointment with a consultant for a resident (Resident #15). This was evident for 1 of 42 residents reviewed during a complaint survey. The findings include: Review of Resident #15's medical record on 2/14/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include hydronephrosis. Hydronephrosis is a condition where urine backs up into the kidney, causing it to swell. Review of a nurse's note on 3/31/24 at 11:37 PM stated the Resident had a Foley in place. A Foley catheter is a thin, flexible tube inserted into the bladder to drain urine. Review of the Resident's hospital discharge summary dated 3/31/24 revealed the Resident's plan: 1. Will need outpatient urology follow up for moderate right hydronephrosis, referral for urology appointment has been made. 2. Foley catheter currently in place, will need voiding trial. Further review of Resident #15's medical record revealed a nurse's note on 4/2/24 at 2:05 PM that stated, Patient was scheduled for follow up urology 4/9/24 appointment as writer spoke to the Resident's responsible party. Medical records was made aware and reported appointment was canceled due to out of network insurance. During interview with Medical Records Staff #19 on 2/19/25 at 8:34 AM, Staff #19 stated no other urology appointment was made for Resident #15 during the Resident's stay until discharge on [DATE]. Further review of Resident #15's medical record revealed no evidence of a voiding trial or follow up urologist appointment was completed for the Resident. Interview with Director of Nursing on 2/19/25 at 8:19 AM confirmed the Surveyor's findings.

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	215209	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Overlea	6116 Belair Road Baltimore, MD 21206

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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 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 4 (#12, #23, #7, #21) of 42 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. 1.Review of Resident #12's medical record on 2/13/25 revealed the Resident was admitted to the facility on [DATE] with a diagnosis to include cerebral infarction. Cerebral infarction, also known as an ischemic stroke, is a condition where blood flow to the brain is interrupted, causing brain cells to die. Further review of Resident #12's medical record revealed a nurse's note on 7/3/24 at 10:15 AM that stated, Resident left facility stable in wheelchair with daughter who will be escorting him/her to neurology appointment that the daughter had scheduled. A nurse's note on 7/3/24 at 3:48 PM stated, Resident returned back to facility on a wheelchair accompanied by his/her daughter with no new orders. Further review of Resident #12's paper and electronic medical record revealed no documentation from the neurology appointment on 7/3/24. Interview with the Director of Nursing on 2/18/25 at 10:15 AM confirmed Resident #12's medical record did not include documentation from the neurology appointment on 7/3/24. 31145 2) On 2/14/25 at 10:42 AM a review of Resident #23's medical record was conducted. While reviewing the medical record it was noted that the last progress note in Resident #23's medical record was dated 5/13/23. There were notes after that date. The last evaluation note in the medical record was dated 5/15/23. Review of the census tab in the electronic medical record revealed Resident #23 was discharged on [DATE]. There was no nursing documentation in the medical record that Resident #23 had left the building to be discharged to an assisted living facility. There was no documentation as to the condition of the resident, how the resident left the building and with whom, and what the resident took when he/she left and what documentation was given to the resident prior to discharge. On 2/14/25 at 12:45 PM with the Director of Nursing (DON), Resident #23's entire closed record was reviewed and there was no documentation of Resident #23's discharge. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/14/25 at 1:40 PM the Nursing Home Administrator (NHA) brought the discharge summary dated 5/1/23 and gave to the surveyor. The NHA stated that what he remembered was that Resident #23 wanted to discharge to assisted living (ALF) but ALF needed the resident to be there by the first of the month in order to collect payment so the resident did not discharge from the facility until 6/1/23. The NHA confirmed that there were no nursing notes to reflect when the resident was discharged . 3) On 2/18/25 at 1:19 PM a review of Resident #7's medical record was conducted and revealed a physician's order dated 9/21/22 that ordered a CT (CAT) scan of the chest without contrast to evaluate for malignancy. Review of the medical record failed to produce the results of a CT in September or October 2022. On 2/18/25 at 1:43 PM an interview was conducted with the DON. The DON brought a copy of the CT of the chest dated 5/8/23. The DON was asked where the documentation was as to why the CT scan was not done in September 2022. The DON stated she found a 2/17/23 note that the resident's appointment was rescheduled but she could not find documentation as to why it did not happen in September 2022. The DON thought maybe the resident refused because the resident normally refuses, but there was no documentation to substantiate that statement. The DON stated she was not here during that time period, however she would have expected to see documentation in the medical record. On 2/19/25 at 8:39 AM Staff #19, medical records/scheduler for appointments was interviewed about the CT order that was written in September 2022. Staff #19 was asked why the appointment did not happen in September 2022. Staff #19 stated she was not in that position back in September 2022. Staff #19 looked through the medical record and did not see anything documented regarding that order. Staff #19 stated she saw something for February 2023 for an appointment at the hospital and the family was supposed to take the resident. On 2/20/25 at 2:30 PM the Nursing Home Administrator was informed of the concern related to complete and accurate medical records. 31982 4) Resident #21's medical record was reviewed on 2/13/25 at 9:30 AM. A Wound Physician progress note dated 6/6/22 identified a Stage II pressure wound, on the resident's Sacrum (lower back above the tail bone), and indicated it was healed on that date. A Weekly Wound Assessment form also dated 6/6/22 indicated the resident had a Stage II pressure ulcer on his/her sacrum. There was no description of the wound, no indication if the wound was healed as indicated in the wound physicians note or if the nurse was identifying a new wound. Another Weekly Wound Assessment form dated 6/13/22 indicated only, Patient wound has healed up and resolved it did not identify the location of the wound it was referring to. No documentation was found to reflect ongoing monitoring of the sacral wound prior to 6/6/22. Two Weekly Wound Assessment forms dated 7/25/22 indicated only: cleared to clean pcc it was unclear what pcc was or if the resident had a wound. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Weekly Skin Evaluation form dated 6/25/22 identified Open pressure ulcer at sacrum there was no assessment of the wound, or a date the wound was first identified. Another Weekly Skin Evaluation form was dated 7/27/22. It identified a right trochanter (hip) blister, and skin is not open. There was no assessment of the wound. One additional Weekly Skin Evaluation form dated 8/3/22 did not identify any wounds but stated: Resident can't verbalize pains. The physicians' orders revealed an order written 2/23/23 for Wound Consult -Sacrum. No documentation was found in the medical record regarding the identification or ongoing monitoring of a Sacral wound at that time. The record failed to include clear ongoing documentation of the progress or lack of progress related to Resident #21's wounds. 5) 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. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Care Conferences are to be conducted after each Comprehensive and Quarterly MDS assessment. MDS assessments were conducted for Resident #21 on 5/6/22, 5/20/22, and 7/8/22. The resident was discharged from the facility on 8/3/22. Resident #21's Record revealed a progress note dated 2/23/22 documenting that a Care Conference was held and included the participants. No documentation was found to reflect that conferences were held to update Resident #21's plan of care after the MDS assessments dated 5/6/22, 5/20/22 and 7/8/22. On 2/13/25 at 1:20 PM the Director of Nursing (DON) was made aware that the surveyor was unable to find the wound and Care Conference documentation in Resident #21's medical record. She indicated that she did not work in the facility at that time but would see if she could find any additional documentation. On 2/18/25 at 9:40 AM the DON was again asked about the wound and Care Conference documentation. She confirmed that after reviewing the medical record she was unable to find the documentation.