STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 14894 Based on clinical record review and staff interview it was determined that the facility staff failed to ensure a resident's responsible party (RP) was informed of a change in the medical regimen. This was evident for 1 (#89) out of 53 residents that were part of the survey sample. The findings include: An investigation into intake #MD00178510 revealed Resident #89's primary physician prescribed Seroquel (an antipsychotic) on 4/8/21, Haldol (an antipsychotic) on 3/4/22 and Depakote (an anticonvulsant used to treat epilepsy and bipolar disorder) on 3/4/22. The resident's RP was not informed of the medications being ordered for the resident and the medications were administered before the RP was aware of the orders per the complaint. A review of Resident #89's clinical record revealed the RP was not informed of the medications being ordered. The Director of Nursing (DON) was interviewed on 3/4/24 at 1:25 PM. She was informed of the three medications that were ordered and started without informing the RP. She said she would check the Electronic Health Record because she thought it may have been noted in there. The DON was interviewed on 3/4/24 at 2:00 PM. She said she could not find in the electronic health record but would have the medical records person check the hard (paper) chart. The DON was able to show on 3/5/24 at 8:53 AM that the RP was informed of the Depakote being ordered. She was asked what the policy was on notifying a resident's RP when a medication is started. She replied when a medication is started or changed in any way, we are supposed to call the RP if the resident is not capable. These changes occurred with the prior nursing home company. She reviewed all of the progress notes and every single one of those nurses no longer works for the nursing home.

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 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. 14894 Based on clinical record review it was determined that the facility staff failed to ensure a resident's responsible party (RP) was informed of a fall. This was evident for 1 (#88) out of 53 residents in the survey sample. The findings include: An investigation into intake #MD00178237 revealed Resident #88 had a fall in April of 2022. The resident informed their cardiologist on 4/9/22 that they fell a couple of nights ago. The cardiologist assessed the resident for signs of an injury but did not observe any injury. The resident complained of left side pain along the ribcage. Cardiologist collaborated with primary physician regarding care and an x-ray was ordered for a chest x-ray. The x-ray was obtained the next day. Further review of the clinical record revealed that the resident's RP was not notified of the fall.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 44440 Based on interviews, and record review, it was determined that the facility failed to protect a Resident from abuse from a staff member. This was found evident of 1 of 17 (Resident #37) Residents reviewed for abuse allegations during an annual and complaint survey. The findings include: On 2/12/24 at 12:01 PM, the surveyor interviewed Resident #37. During this interview Resident #37 described an event in which Geriatric Nursing Assistant (GNA) Staff #26, responded to his/her call for assistance. After Resident #37 requested assistance with an incontinent incident, Staff #26 laughed at him/her and walked out of the room without responding to the request for assistance. Resident #37 reported this incident to the facility. On 2/22/24 at 10:19 AM, the surveyor reviewed the report of the investigation the facility conducted on the incident Resident #37 alleged about Staff #26. The report contained a copy of the Facility Reported Incident investigation that was submitted to the Office of Health Care Quality on 1/3/24. The report stated the facility suspended Staff #26 pending the conclusion of the investigation. Further in the report the surveyor reviewed Staff #26 written statement, which stated that Resident #37 refused to be changed. However, the conclusion of the facility' investigation stated the allegation was verified by evidence collected during the investigation. If further stated that Staff #26 was terminated on 1/9/24. On 2/29/24 at 9:50 AM, the surveyor conducted an interview with the Director of Nursing (DON). During the interview the DON was asked how she verified the abuse allegation. The DON stated she conducted an interview with Staff #26. During that interview Staff #26 told the DON she did not assist Resident #37 after knowing he/she needed incontinence care. Staff #26 reported to the DON she was having a bad day. The DON stated she didn't review Staff #26 written statement before she conducted an interview with Staff #26 to notice the discrepancy. The DON confirmed Staff #26 was terminated after the interview and the allegation was verified.

