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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47758 Based on observations and interviews, it was determined that the facility failed to provide residents with a homelike environment. This was found to be evident for 15 residents (#11, #20, #24, #35, #39, #52, #58, #60, #61, #62, #65, #68, #70, #79, #238) out of 94 resident environments observed by the surveyors during the survey. The findings include: During the initial screening on 02/12/24 at 10:04 AM, the surveyor observed that walls above the sink were damaged in rooms 73, 75, 80, 83, 84, 85, 87, and 89 on the Choptank Unit. The Corporate Maintenance Director was informed of the wall damage in the bathroom walls on the Choptank Unit on 02/15/24 at 09:38 AM. He stated he would investigate it and get back to the surveyor with his observations. On 02/15/24 at 11:03 AM, the Corporate Maintenance Director told the surveyor that he observed that the walls above the sinks were damaged from water splashing and the walls would be repaired and covered with fiberglass to protect the walls from future damage. During an interview with the Administrator and Director of Nursing on 2/23/24 at 11:10 AM, the surveyor was informed that they were aware of the damaged walls and that repairs were in progress.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44440 Based on record review, and interviews, it was determined that the facility failed to accurately document wound assessments in a resident 's medical record. This was found evident for 1 (Resident #17) of 2 Residents reviewed for pressure ulcers. The findings include: The MDS is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. On 2/20/24 at 10:28 AM, the surveyor reviewed Resident #17's medical record. The review revealed a wound note from Wound Nurse Practitioner Staff #31. The note revealed that on 3/30/23, Staff #31 evaluated Resident #17 and documented the resident had a stage 3 pressure ulcer (classification of wound; stage 3 is a full -thickness wound, where the wound is through the top two layers of the skin and into the fatty tissue below). Further review revealed an assessment dated [DATE] in section M, skin, of the Minimum Data Set (MDS) assessment documented yes to Resident #17 having a pressure ulcer but coded zero to the staging of the wound. The MDS assessment completed on 10/9/23 in section M, skin, the assessment documented no to pressure wound. Pressure wounds documentation on the MDS allows the facility to monitor pressure wound progression. Once a stage 3 wound is documented on the MDS assessment it is to always be classified as a stage 3 with a notation that that the wound is healing to lower to a lower stage or if the wound deepened, it would move to a stage 4. On 2/20/24 at 11:34 AM, the surveyor interviewed Minimum Data Set (MDS) Coordinator Staff #28. During this interview the Staff #28 stated when she codes pressure ulcer and documents their stages she reviews the wound care teams documentation. Staff #28 stated she was out on leave for some of Resident 17's MDS assessments and that Resident #17's MDS wound assessment is currently accurate. On 2/20/24 at 12:27 PM, the surveyor interviewed the Director of Nursing. During this interview the DON stated that when the MDS Coordinator was out on leave a corporate MDS nurse was completing the MDS assessments. The DON confirmed that the coding for Resident #17's pressure ulcer on 3/30/23 and 10/9/23 was incorrect.

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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. 42828 cite Resident #25 Care Planning Cite F657. Care Plan added on 2/27/2024 after surveyor intervention on 2/27/2024. 02/27/24 04:50 PM Rivaroxaban (XARELTO F/C 20MG TABLET) Active 5/24/2023 Give 1 tablet by mouth one time a day related to HEART FAILURE, UNSPECIFIED Care Plan Care Plan added on 2/27/2024 after surveyor intervention on 2/27/2024. The resident has an alteration in hematological status r/t Anticoagulant Rivaroxaban side effects Date Initiated: 02/27/2024 Revision on: 02/27/2024 44440 Based on record review, and interviews, it was determined that the facility failed to hold care plan meetings with an interdisciplinary team for residents at the time of the Minimum Data Set (MDS) assessment. This was found evident for 1 (Resident #17) of 5 residents reviewed for care planning. The finding include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team. On 2/12/24 at 10:56 AM, the surveyor interviewed Resident #17. In this interview Resident #17 stated he/she had not been to a care plan recently. