STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215226	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Rehab at Autumn Lake Healthcare	515 Brightfield Road Lutherville, MD 21093

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 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. 42782 Based on record review and interview it was determined that the facility staff failed to notify the state agency of an alleged case of abuse within the 2-hour allotted timeframe and failed to report allegations of abuse to the state health department and to law enforcement. This was found to be evident for 2 (Resident # 83 and Resident #101) of 15 residents reviewed for abuse during the facility's survey. The findings include: 1. On 06/18/24 at 9:20 am surveyor received a copy of the facility's investigation of the facility reported incident MD00183880. Review of the self-report form revealed the alleged incident occurred on 09/25/22 during 3 pm to 11 pm shift. The alleged incident was reported to the state agency on 09/26/22 at 1 pm which was outside of the 2-hour allotted timeframe for reporting alleged abuse case. On 06/20/24 at 10:34 am a review of the facility's Abuse, Neglect, and Exhibition policy revealed under Section VII Reporting Abuse Reporting of all alleged violations to the Administrator, state agency, Adult Protective Services and to all other required agencies immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse. On 06/21/24 at 10:29 am during an interview with Administrator #3 who verbalized any concern is followed up with them and the Director of Nursing. They discuss the issue and determine if it is reportable. For alleged abuse cases they are reported within 2 hours. Interviews are done with staff, residents, and witnesses. The police are notified; the alleged employee is suspended. Other residents are interviewed to see if there are any concerns. Administrator #3 was made aware the facility reported incident was reported outside of the allotted 2-hour window, verbalized understanding. 30440 2. During a screening of residents during the facility's annual survey, resident # 83 was interviewed by two surveyors and the resident stated that an agency Registered Nurse (RN) (# 53) was very disrespectful when s/he asked the nurse for a shower. The resident further stated that s/he was called out of their name and the nurse (# 53) was verbally abusive. The resident went on to say that s/he does not feel safe receiving medications from the nurse and that s/he spoke to the Director of Nursing (DON) (# 17) about this incident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same date at 9:15 AM an interview was conducted with the DON and the Administrator (# 3), and they were made aware of resident # 83's concerns. The DON stated that she spoke with the resident on 6/11/24 regarding the resident concerns. During a subsequent interview with the DON on 6/12/24 at 1:30 PM, she was asked if the facility reported the abuse allegations to the state office and she responded, no. The DON was asked if law enforcement was notified and she responded, no. She acknowledged that all allegations of abuse are to be reported immediately within the two (2) hour required time frame. On 6/13/24 at 2:00 PM, the DON informed the survey team that the abuse allegations were reported to the Office of Health Care Quality and provided a copy of the initial report to the survey team. All concerns were discussed with the Administration team at the time of exit on 6/28/24 at 3:00 PM.

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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. 30440 Based on administrative record review and interviews with facility staff, it was determined the facility failed to complete a thorough investigation and maintain documents regarding allegations of resident abuse. This was found to be evident for 4 (Resident #424, Resident #101, Resident #120, and Resident # 99) of 25 residents reviewed for abuse during the facility's survey. Findings include, 1. MD00190231 was reviewed on 6/17/24 at 12:30PM for allegations of abuse. The survey team requested a copy of the facility's investigation for the incident that occurred on 2/27/23 with Resident #424. On the same date at 1:30PM the Regional Nurse (Staff # 9) provided the survey team with a copy of the investigation and upon review, it included the following documents: a list of the resident's diagnosis, an initial 5-day report and a summary page. There were no interviews with residents or staff and no signed statements. The DON was interviewed on the same date at 1:45 PM and she was asked if the facility had any additional documentation of resident and staff interviews as part of their investigation and she stated, no. She further stated that the facility obtained new ownership in May 2023. The DON went on to say that part of completing a thorough investigation is interviews of staff and residents to determine if or not abuse occurred. The DON stated that education would be provided to the staff. On 6/17/24 at 1:45PM the DON provided the survey team a typed statement from the Director of Guest Services (# 22). In the statement, staff # 22 indicated that at the time of the incident residents were interviewed and a handwritten copy of the interviews were provided to the DON. This document was not included in the facility's investigation. The DON again confirmed that they are unable to produce documentation of residents and staff interviews. 42782 2. On 06/18/24 at 9:20 AM, a review of the facility reported incident MD00183880 revealed Resident #101 reported verbal abuse from a Registered Nurse (RN) #50. Further review of the investigation revealed a Geriatric Nursing Assistant (GNA) notified RN#50 of the alleged verbal abuse, but a statement from the GNA was not included in the investigation. The resident was interviewed by Unit Manager #51, but there was not a statement for the surveyor to review. Also, a statement from Resident #101 was not included in the investigation. On 06/21/24 at 10:29 am during an interview with Administrator #3 the surveyor verbalized different parts of the investigation were missing. Administrator #3 verbalized the case happened prior to the change of ownership of the building and that was all that was in the record. 