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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. 44440 Based on interview, and record review, it was determined that the facility failed to immediately report an allegation of abuse to the State Office of Health Care Quality. This was found evident in 1 out of 17 (Resident #189) Residents reviewed for abuse allegations during an annual and complaint survey. The findings include: On 3/04/24 at 1:05 PM, the surveyor reviewed an investigation report the facility conducted regarding an allegation of abuse of Resident #3. The surveyor reviewed 8 questionnaires titled, 'Resident Interviews'. All 8 questionnaires were conducted on 10/2/23. Each questionnaire had the name of the resident being interviewed but did not indicate who conducted the interview. The last question on the form stated; Has anyone hurt or harmed you? One resident (Resident #189's) response to the question was, Only verbal abuse by Aids. On 3/4/24 at 1:26 PM, the surveyor interviewed the Director of Nursing (DON). During the interview the DON stated she along with the Administer In Training (AIT) conducted the investigation regarding Resident #3. She further stated she was not the one who conducted the interviews and was not aware of Resident #189's responses. The DON stated she would look into the matter and speak with the Unit Manager on the Chesapeake Wing as she sometimes conducts the interviews. On 3/5/24 at 9:01 AM, the surveyor conducted an interview with Unit Manager Staff #6. During the interview Staff #6 stated she does conduct interview questionnaires when assisting with investigations, however, Staff #6 denied conducting the interview for this investigation. On 3/5/24 at 9:23 AM, the surveyor conducted a follow-up interview with the DON. In this follow-up interview the DON stated, before the follow-up investigation report is submitted a review of the entire investigation should be completed. She further stated this allegation was reported to the facility by the staff member taking the interviews but was not addressed. The DON stated an investigation into this allegation would be started now. Following the interview the surveyor received an initial investigation form that the DON submitted to the Office of Health Care Quality dated 3/5/2024 at 10:15 AM.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on clinical record review and staff interview it was determined that the facility staff failed to ensure a thorough investigation was conducted and maintain documentation of the investigation. This was evident for 2 (Resident # 88 and #90) out of the 53 residents that were part of the survey sample. The findings include: 1a) An investigation into intake #MD00178237 revealed Resident #88 had a fall in April of 2022. The resident informed their cardiologist on 4/9/22 that they fell a couple of nights ago. The cardiologist assessed the resident for signs of an injury but did not observe any injury. The resident complained of left side pain along the ribcage. Cardiologist collaborated with primary physician regarding care and an x-ray was ordered for a chest x-ray. The x-ray was obtained the next day. A review of the facility's investigation of the fall revealed that the nurse conducting the investigation completed a checklist of tasks that needed to be completed for a thorough investigation. One of the items was staff interviews. Interviewing staff is mandatory because it not only helps to determine a possible cause but also to rule out abuse. A review of the investigation folder revealed that there were no interviews inside the folder which suggested that interviews were not conducted and, therefore, abuse could not be definitively ruled out. The Director of Nursing (DON) was interviewed on 3/1/24 at 9:46 AM. She was shown the fall investigation folder on 5/19/22 and confirmed that there were no staff interviews present. She looked at the name of the nurse who allegedly conducted the interviews and said she was an agency nurse. DON said she is aware that they have had issues with investigations in the past and is trying to fix it. She said she would look for the interviews in case they were filed elsewhere. She agreed that interviews should have been conducted and does not understand why the Manager's checklist listed that the witness statements reviewed. The DON was interviewed on 3/1/24 at 11:00 AM. She confirmed that they do not have any witness statements. 