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/16/24 at 9:27 AM, the surveyor interviewed Social Worker, Staff #8. During the interview Staff #8 described how care plan meetings are set up. She stated when a care plan is scheduled a letter is sent to either the Resident or the Resident's Representative as appropriate. The letter gives the date and time and also asks for confirmation from the Resident or Representative if they are planning to attend. She further stated if a resident is unable to get notified this way other measures are taken to inform them about the meeting. Staff #8 stated she writes a progress note on the meeting and keeps a copy of the invitation letter. Staff #8 Stated she would produce the letter that was recently sent for Resident #17. On 2/15/24 at 10:07 AM, the surveyor reviewed the documents with Staff #8. A letter was given to Resident #17 inviting him/her to the most recent care plan meeting scheduled for 12/21/23. The surveyor then asked the Staff #8 for the care plan notes written from the meeting. On 2/16/24 10:07 AM, the surveyor conducted a follow-up interview with the Staff #8. In this interview Staff #8 stated there were no notes from the 12/21/23 care plan meeting and reported she was on leave when the care plan was scheduled. She further stated it would be the responsibility of the Unit Manager or the nurse to document the results of the care plan meeting. On 2/26/24 at 11:09 AM, the surveyor interviewed the Director of Nursing (DON). During this interview the DON stated she was unable to find documentation from the care plan meeting on 12/21/23 and believes that the care plan meeting was missed.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44440 Based on interviews, record review, and facility policy, it was determined that the facility failed to provide respiratory care consistent with the professional standards for oxygen administration. This was found evident of 1 out of 3 (Resident #17) residents reviewed for respiratory care during an annual and complaint survey. The findings include: Pulse oximeter - a device that uses a light source to analyze the light that passes through a finger and can determine the percentage of oxygen saturation in the red blood cells, referred to as a pulse ox. Nasal cannula- a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels. On February /2024 at 9:55 AM, the surveyor reviewed Resident #17's medical record. The review revealed that Resident #17 had a care plan initiated on 11/6/23 related to the resident's emphysema (a lung condition that causes shortness of breath) and Chronic Obstructive Pulmonary Disease (COPD) (condition involving constriction of the airways and difficulty or discomfort in breathing). One of the interventions listed was, give oxygen therapy as ordered by the physician. Further review revealed an order written on 12/8/23 for oxygen to be given at 4 Liters (unit of measurement for oxygen administration) via nasal cannula. An additional order written on 12/8/23 stated to obtain pulse ox every shift to keep oxygenation saturations greater than or equal to 90 (percent) every shift. On 2/26/24 at 9:35 AM, the surveyor reviewed the pulse ox readings along with the Treatment Administration Record (TAR) for December 2023. There were no pulse ox readings recorded on 12/15/23, 12/19/23, 12/24/23, 12/25/23, however oxygen was checked off as administered on all three shifts for those days. On 2/26/24 at 11:30 AM, the surveyor reviewed the facility's policy on oxygen administration. The policy states: The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders. The policy further stated: Monitoring of oxygen saturation levels and/or vital signs, as ordered. On 2/26/24 at 12:18 PM, the surveyor reviewed the order and missing pulse ox reading with the Director of Nursing (DON). The DON stated, the pulse ox readings should have been recorded and were necessary to evaluate if Resident #17's pulse ox was greater than 90 as described in his/her order for monitoring of oxygen.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44440 Based on record review, interviews and facility policy, it was determined that the facility failed to have a process in place that ensured a resident's medication irregularity report was reviewed by the primary care physician and that the recommendations were addressed timely. This was found evident of 1 (#17) of 5 residents reviewed for medication regimen review. Then findings include: Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the Inter-Disciplinary Team (IDT), including the resident, their family, and/or resident representative. On 2/26/24 at 12:25 PM the surveyor reviewed the Medication Regimen Review (MRR) for Resident #17. During the review it was noted that Resident #17 had reviews done monthly and on 8/16/23, 9/18/23, 10/11/23, 11/20/23, 12/4/23 and 12/11/23 the reviews had a comment, recommendation noted, see report. On 2/26/24 at 12:45 PM, the surveyor conducted an interview with the Director of Nursing (DON). The DON stated that the MMR were completed every month by the Pharmacist and if an irregularity was identified a report would be emailed to the Unit Manager and DON. She further stated that the reports were printed and placed in a binder for the physician to review. The surveyor asked the DON for the reports that were generated for Resident #17 by the Pharmacist. On 2/27/24 at 9:51 AM, the surveyor conducted a follow-up interview with the DON. In this interview the DON stated that the reports were not being kept in the binder, however she was able to request the reports from that pharmacy. The DON stated the reports did not contain the required physician's acknowledgement of irregularity or the action taken to address the irregularity. She further stated education was started with the Unit Managers on expectations of the pharmacy recommendation/irregularity report process. On 2/27/24 at 10 AM, the surveyor reviewed the policy Titled; Addressing Medication Regimen Review Irregularities. The policy states: Any irregularities noted by the pharmacist during this review must be documented on a separate written report which may be in paper or electronic form. The report will be sent to the attending physician, the facility's medical director and the director of nursing and list, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

