| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215226 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Advanced Rehab at Autumn Lake Healthcare | 515 Brightfield Road<br>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.

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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observation and interviews, it was determined that the facility failed to ensure a resident's dignified existence was maintained during a meal. This was evident for 1 of several observations made during meal times on the second floor units.<br><br>The findings include:<br><br>On 12/05/2025 at 12:14 PM, an observation while walking around the second floor units revealed Resident #2 in their room eating their lunch meal. The resident's bed was completely lowered to the floor and the resident was reaching their right hand up above their head onto the bedside table to eat off of their plate. The resident's bedside table which had their meal tray on it was above the resident's eye level.<br><br>On 12/05/2025 at 12:16 PM, an interview with the resident revealed that staff informed him/her that their bed had to be in the lowest position. Further interview revealed that he/she was unable to see what he/she was grabbing off of their plate nor how much food was left on the plate as it was above their eye level. The resident further indicated they had to feel the plate to determine how much food was left on it. On 12/05/2025 at 12:26 PM, Geriatric Nursing Assistant (Staff #9) walked into the room where the surveyor was with the resident.<br><br>At the same time, an interview with Staff #9 revealed that the expectation was when staff drop off a resident's tray, that they adjust their bed, the resident, and/or the bedside table to ensure the resident can eat properly. She further indicated that although Resident #2's bedside table was above their eye level, it was in the lowest position. She further indicated the staff keep the bed in the lowest position as the resident was a fall risk.<br><br>Further interview with Staff #9 revealed that she agreed the bedside table was above the resident's eye level and there should have been some adjustment made with the bed and/or bedside table so that the resident's dignity was maintained while eating.<br><br>On 12/05/2025 at 1:29 PM, the surveyor reviewed the finding with the Director of Nursing and she indicated that some adjustment should have been made so that the resident was able to see what was on their plate and not have to reach above their head to grab their food. She further indicated that she understood the concern. |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>Based on record review and interviews, it was determined that the facility failed to facilitate care plan meetings for residents. This was evident for 2 (Resident #45 and Resident #80) out of 3 residents reviewed for care planning.<br><br>Care plan meetings are scheduled discussions where the healthcare team reviews a resident's condition, needs, and progress, using information such as the Minimum Data Set (MDS). The team collaborates to set or update care goals and interventions, address concerts, and ensure care is coordinated and individualized, with input from the resident and/or family when possible.<br><br>The findings include:<br><br>1) On 12/04/2025 at 11:42 AM, an interview with Resident #45's representative revealed that he/she hadn't been invited to a care plan meeting in 2 years.<br><br>On 12/04/2025 at 1:14 PM, an interview with the Social Services Director (Staff #7) revealed that the expectation was that care plans were completed at least quarterly.<br><br>Further interview with Staff #7 revealed that residents and family members were invited to the care plan meetings, and the records of who attended were kept in a log book.<br><br>On 12/05/2025 at 1:19 PM, the surveyor requested the sign in sheet for Resident #45's care plan meetings within the last year.<br><br>On 12/08/2025 at 12:30 PM, an interview with Staff #7 revealed that the last care plan meeting date that she was able to find for Resident #45 was 12/27/2022.<br><br>2) On 12/11/2025 at 9:33 AM, an interview with Resident #80 revealed that the resident had not had a care plan meeting in a while.<br><br>On 12/11/2025 at 9:55 AM, record review revealed a progress note dated 06/20/2024 that mentioned a care plan meeting had been planned for 07/03/2024. The surveyor was unable to find any further documentation regarding a care plan meeting for the resident since the progress note dated 07/03/2024.<br><br>On 12/11/2025 at 10:29 AM, an interview with the Social Services Director (Staff #7) revealed that she was unable to find record of Resident #80's last care meeting date.<br><br>On 12/11/2025 at 1:09 PM, the concern was reviewed with the Director of Nursing and she indicated that she understood. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on record review, observations, and interviews, it was determined that the facility failed to accommodate a resident's needs based on their condition. This was evident for 1 (Resident #45) out of 1 residents reviewed for accommodation of needs.<br><br>The findings include:<br><br>On 12/04/2025 at 9:23 AM, record review revealed that Resident #45 was paralyzed on the left side (cannot move the left side of their body).