42828 1b) On 2/20/2024 at 9:45 AM surveyor conducted a review of Resident #90s electronic and paper chart medical records which revealed that Resident #90 was admitted to the facility on [DATE] with diagnoses including heart disease and stroke requiring rehabilitation. The facility determined on 3/11/2024 that Resident #90 had severe cognitive impairments and was unable to make decisions for his/her well-being. A review of the facility's self-report revealed that Resident #90 reported to facility staff that on 3/21/2022, a Geriatric Nursing Assistant (GNA), Staff #14, grabbed Resident #90's wrist and shoved Resident #90 into the bed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of Resident #90's medical records revealed a skin evaluation conducted by the Director of Nursing, DON, on 03/22/2022 at 3:35 PM. The assessment revealed a nursing narrative that stated, Skin intact, bruised area on right wrist, not open. On 2/20/2022 at 9:30 AM the current Director of Human Resources, Staff #9, provided the surveyors with a personnel file for Staff #14. On 2/20/2024 at 12:30 PM surveyors held an interview with the DON and the Administrator. Surveyors asked if the file provided to surveyors was their complete employee record for Staff #14. The DON replied, Unfortunately, Yes, it is. The surveyor reviewed the file with the DON and identified that there is no evidence of a completed criminal background check, abuse/neglect trainings nor the GNAs license verification. On 2/21/2024 at 5:20 PM surveyors conducted an interview with the DON. The surveyor asked the DON how the allegation of physical abuse was substantiated. The DON replied that on 3/22/2022 she interviewed Resident #90 and asked what happened. During the interview, the DON stated that she completed a skin assessment for Resident #90 and saw a circular bruise on the resident's right wrist. The DON went on to say that Resident #90 told her that Staff #14 grabbed his/her wrist and shoved him/her in the bed. The DON stated that she believed Resident #90 because he/she knew what they were talking about, and he/she identified the GNA as Staff #14. The DON also stated that Resident #90 was a believable and credible source and substantiated the abuse. The DON further stated that the GNA was suspended from working at the facility during the investigation on 3/22/2022 and subsequently terminated from employment on 3/25/2022. On 2/23/2024 at 8:30 AM surveyors held an interview with the DON at which time the surveyor asked if all the documentation submitted was the complete investigation conducted for the allegation of staff to resident abuse related to Resident #90. The DON verified that all the information submitted was their complete file and no other documents were missing from their investigation file. The DON confirmed their investigation did not include documentation of interviews with Staff #14, other staff on the unit that worked with Resident #90, other residents that Staff #14 provided care for, or skin assessments of other residents on the units where Staff #14 was assigned. The DON further stated, I do know that after that incident, I have made sure to conduct skin assessments and interviews for every resident that could've been harmed.

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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. 44440 Based on review of resident's medical records, and interviews, it was determined that the facility staff failed to provide activities of daily living (ADL) care in accordance with the resident's plan of care. This was found to be evident for 2 of 4 (Resident #188 and #17) residents reviewed for ADLs during an annual and complaint survey. The findings include: Activities of Daily Living (ADLs) is a term used collectively to describe fundamental skills required to independently care for oneself, such as eating, bathing, and mobility. 1a) On 2/28/24 at 9:25 AM, the surveyor reviewed Resident #188's medical record. The review revealed that Resident #188 was admitted to the facility in June of 2022. Further review revealed that Resident #188 had a baseline care plan initiated shortly after being admitted . The care plan indicated that Resident #188 preferred to receive showers. On 3/5/24 at approximately 10:30 AM, the surveyor asked for shower documentation for Resident #188 for the month of September of 2022. On 3/5/24 at 11:15 AM, the surveyor reviewed the documentation with the Director of Nursing (DON). The documentation was for bathing and there were two places each day where bathing could be documented as given. One labeled day and the other evening. Bathing was documented 34 out of the 39 opportunities offered. Two places were blank and 3 were documented as not applicable (NA). The surveyor asked the DON if showers were given to Resident #188. The DON stated there was no documentation of showers given to Resident #188. She further stated that the shower scheduled was not triggered for Resident #188 on the Kardex (a tool used by Geriatric Nursing Assistants for tasks that need to be completed for each Resident). The DON stated Resident #188 would have had two scheduled shower days but could not provide the documentation they were provided. 