42863 3. The surveyor reviewed MD00165055 on 06.18.24 at 10:30 AM related to a facility reported incident (FRI) dated 03.14.2021. The facility reported that Resident #120 accused RN staff #27 did not stop pushing while administering an enema as requested by the resident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06.18.24 at 09:15 AM the surveyor interviewed the regional nurse, staff # 9. Staff # 9 stated that the facility incident reports prior to the year 2023 may be in storage and would take a couple of days to retrieve. During an interview with staff #9 on 06.18.24 at 10:38 AM stated that she was not able to find the complete facility report for Resident #120. However, she would look within the system to try to retrieve additional information. The surveyor requested the hard copy of Resident #120's closed record and FRI for the second time on 06. 21.24 at 11:40 AM. The facility failed to provide the complete facility report by the close of the exit conference on 06.28.24 at 3:00 PM. The facility reported incident documents provided did not include any documentation related to post event educational training of facility staff related to resident rights, abuse training, or documentation or the suspension of the alleged perpetrator, RN #27 immediately after the incident was reported by Resident #120. 50457 4. On 6/17/24 at 12:36 pm, the surveyor received a copy of the facility's self-report investigation MD00166760 for Resident #99. The report revealed physical abuse allegation from Geriatric Nursing Assistant (GNA) #51. Further review of investigation revealed no staff interviews or staff written statements, and there was not a copy of the 5-day investigation results. During an interview on 6/21/24 at 10:31am, Administrator #3 and Regional Nurse #9 regarding the process for reporting abuse allegations, the Administrator #3 explained that all grievances reported by staff should be reported to either the Administrator or Director of Nursing. The alleged staff member would be suspended pending an investigation and written statements are gathered from alleged staff members. On 06/21/24 at 11:29 am during an interview with Administrator #3 and Regional Nurse #9, who verbalized that the facility did not have a complete investigation file for MD00166760. All concerns were discussed with the administrative team at the time of exit on 6/28/24 at 3:00PM.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 30440 Based on interview and medical record review, it was determined the facility failed to ensure comprehensive care plans were developed and implemented. This was found to be evident for 2 (Resident #112 and Resident #85) of 18 residents reviewed for care plans during the facility's survey. Findings include: 1. 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 they receive in a facility. It should describe the resident's goals and desired outcomes, the care/services that will be furnished, the resident's discharge plans, and refusals of care and action taken by facility staff to educate the resident. Review of Resident #112's medical record revealed the resident was admitted with the following but not limited diagnosis: Type 1 Diabetes Mellitus (a lifelong condition where the pancreas makes little or no insulin, which leads to high blood sugar levels). MD00203565 was reviewed on 6/25/24 at 4:00 PM for allegations of neglect in which Resident #112 reported not receiving insulin medication when at the facility. The allegation was unsubstantiated. Further record review on the same date revealed resident #112 receives insulin (a hormone that lowers the level of glucose in the blood), however there was no Diabetes care plan in place. An interview was conducted with the DON (# 17) and Regional DON (# 9) on 6/26/24 at 9:45 AM and she was made aware that resident #112 did not have a diabetes care plan. The DON went on to explain that a care plan should have been developed for the resident, specifically to address the resident care concerns related to Diabetes and that education would be provided to her staff. . All concerns were discussed with the administrative team at the time of exit on 6/28/24 at 3:00 PM. 49304 2. On 6/13/24 at 11:31 AM in an interview with Resident #85 they stated they had not been invited or participated in a care plan meeting. Resident #85's medical record was reviewed on 6/14/24 at 1:15PM and revealed the resident's diagnoses included chronic obstructive pulmonary disease, emphysema, atrial fibrillation, and atherosclerotic heart disease, all of which can affect a person's breathing and respiratory care and services needed. However, there was no respiratory care plan that identified a focus, goal, or intervention to address the resident's respiratory care or services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/24 at 3:36 PM, review of the facility's Oxygen Administration policy revealed, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Further review revealed Policy Explanation and Compliance Guidelines section: The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment settings for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49304 Based on observations, review of medical records, and interview with facility staff, it was determined that the facility failed to follow physician orders as evidenced by: 1) ensuring ordered ACE wraps were in place, 2) administering medication as ordered by the physician, and 3) a resident not receiving the ordered amount of oxygen. This was evident for 3 (Residents #40, #15, #37) of 9 residents reviewed during the survey. The findings include: 1) On 6/13/24 during initial tours of the facility and multiple surveyor observations of Resident #40 with the last observation of the day made at 2:12 PM, Resident #40 was observed without any ACE wraps in place anywhere on the resident. Medical record review for Resident #40 