<br><br>On 12/04/2025 at 12:45 PM, an observation of Resident #45 revealed that the resident's call bell was hung on the left hand side bed rail.<br><br>On 12/05/2025 at 12:11 PM, an observation of the resident revealed that the call bell was still on the resident's left side. At the same time, the resident requested the surveyor to adjust his/her bed. When the surveyor asked if he/she could reach the bed adjustment remote or call bell, he/she reached and further indicated they were unable to.<br><br>On 12/05/2025 at 12:16 PM, an interview with Geriatric Nursing Assistant (Staff #9) revealed that the expectation was that the call bell should be within the resident's reach.<br><br>On 12/05/2025 at 1:26 PM, the concern was reviewed with the Director of Nursing and she indicated that she understood. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>Based on record review and interviews, it was determined that the facility failed to ensure that proper information was provided to the resident and/or resident representative regarding advanced directives. This was evident for 3 (Resident #4, #8, and #10) out of 6 residents reviewed for advance directives during an annual survey.<br><br>The findings include:<br><br>Advance directives are legal documents that explain a person's wishes for medical care if they are unable to speak for themselves. They may include instructions about treatments a person does or does not want and the designation of a healthcare proxy to make decisions on their behalf. These documents help ensure that medical care aligns with the person's values and preferences.<br><br>1) On 12/04/2025 at 1:32 PM, review of Resident #4's medical record failed to reveal an advanced directive.<br><br>On 12/05/2025 at 1:08 PM, an interview with the Social Services Director (Staff #7) revealed that the expectation was that advance directives were addressed upon admission and if a resident did not have one that the facility would provide them information to formulate one.<br><br>On 12/05/2025 at 1:12 PM, record review of the document titled, social service assessment, dated 11/08/2025, indicated that Resident #4 did not have an advanced directive on file and failed to reveal indication that information was provided to formulate one in result.<br><br>On 12/08/2025 at 9:38 AM, an interview with Staff #7 revealed that if information to formulate an advance directive was offered, it would be documented on the social service assessment form. The surveyor requested any further documentation that would indicate that the advance directive was offered.<br><br>On 12/08/2025 at 11:17 AM, a follow up interview with Staff #7 revealed that she was unable to find further documentation that the facility provided information to the resident and or representative to formulate an advanced directive.<br><br>2) On 12/04/2025 at 12:18 PM, review of Resident #8's medical record failed to reveal an advanced directive.<br><br>On 12/08/2025 at 8:38 AM, record review of the document titled, social service assessment, dated 10/21/2025, indicated that Resident #8 did not have an advanced directive on file and failed to reveal indication that information was provided to formulate one in result.<br><br>On 12/08/2025 at 1:48 PM, an interview with Staff #7 revealed that she was unable to provide the surveyor with documentation that would indicate information was provided to the resident and/or resident representative to formulate an advanced directive.<br><br>3) On 12/04/2025 at 1:45 PM, review of Resident #10's medical record failed to reveal an advanced directive.<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/08/2025 at 7:32 AM, record review of the document titled, social service assessment, dated 11/04/2025, indicated that Resident #10 did not have an advanced directive on file and failed to reveal indication that information was provided to formulate one in result.<br><br>On 12/08/2025 at 11:17 AM, an interview with Staff #7 revealed that she was unable to provide the surveyor with documentation that would indicate information was provided to the resident and/or resident representative to formulate an advanced directive.<br><br>On 12/11/2025 at 12:30 PM, the concerns were reviewed with the Director of Nursing and she indicated that she understood. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that facility staff failed to ensure that residents and/or resident representative received complete and written notice of transfer and/or bed hold rights. This deficient practice was evident for 2 (Resident #55 and #84) out of 5 residents review for hospitalization/discharge during the annual survey.<br><br>The findings include:<br><br>1) On 12/09/2025 at 8:11 AM, a review of Resident #55's medical record revealed that the resident was transferred from the nursing facility to the hospital on [DATE] and 10/26/2025. Further review showed a nurse progress note dated 10/13/2025 at 10:49 AM that documented the resident was transferred to the hospital due to altered mental status and the emergency contact was made aware. On 10/26/2025 at 4:32 PM, a nurse progress note documented the resident was pocketing food, appeared lethargic, and was difficult to arose. The resident was ordered to be transferred to the emergency department. The emergency contact was notified and made aware.