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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. 44440 Based on medical record review and staff interview, it was determined that the facility staff failed to ensure that a resident's medication regimen was free from unnecessary drugs. This was evident for 1 (Resident #17) or 5 residents reviewed for unnecessary medications. The findings include: On 2/26/24 at 12:25 PM the surveyor reviewed Resident #17's medical record. The review revealed a Medication Regimen Review (MRR) for Resident #17 completed on 12/11/23. The report stated Resident #17 was ordered two vitamin D3 oral medications. One dose every 7 days and the other one to be given every day. The Pharmacist recommended the provider evaluate if both agents were needed and consider discontinuing one of them. On 2/27/24 at 9:45 AM, the surveyor reviewed the Vitamin D3 orders. Both orders were written on 12/8/23. The order for the Vitamin D3 to be given every 7 days was discontinued on 2/27/24 at 8:34 AM, one day after the recommendations were requested by the surveyor. On 2/27/24 at 9:51 AM, the surveyor conducted an interview with the DON. In this interview the DON stated she acknowledged that there was some lack of action taken to address the irregularity reports from the pharmacy. She further stated education was started with the unit managers on expectations of the pharmacy recommendation/irregularity report process.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 44440 Based on interview, and medical record review, it was determined that the facility failed to limit a as needed psychotropic medication from being prescribed for less than 14 days. This was found evident in 1 (Resident #17) out of 5 residents reviewed for unnecessary medications. The finding include: On 2/26/24 at 12:25 PM the surveyor reviewed Resident #17's medical record. The review revealed a Medication Regimen Review (MRR) irregularity report was completed for Resident #17 on 11/20/23 and 12/4/23, both for the same medication alprazolam (prescribed to treat anxiety). On 11/20/23 the Pharmacist recommended a 14-day stop date with the as needed alprazolam order. On 12/4/23 the Pharmacist recommended discontinuing alprazolam order and stated; if the medication cannot be discontinued then the provider should document the indication for use, intended duration and rationale for the extended time period. On 2/27/24 at 9:45 AM, the surveyor reviewed the alprazolam order written for Resident #17. The order was written on 11/1/23 and was written to be given as needed. The order was not discontinued until 12/4/23. The psychotropic medication was available as needed over 30 days. On 2/27/24 at 9:51 AM, the surveyor conducted an interview with the DON. In this interview the DON stated she acknowledged that there was some lack of action taken to address the irregularity reports from the pharmacy. She further stated education was started with the unit managers on expectations of the pharmacy recommendation/irregularity report process.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42828 Based on observations and interviews, it was determined that the facility failed to store medications appropriately according to standards of practice. This was evident for 1 of 30 medications observed during medication administration and 1 of 1 random floor observations. The findings include: Gout- a type of inflammatory arthritis that causes pain and swelling in the joints. On 03/01/2024 at 10:02 AM the surveyor observed a Licensed Practical Nurse (LPN), Staff #34, prepare and administer medications for Resident # 26. The Infection Preventionist/ Staff Educator, Staff #2, was present and stood opposite the surveyor and Staff # 34 for the duration of the observation. During preparation, the surveyor observed Staff #34 retrieve a blister pack with Allopurinol tablets, a medication prescribed to treat gout. Staff #34 reviewed the expiration date printed on the package and it was listed as 2/29/2024. Staff #34 pulled then retrieved another blister pack of Allopurinol from the medication cart prescribed for Resident #26 and the expiration date was 12/23/2023. Staff #34 retrieved another blister pack of Allopurinol prescribed for Resident #26 and the expiration date was listed as 7/31/2024. Staff #34 dispensed the Allopurinol tablets as prescribed. On 3/01/2024 at 10:17 