on 6/14/24 at 10:20 AM revealed multiple diagnosis including lymphedema, essential (primary) hypertension, pulmonary embolism, personal history of transient ischemic attack, atherosclerotic heart disease of native coronary artery, and chronic kidney disease, stage 4 (severe). Furthermore, Resident #40's physician orders were reviewed and noted the following, ACE wraps toes to knees on in am, off in pm, one time a day for edema, with a facility time code noted as QD 9a (every day at 9:00 AM). The order was created by Physician #31 on 6/12/24 at 5:33 PM. Resident #40 was observed again on 6/14/24 at 10:30 AM. The resident was lying in bed and at that time no ACE wraps were observed on the resident. Surveyor observed on 6/18/24 at 9:21 AM, the resident was lying in bed with no ACE wraps observed on their legs. On 6/18/24 at 10:01 AM, in an interview with Licensed Practical Nurse (LPN) #54, when asked about Resident #40's ACE wraps for his/her legs, she stated this is my first day ever working in this building. When asked if LPN #54 had reviewed Resident #40's orders, she indicated she had not logged on to the system yet as she had a log in, but it had to get reset. On 6/18/24 at 10:09 AM in an interview with Unit Manager (UM) #6, when asked the process for when staff do not have access to the electronic health record (EHR), she stated they can come to one of us [clarified us as the UM, Director of Nursing (DON), or Assistant Director of Nursing (ADON)] and we can email IT (information technology for the EHR). They can also call the IT number. The response time is sometimes quick and sometimes not. During the interview, when asked why Resident #40 was ordered ACE wraps she stated, he/she has lymphedema. When asked when they are to be applied, UM #6 stated, in the morning and removed at night. When asked about the application and removal time on the order, she looked in the EHR and stated, it seems the doctor came in after [me] and also created an order. UM #6 stated, I will update and get rid of one of these orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The second order stated, Apply ace wraps to BLEs (bilateral lower extremities) on in the morning and remove at bedtime every evening and night shift for lymphedema with a facility time code of 3-11/11-7 (ace wraps removed for the 3PM-11PM and 11PM-7AM shift). Therefore, per this order, starting at 7:01AM, the ACE wraps should have been applied to both of the resident's lower legs. When asked why the ACE wraps were not currently on Resident #40's legs, UM #6 stated, Clarification of the orders since there are two ACE wrap orders. However, either order a staff member read in the EHR, the ACE wraps should have been applied to the resident's legs [per the physician orders] at all the above times the resident was observed without ACE wraps. 2) On 6/13/24 10:24 AM in an interview with Resident #15, they stated there are times when they are in pain because their pain medicine has run out and they have to wait for it. Medical record review for Resident #15 on 6/17/24 at 10:33 AM revealed on 4/22/24 the physician ordered: Ibuprofen Oral Tablet 400 MG (Ibuprofen), Give 2 tablet by mouth every 6 hours as needed for pain 1-3, Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate) *Controlled Drug*, Give 1 tablet by mouth every 4 hours as needed for Pain scale 4-5, Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate) *Controlled Drug*, Give 2 tablet by mouth every 4 hours as needed for pain scale 6-10. On 6/21/24 at 12:57 PM review of the Medication Administration Record (MAR) revealed the facility staff documented on: 5/27/24 at 5:00 PM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 5/29/24 at 9:01 AM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 5/31/24 at 5:53 PM a pain score of 8 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 5/31/24 at 10:03 PM a pain score of 8 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/1/24 at 3:00 AM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 6/1/24 at 9:19 AM a pain score of 6 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/1/24 at 2:02: PM a pain score of 8 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/1/24 at 5:55 PM a pain score of 5 and administered 2, 400mg tablet of Ibuprofen Oral Tablet, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/2/24 at 6:13 AM a pain score of 6 and administered 1, 15mg tablet of Morphine Sulfate Oral Tablet, 6/4/24 at 12:30 AM a pain score of 5 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 6/4/24 at 4:00 PM a pain score of 4 and administered 2, 15mg tablet of Morphine Sulfate Tablet, 6/11/24 at 12:30 AM a pain score of 0 and administered 2, 15mg tablet of Morphine Sulfate Tablet; however, the documented pain scale and pain medications administered were outside the parameters as indicated by the physician. Interview with the DON and ADON on 6/21/24 at 1:27 PM were notified of the concerns related to administration of pain medication outside of the physician ordered parameters for Resident #15. 50457 3) On 06/13/24 at 09:49 am the surveyor observed Resident #37 resting in bed with oxygen tubing in their nose and the oxygen concentrator was set to humidified 3 liters(L) of oxygen (02) via nasal cannula (NC). On 06/13/24 at 1:43 pm A review of the medical record revealed an order dated 05/02/24, at 6:39 pm for Resident #37 to receive 2 liters of oxygen via nasal cannula continuously. It also specified that after every shift post treatment the resident's heart rate, respiratory rate, pulse oximetry, skin color, and breath sounds should be evaluated. On 06/17/24 at 11:54 am, Resident #37 was observed resting in bed with humified oxygen set at 3L via NC. On 06/17/24 at 11:55 am during an interview with the resident's assigned nurse LPN #14, the surveyor asked how many liters of 02 Resident #37 was ordered. LPN #14 stated it was set to 2 liters. LPN #14 and the surveyor entered Resident #37 room and confirmed that the oxygen concentrator was set at 3 liters. LPN #14 reported they would contact the resident's doctor for a new oxygen order.