1b) On 2/12/24 at 10:58 AM, the surveyor interviewed Resident #17. During this interview Resident #17 stated he/she had not been getting showers consistently. On 2/20/24 at 9:55 AM, the surveyor reviewed Resident #17's care plan. The review revealed that Resident #17 had a care plan initiated on 11/6/23 stating, Resident #17 has an Activities of Daily Living performance deficit related to hemiplegia (loss of movement on one side). One of the interventions listed was, assist resident in completing ADL tasks as needed. On 2/20/24 at 11:03 AM, the surveyor interviewed Geriatric Nursing Assistant (GNA) Staff #27. During the interview Staff #27 described how to identify the residents that were scheduled for a shower that day. She further stated that residents are scheduled for two showers a week and would get baths on the days they were not on the schedule for a shower. Staff #27 stated showers are documented and if a resident refuses a shower she would documents the refusal and notify the nurse. Staff # 27 reviewed the book and stated that Resident # 17 was scheduled for showers on Tuesdays and Fridays. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/24 at 11:49 AM, the surveyor reviewed the shower log documentation for the months of January and February of 2024 with the Director of Nursing (DON). On review the DON stated that Resident #17's showers were changed to Wednesday and Saturday and that the updated schedule was in the shower binder but was behind the old schedule. In January Resident #17 did not have a shower documented until Monday January 8th. The next shower documented was Thursday 1/11/24. No, was documented on Monday 1/15/24, NA on Thursday, 1/18/24, and Resident Refused documented on both Monday 1/22/24 & Thursday 1/25/24. On Monday 1/29/24 a shower was documented, yes. Twice in the month of January Resident #17 went over 7 days without a shower without any refusals. Next February 2024 shower schedule was reviewed. One time Resident #17 refused a shower, two showers were documented as given, three times NA was documented. Resident #17 went 9 days without a shower being documented without any refusals in-between. On 2/28/24 at 8:42 AM, the surveyor conducted a follow up interview with the DON. During this interview the DON stated she was unsure why NA was documented for showers and why Resident #17 scheduled shower days were not entered in as Wednesday and Thursdays. The DON further stated education was being done about documentation and communication of showers.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on clinical record review and staff interview it was determined that the facility staff failed: 1) to ensure that a physician sent a death certificate to a funeral home and 2) failed to ensure the physician provided supervision for a resident with significant weight loss. This was evident for 1 (#337) out 3 residents reviewed for death and 1 (Resident # 96) out of 1 resident reviewed for weight loss. The findings include: The investigation into intake #MD00198914 revealed Resident #337 died on [DATE]. The funeral home handling the funeral did not receive the resident's death certificate. A review of the resident's clinical record revealed that there was no evidence that the facility sent the death certificate to the funeral home that picked up the body or to the funeral home that received the body. Staff #21 was interviewed on [DATE] at 9:09 AM. She said the second funeral home called her to ask for the death certificate. She didn't realize they didn't have it, so she called the Director of Nursing and got the death certificate. She was not sure which day she sent the death certificate but was sure it was one or two days prior to the funeral. Staff #21 was interviewed again on [DATE] at 12:35 PM. She spoke with the first funeral home. They said that 99% of deaths involve the doctor sending the funeral home an electronic death certificate. If they don't get a death certificate, then they contact the doctor. The funeral home did not get a death certificate and then reached out to the doctor. Evidence was not presented prior to the exit conference that the physician sent the death certificate to either funeral home. 47758 2) According to the Centers of Medicare and Medicaid (CMS) a significant weight loss is a weight loss of: 5% in one month; 7.5% in 3 months; or 10% in 6 months. During a phone interview conducted on [DATE] at 10:26 AM, the complainant stated Resident #96 lost a lot of weight and the facility had not addressed it. During a review of Resident #96 weights on [DATE] at 09:42 AM, it was determined that Resident #96 weighed 134.4 pounds on [DATE], 124 pounds on [DATE], and 121.3 pounds on [DATE], which was a 9.75 % weight loss over a three-month period. Weight change alerts were noted in the electronic record on [DATE], and [DATE], however the physician progress notes from [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] reported no weight changes and the Physician Assistant, Certified (PA-C) notes written on [DATE], [DATE], and [DATE], reported no weight changes. During an interview on [DATE] at 12:27 PM, the Director of Nursing (DON) was informed of the concern that no weight loss or changes were addressed in Resident # 96's medical record by the physician or PA-C. The DON stated that she would look for documentation. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON reported back on [DATE] at 1:22 PM that although the facility Dietician documented the weight changes and implemented dietary changes, the lack of physician supervision was a concern and the current providers have been requested to focus on weight changes more precisely.