<br><br>During an interview with the Director of Nursing (DON) on 12/09/2025 at 8:17 AM, when asked about the process for resident transfer notices and bed hold notices, she explained that the facility follows multidisciplinary team approach. The nurse responsible for the resident at the time of transfer initiates the transfer notice and bed hold notice process, and the social worker sends the notices to the resident representative and the ombudsman. The surveyor requested to view the transfer notice and bed hold notice for Resident #55 dated 10/13/2025 and 10/26/2025.<br><br>During an interview with Registered Nurse (RN) #15 on 12/09/2025 at 8:30 AM, she explained that bed-hold notices and transfer notice forms are completed by nursing staff prior to a resident's transfer to the hospital. The original copy is placed in the resident's paper chart, and a copy is provided to the resident and/or the resident's family. The social worker is responsible for maintaining the transfer notices and bed hold notices forms.<br><br>On 12/09/2025 at 10:13 PM, the DON provided the surveyor with Resident #55's transfer notices dated 10/13/2025 and 10/26/2025. Review of the bottom of each form stated that the signature below acknowledges receipt of the transfer notice. The signature section was left blank on both forms.<br><br>A review of the bed hold notices dated 10/13/2025 revealed that the form was incomplete. Additionally, the bed hold notice dated 10/26/2025, was entirely blank, except for a section that was checked indicating the resident's emergency contact name was listed under the release of bed hold information.<br><br>12/09/2025 9:22 AM During an interview with the Social Services Director (SSD) #7, she explained the facility's transfer and bed hold notice process and stated that the completed notices are placed in a binder. When asked who is responsible for sending the written transfer and bed hold notices to the resident's representative, the SSD #7 stated that she does not mail the transfer or bed hold notices and further explained that she was unsure which staff member is responsible for mailing notices.<br><br>On 12/09/2025 at 10:43 AM, the surveyor reviewed the incomplete transfer and bed hold notice forms (continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | for Resident #55 dated 10/13/2025 and 10/26/2025. The surveyor informed the Administrator and DON that SSD #7 was unaware she is responsible for providing the resident's representative with written transfer and bed hold notices. Both the Administrator and DON acknowledged this information.<br><br>2) On 12/10/2025 at 9:50 AM, record review revealed Resident #84 was hospitalized on [DATE].<br><br>Further record review revealed a document titled, Notice of Resident Transfer or Discharge, dated 10/10/2025. Review of the document failed to reveal that a reason for the transfer was completed; the section was left blank. Further review of the document revealed at the bottom of the form it stated that the signature below acknowledges receipt of the transfer notice by the resident and/or resident representative. The signature section was left blank.<br><br>On 12/10/2025 at 11:57 AM, the surveyor reviewed the concern with the Director of Nursing and she indicated it should have been filled out by the resident or resident representative. She indicated she had no further documentation to support that a written notice of transfer was provided. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, it was determined that facility staff failed to accurately code the resident's status on the Minimum Data Set (MDS) assessment. This failure was evident for 1 resident (Resident #77) out of 8 residents reviewed for MDS assessments during the facility's recertification/complaint survey.<br><br>The findings include:<br><br>The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement.<br><br>On 12/05/2025 at 9:08 AM, review of physician orders dated 10/15/2025 showed an order for a hospice consultation, and physician orders dated 10/16/2025 showed the resident was admitted under [NAME] Hospice services, effective 10/15/2025.<br><br>On 12/05/2025 at 9:26 AM, review of Resident #77's most recent Significant Change in Condition (SCSA) MDS, completed on 10/15/2025, revealed that Section O, Item K1 (Hospice Care) was inaccurately coded. The MDS indicated that the resident was not on hospice, with a response of No, despite documentation showing hospice services were initiated effective that same date.<br><br>On 12/05/2025 at 10:46 AM, an interview was conducted with the MDS Coordinator (Staff #5). When asked about expectations regarding MDS accuracy, Staff #5 stated that all MDS assessments were expected to be coded accurately. When asked to identify the resident's significant change in condition, Staff #5 stated that the resident's admission to hospice on 10/15/2025 constituted the significant change. When asked how Section O should have been coded regarding hospice services, Staff #5 stated that the response should have been coded Yes instead of No and acknowledged that the incorrect coding was an error. Staff #5 further stated that, going forward, significant changes in condition would be accurately reflected and appropriately coded on the MDS.