AM the surveyor asked Staff #2 who was responsible for medication cart audits. Staff #2 replied that the Certified Medication Aides (CMA) restock resident medications that are stored in the medication carts and that nurses are ultimately responsible for reviewing the medication expiration dates before administering medications to residents. On 03/01/24 at 11:06 AM surveyor observed LPN, Staff #35, prepare and administer medications for Resident #3. Staff # 35 retrieved a blister pack of Paroxetine tablets labelled, 20 mg tablets, give one tablet every day. The medication order in Resident # 3's chart read, Paroxetine 10 mg, give one 10mg tablet every day. Staff #35 did not pour the medication. Staff #35 located another blister pack of Paroxetine tablets prescribed for Resident #3 that read: Paroxetine 10 mg, give one 10mg tablet every day. Staff #35 reviewed the medication order for Paroxetine and identified that the medication dosage was changed and active on 2/2/2024 by Physician's Assistant, Staff # 18. Resident #3's chart and dispensed the medication as ordered. 03/01/24 at 11:45 AM Staff #35 and surveyor met with the Unit Manager, Staff #6. Staff #35 with surveyor present, explains to Staff #6 what was identified during preparing Resident #3's medications. Surveyor asked Staff #6, how are resident specific medications restocked in medication carts? Staff #6 stated that what should have happened was it should have been pulled out once the new order was placed and the new dosage of said medication was received. Staff #6 also stated that she will initiate an immediate all nursing staff education on medication storage policies. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/01/24 at 12:10 PM surveyor conducted an interview with the Director of Nursing (DON) and discussed the observations during medication administration and the conversation held with Unit Manager, Staff #6. The surveyor requested the facility's Medication Storage Policy. Upon exit on 3/5/2024, the policy was not received. 44440 1b) On 2/12/24 at 12:16 PM, the surveyor observed a medication cart that was unattended and unlocked located on Chesapeake Unit across from the B hallway. At this time no staff were observed managing the medication cart. On 2/12/24 at 12:18 PM, the surveyor interviewed Licensed Practical Nurse (LPN) Staff #29. During the interview Staff #29 locked the medication cart and confirmed that the medication cart should not be left unlocked. She identified that the cart belonged to the nurse 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 to lock the cart 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 medication carts need to be locked when unattended.

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

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	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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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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47758 Based on observations, interviews, and review of policies and procedures, the facility failed to ensure that staff performed hand hygiene. This was evident for 2 (# 28 and # 29) out of 7 staff observed for hand hygiene. The findings include: On 02/20/24 at 08:18 AM, the surveyor observed Geriatric Nursing Assistant (GNA) #23 go into room [ROOM NUMBER] to serve breakfast, touch the resident environment, then proceed to the juice cart and return to room to finish helping the resident. She then went into room [ROOM NUMBER] and assisted the resident, touching the resident environment and exited the room towards the breakfast cart. When asked what the facility hand hygiene policy was GNA #23 stated we perform hand hygiene after touching a patient. She further stated I haven't touched a pt, but I can find hand sanitizer on the medication cart. The surveyor observed GNA #24 on 02/20/24 at 08:20 AM, enter room [ROOM NUMBER]. GNA #24 helped the resident set up breakfast, touching the resident environment and exited. GNA #24 then entered room [ROOM NUMBER], touched the bed, went back to the breakfast cart, picked up food, and returned to room [ROOM NUMBER] and helped with the food and exited without performing hand hygiene. When asked about the facility hand hygiene policy GNA #24 replied that the policy was to perform hand hygiene after every 2 rooms. On 02/20/24 at 08:27 AM, the surveyor asked CMA/GNA # 25 what the facility hand hygiene policy was? She responded, we sanitize with hand sanitizer before and after each patient and wash with soap and water every few times. During an interview on 02/20/24 at 08:29 AM, the Choptank Unit Manager stated she would educate staff immediately and investigate obtaining hand sanitizers for staff to carry in their pockets. During an interview on 02/28/24 at 12:29 PM the Director of Nursing stated she was aware of the missed hand hygiene opportunities observed on 2/20/23. She further stated, we ordered pocket sanitizers, hand hygiene would be discussed in the Quality Assurance Performance Improvement meeting that day and education would be provided.