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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. 44440 Based on observation, interviews, facility policy review, and record review, it was determined that the facility failed to maintain medical records in accordance with acceptable professional standards and practices by 1) safeguarding Resident identifiable information from the public and 2) Keeping accurate documentation. This was found evident in 3 (Resident #17, #21 and #188) of 53 Residents reviewed during the survey. The findings include: 1. On 2/12/24 at 12:16 PM, the surveyor observed a medication cart with a computer on top of the cart. The computer screen was facing the B hallway on the Chesapeake wing. On further observations, the computer screen had Resident #17's medication profile displayed and the surveyor could see a list of medications. On 2/12/24 at 12:18 PM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #29. During the interview Staff #29 locks the computer screen and confirms that the computer screen should not be displaying the Resident ' s health care information. She also identifies the cart belong to the nurse that is working in the B hallway LPN Staff #30. On 2/12/24 at 12:21 PM, the surveyor interviewed LPN Staff #30. During the interview Staff #30 stated she was responsible for the medication cart and had walked away to get water. She further stated she was aware of the expectations not to leave the computer screen with Resident ' s healthcare information left up and visible to others before walking away. On 2/12/24 at 1:05 PM, the surveyor interviewed the Chesapeake Unit Manager Staff #6. During the interview Staff #6 stated she would initiate education on the expectation that computer screens should be locked out when left unattended. 2a. On 2/16/24 at 9:05 AM, the surveyor reviewed Resident #21's electronic medical record. During the review a consult note written on 2/13/24 was reviewed. The note was hand written and had been scanned into Resident #21 ' s electronic medical record, however only the first name was the same as Resident #21 ' s. The last name was different as well as the room number identified on the consult note. On 2/16/24 at 10:11 AM, the surveyor interviewed the Medical Records Personnel Staff #21. During the interview, Staff #21 described when Residents return from consults she scans the documents they bring back to an email account and then uploads the document into Point Click Care (PCC)(a cloud-based healthcare software) which becomes part of the Resident ' s electronic health care record. She stated the paper copy goes into the Resident ' s paper chart. She further stated she reviews the Residents ' entire name to evaluate where to place the record in the correct medical record. After the surveyor showed Staff #21 the consult document in Resident #21's electronic record with the incorrect Resident Staff #21 stated she must have made an error. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2b. On 2/28/24 at 9:25 AM, the surveyor reviewed Resident #188 ' s medical record. The review revealed Resident #188 ' s profile which stated Resident #188 ' s daughter was his/her substitute decision maker. Further review revealed a Social Worker Assessment that was completed on 6/22/22 for Resident #188. In this assessment a health care decision making evaluation was done. Resident #188 had no advanced directives on file. On 2/29/24 at 12:27 PM, the surveyor interviewed the Social Worker Staff #8. During the interview Staff #8 stated in order for someone to be the substitute decision maker there would be documentation that the resident gave the authorization and that she follows orders of the Health Care Decision Act. She further stated the facility's admission department enters the profile information into PCC. The surveyor asked Staff #8 if Resident #188 had any advanced directive or decision-making paperwork in his/her medical record. Staff #8 stated she would look. On 2/29/24 at 12:47 PM, the surveyor conducted a follow-up interview with the Staff #8. In this interview the social worker confirmed that Resident #188 did not have an advanced directive or decision-making declarations and was his/her own decision maker. On 2/29/24 at 1 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated the previous Admissions Director was in charge of updating the profile page and must have not verified nor updated the profile when Resident #188 was admitted . 2c) On 3/4/24 at 9:05 AM, the surveyor reviewed a nursing note in Resident #188's medical record. The note was written by Registered Nurse Staff #32 on 8/1/22 at 2:08 PM. The note stated Resident #188 had an area of open skin located at the sacrum (bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis). Staff #32 stated the area looks to be healed/healing and to continue monitoring. Further review revealed a Weekly Skin Evaluation completed on that same day at 10:06 AM by Nurse #33 and signed on 8/16/22. The evaluation identified no skin area of concern even though Staff #32 identified an open skin that same day. On 2/4/24 at 10:48 AM, the surveyor reviewed the facility's skin evaluation policy which stated; A full body, or head-to-toe, skin evaluations will be conducted by a licensed or registered nurse upon admission/re-admission then weekly thereafter. The evaluation may also be performed after a change of condition or after a newly identified pressure injury. On 2/4/24 at 12:55 PM, the surveyor conducted an interview with the DON. During the interview the surveyor asked about the inconsistent documentation of Resident #188's skin evaluation done on the same day. The DON stated Staff #33 no longer worked at the facility after poor documentation was identified.