<br><br>On 12/05/2025 at 11:02 AM, the Director of Nursing (DON) was informed of the concern regarding the inaccurate MDS coding for Resident #77. The DON acknowledged the concern. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews it was determined that the facility failed to ensure 1) a resident's comprehensive care plan included a resident's medical need regarding oxygen and medication, 2) to develop and implement a comprehensive, person-centered care plan to address a resident's significant change in condition related to hospice admission and end-of-life care needs, and 3) to conduct quarterly care plan meetings. This was evident for 1 (Resident #5) out of 2 residents reviewed for respiratory care, 1 (Resident #5) of 5 residents reviewed for medications,1 resident (Resident #77) out of 1 resident reviewed for hospice care, and 1 (Resident #90) out of 5 complaints reviewed during annual survey.<br><br>The findings include:<br><br>1a) A care plan is a resident-centered document that outlines identified needs, goals and interventions to guide the care provided. It must directly reflect the residents minimum data set (MDS), as the MDS identifies the resident's conditions, risks, and functional status. Any problems, risks, or changes identified on the MDS should be addressed in the care plan with appropriate goals and interventions, and the care plan should be updated to remain consistent with the resident's current assessed needs.<br><br>On 12/04/2025 at 1:05 PM, an observation of Resident #5 revealed that the resident was on oxygen.<br><br>On 12/05/2025 at 11:15 AM, review of section O of the MDS dated [DATE] revealed that Resident #5 was receiving oxygen at the facility.<br><br>Further record review failed to reveal that oxygen was included in Resident #5's comprehensive care plan.<br><br>On 12/05/2025 at 1:21 PM, an interview with the Director of Nursing (DON) revealed that the expectation was that oxygen would be in the care plan based on the medical services provided to meet the resident's needs.<br><br>On 12/08/2025 at 9:33 AM, the concerns were reviewed with the DON and she indicated that she understood.<br><br>1b) On 12/08/2025 at 9:41 AM, review of Resident #5's medical record revealed that he/she was admitted to the facility on [DATE].<br><br>At the same time, further record review revealed that the resident was admitted on [DATE] with an active diagnosis of mood disorder (a mental health condition where moods can change quickly), and was ordered risperidone (a medication used to treat mood disorder) upon admission. On 12/08/2025 at 9:52 AM, further record review failed to reveal that the condition nor medication that the resident was actively receiving treatment for was addressed in the comprehensive care plan.<br><br>On 12/08/2025 at 11:29 AM, an interview with the Director of Nursing (DON) revealed that the expectation was that resident diagnoses that were actively being treated at the facility should be included in the comprehensive care plan. The surveyor reviewed the concern with the DON and she indicated she understood.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2) The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement.<br><br>Care Area Assessments (CAAs) are a crucial part of the Minimum Data Set (MDS) process in skilled nursing facilities, serving as prompts for detailed reviews of specific resident issues like delirium, nutrition, falls, or mood, forming the basis for personalized care plans by an interdisciplinary team (IDT) to address needs, set goals, and enhance resident well-being. These assessments trigger deeper evaluations beyond basic MDS data, ensuring comprehensive, individualized care plans for residents.<br><br>On 12/05/2025 at 9:08 AM, review of physician orders dated 10/15/2025 showed an order for a hospice consultation for Resident #77, and physician orders dated 10/16/2025 showed the resident was admitted under [NAME] Hospice services, effective 10/15/2025.<br><br>On 12/05/2025 at 9:26 AM, a review of the resident's most current comprehensive and most recent quarterly Minimum Data Set (MDS) and Care Area Assessments (CAAs) related to the resident's significant change in condition on 10/15/2025 was conducted for areas pertinent to the resident's end-of-life care, services, and needs.<br><br>On 12/05/2025 at 9:31 AM, review of pertinent documentation revealed that the resident began receiving hospice services effective 10/15/2025; however, no care plan addressing hospice or end-of-life care needs was present in the medical record.<br><br>On 12/05/2025 at 9:37 AM, review of the resident's care plan showed that the care plan was not initiated until 12/04/2025, the date the survey team arrived at the facility.<br><br>On 12/05/2025 at 10:01 AM, an interview was conducted with the Unit Manager, Licensed Practical Nurse (LPN) #4, when asked about expectations regarding care plans, he stated that a baseline care plan was completed upon admission and reviewed and updated as needed. When asked about care plan updates following a change in condition, he stated that care plans were updated after a change in condition. When asked when the resident was admitted to hospice, he stated that the resident was admitted in October and added that the care plan should have been initiated on the day of hospice admission or the following day.