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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. 49304 Based on record review and interview with facility staff, it was determined the facility failed to provide documentation whether a resident had signs and symptoms of abuse immediately following an allegation of abuse and failed to provide documentation to verify monthly pharmacy review was completed in 2024. This was evident for 3 (#508, #11, #21) of 15 residents reviewed during the survey. The findings include: 1) Review of the facility's Abuse, Neglect and Exploitation Policy on 6/25/24 at 3:01 PM revealed in the Investigation of Alleged Abuse, Neglect and Exploitation section, Written procedures for investigations include: Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent, and cause; and Providing complete and thorough documentation of the investigation. Further review of the policy in the Protection of Resident section, Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed . Resident #508's medical record was reviewed on 6/26/24 at 11:22 AM. During the review, there was no evidence of documentation whether the resident had signs and symptoms of abuse promptly following an allegation of abuse. On 6/26/24 at 12:17 PM in an interview with the Assistant Director of Nursing (ADON), when asked for documentation the physician was notified, she stated I did not see a progress note or documentation that the physician was notified, but I did bring a copy of the x-ray ordered by the physician. Review of the Radiology Results Report on 6/26/24 at 12:44 PM revealed, Findings: There is shoulder arthritis .There is no acute fracture. However, the alleged abuse occurred on the 5/29/23 11PM-7AM shift and the x-ray order date and time was 5/31/23 at 10:18 AM. On 6/26/24 at 12:51PM in an interview with the ADON, when asked the expectation if a resident alleges abuse, she stated the expectation is that nurses complete a change in condition or risk management. On 6/26/24 at 2:00 PM, review of the facility's policy, Charting and Documentation revealed, All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Furthermore, it stated, All incidents, accidents, or changes in the resident's condition must be recorded. On ADON 6/26/24 at 2:18PM in an interview with the ADON she stated, I do not see a change in condition or risk management in the medical record for Resident #508. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 12:25PM in an interview with the DON, when asked after Resident #508 reported an allegation of abuse if a nurse assessed the resident, she stated the expectation was to complete a head to toe assessment and document a progress note or a change in condition. During the interview, she reported there was no progress note or change in condition from a nurse that is documented in the resident's medical record. 50457 2) On 06/17/24 at 11:30 am A review of Resident #11 and Resident #21, paper charts and electronic medical records, revealed there were no files or documentation to verify the monthly pharmacy reviews were completed. On 06/17/24 at 11:40 am During an interview with License Practical Nurse (LPN) Unit Manager (UM) #11 verbalized uncertainty about where to locate the pharmacy reviews. They mentioned that they would contact the pharmacy to obtain this information. The surveyor waited, but LPN UM #11 was unable to confirm the pharmacy reviews for Resident #11 and Resident #21 were completed. On 06/17/24 at 11:43 am During an interview with LPN #34, they checked Resident #11 and #21 charts for the pharmacy reviews and reported they did not see a pharmacy reviews for either resident. LPN #34 explained that when pharmacy reviews are received, the doctor reviews them, and decides the next course of action. However, LPN #34 was not sure about the process of how the pharmacy review is received. On 06/17/24 at 12:02 pm, during an interview with Director of Nursing (DON) #17, they explained that they print the pharmacy reviews, and the Medical Director reviews them. They also report that they keep copies of the reviews in a binder in their office. The surveyor accompanied the DON #17 to their office to review the requested pharmacy reviews for Resident #11 and Resident #21. DON#17 was unable to locate any pharmacy reviews for both residents. On 6/28/24 prior to existing the facility, the DON was not able to provide evidence of monthly pharmacy review for Resident #11 nor Resident #21.