<br><br>On 12/05/2025 at 10:36 AM, an interview was conducted with the Director of Nursing (DON). When asked about expectations for care plan initiation, the DON stated that a resident should have a baseline care plan within 24 hours of admission and a comprehensive care plan completed within 14 days. The DON further stated that care plans should be initiated or updated following a change in condition, particularly when the change was significant. When asked when the care plan for this resident was completed, the DON stated that it was completed on 12/04/2024. When asked when the care plan should have been initiated, the DON stated that the care plan should have been initiated following the resident's change in condition on 10/15/2025, and not on 12/04/2025.<br><br>On 12/05/2025 at 10:43 AM, when the DON was informed that the failure to initiate and update the care plan following the resident's significant change in condition was a concern, she acknowledged the concern and stated that audits would be conducted, and education would be provided to nursing staff regarding timely care plan initiation and updates.<br>(continued on next page) |

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| | 215226 | A. Building<br>B. Wing | 12/11/2025 |

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| Advanced Rehab at Autumn Lake Healthcare | 515 Brightfield Road<br>Lutherville, MD 21093 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) On 12/09/2025 at 1:39 PM, a review of complaint intake #2624519 revealed concerns related to Resident #90s hearing and vision, which had been reported to facility staff on multiple occasions.<br><br>A review of Resident #90s medical records revealed the resident was admitted to the facility on [DATE], for skilled rehabilitation services. Further review revealed that an initial interdisciplinary care conference was conducted on 04/16/2025, with the resident, two family members, Social Services Director, and Director of Physical Therapy were in attendance.<br><br>Further review of the medical records revealed that the resident was discharged from physical and occupational therapy services on 06/30/2025 and remained in the facility under long term care services until September 2025. Records review failed to show evidence of a care plan meeting nor conference following 04/16/2025.<br><br>On 12/10/2025 at 1:45 PM, the surveyor requested care plan meeting notes and attendance records after 04/16/2025 from the Director of Nursing (DON).<br><br>At 2:10 PM, the Social Services Director informed the surveyor that she was unable to provide the requested information, as no additional care plan meetings were conducted following 04/16/2025. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on observations, record review, and interviews it was determined that the facility failed to maintain professional standards of practice related to oxygen orders. This was evident for 1 (Resident #5) out of 2 residents reviewed for respiratory care.<br><br>The findings include:<br><br>On 12/04/2025 at 1:05 PM, an observation of Resident #5 revealed that the resident was on 4 liters (the amount of oxygen) of oxygen.<br><br>On 12/05/2025 at 10:55 AM, record review failed to reveal an active order for oxygen.<br><br>On 12/05/2025 at 1:21 PM, an interview with the Director of Nursing revealed that the expectation was that if a resident was on oxygen, there should be an order to reflect it. The surveyor reviewed the concern. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, and interviews, it was determined that the facility staff failed to ensure residents received respiratory care consistent with professional standards of practice by: 1) failing to ensure respiratory/oxygen equipment was properly labeled and dated, and 2) providing oxygen therapy without a valid physician order and at flow rates inconsistent with prescribed orders. This deficient practice was evident for 2 residents (Residents #1 and #96) out of 3 residents reviewed for respiratory/oxygen therapy during the facility's recertification/complaint survey.The findings include:The findings include:<br><br>Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from the health care provider.<br><br>Oxygen tubing is a medical-grade hose that connects an oxygen source (like a concentrator or tank) to an oxygen delivery device, such as a nasal cannula or mask. It is designed to be lightweight, flexible, and kink-resistant to ensure a steady and uninterrupted flow of oxygen for therapy.<br><br>Liters per minute (LPM) in oxygen therapy is the prescribed flow rate, measuring how much oxygen is delivered to a patient each minute, to increase the oxygen percentage in the air they breathe, helping to improve blood oxygen levels for conditions like respiratory distress.<br><br>The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement.<br><br>1) On 12/04/2025 at 10:20 AM, during the initial tour of the facility, the surveyor observed Resident #1 in bed receiving oxygen therapy at 3.5 liters per minute (LPM). The oxygen tubing in use was not dated or labeled.<br><br>On 12/04/2025 at 10:24 AM, the Unit Manager, Licensed Practical Nurse (LPN) #4 was called for dual observation. He confirmed that the oxygen tubing was not dated or labeled. When asked about the facility's expectations regarding dating and labeling of oxygen tubing, he stated the tubing should be labeled and dated when initiated and changed weekly per order. When asked when the oxygen therapy for the resident began, he stated the attending provider prescribed oxygen on 12/03/2025 for shortness of breath. When asked what the ordered liter flow rate was, he stated 2 LPM, and confirmed the resident was receiving about 3.5 liters at the time.<br><br>On 12/04/2025 at 10:28 AM, during continued observation, the surveyor observed Resident #96 in bed receiving oxygen at 3.5 liters. The humidifier bottle and oxygen tubing were not dated or labeled.<br><br>On 12/04/2025 at 10:30 AM, the Unit Manager was brought in for dual observation and confirmed the humidifier and oxygen tubing were not dated or labeled. He stated the overnight nurses should have labeled them. When asked when the equipment was last changed, he stated he did not know and would need to review Resident #96's health record.<br><br>On 12/04/2025 at 11:43 PM, the Unit Manager, LPN #4, informed the surveyor that equipment had been labeled for both residents.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 12/05/2025 at 12:16 PM, during a follow-up observation, the surveyor observed Resident #1 receiving oxygen at 3.5 liters per minute with oxygen tubing that was not labeled. The Director of Nursing (DON) was called for dual observation and confirmed that the tubing was not labeled. When asked about the facility's expectations, she stated the tubing should be labeled and dated to ensure timely changes. She stated she would re-educate unit managers and nursing staff regarding the requirement.<br><br>On 12/05/2025 at 12:19 PM, during continued follow-up with Resident #1, the surveyor observed the humidifier had been labeled, but the oxygen tubing remained unlabeled, and oxygen continued to run at 3.5 liters. The surveyor called the DON who was present on the unit at that time for a dual observation and she confirmed again that the tubing was not labeled and reiterated the facility's expectation for proper dating and labeling.<br><br>2) On 12/04/2025 at 10:20 AM, during the initial tour of the facility, the surveyor observed Resident #1 in bed receiving oxygen therapy at 3.5 liters per minute (LPM).<br><br>On 12/04/2025 at 10:24 AM, LPN #4, the Unit Manager, was called for dual observation. When asked when oxygen therapy was initiated for Resident #1, he stated the attending provider prescribed oxygen on 12/03/2025 for shortness of breath. When asked for the ordered flow liter, he stated the resident was to receive 2 LPM and confirmed the resident was receiving about 3.5 LPM at the time of observation.<br><br>On 12/04/2025 at 10:28 AM, during continued observation, the surveyor observed Resident #96 in bed receiving oxygen at 3.5 liters.<br><br>On 12/05/2025 at 10:06 AM, review of Resident #1's electronic health record showed that in his/her MDS assessment dated [DATE], Section J coded the resident as having shortness of breath, and Section O reflected that the resident was not receiving oxygen therapy at that time.<br><br>On 12/05/2025 at 10:10 AM, during a review of Resident #1's physician orders, the surveyor did not see an order for oxygen therapy. The only order present was for labeling oxygen tubing, which the Unit Manager confirmed he had placed after the surveyor informed him that the oxygen tubing was not dated or labeled.<br><br>On 12/05/2025 at 11:52 AM, during a review of Resident #96's electronic health record, the surveyor noted that the resident had an order dated 11/25/2025 stating: OXY Oxygen Inhalation (via nasal cannula at 2 LPM) ATTEMPT TO WEAN. Every shift, check every shift.<br><br>On 12/05/2025 at 12:19 PM, when the surveyor requested Resident #1's oxygen therapy order from the Director of Nursing (DON), she stated she would check and provide it.<br><br>On 12/05/2025 at 12:21 PM, the DON informed the surveyor that there was no oxygen order for the resident and stated that there should have been one in place. She further stated that she would inquire as to why an order had not been obtained.<br><br>On 12/05/2025 at 1:53 PM, the DON informed the surveyor that she had spoken with the physician, who stated that the resident was placed on oxygen at 2 LPM for shortness of breath related to pneumonia. She reported that she had entered the physician's order into Resident #1's electronic record. When informed that the absence of an oxygen order was a concern, she acknowledged the<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | issue and stated that she was implementing measures to audit all residents receiving oxygen to ensure appropriate orders were in place. |

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| F 0728<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that facility staff failed to ensure a geriatric nursing assistant (GNA) maintained an active certification. This deficient practice was evident for 1 (GNA #2) out of 4 GNA employee files reviewed during the annual survey.<br><br>The findings include:<br><br>On [DATE] at 7:30 AM, the surveyor reviewed the employee file for GNA #2, which failed to show evidence of an active GNA license. Further review of the filed revealed that the employee annual performance review was conducted on [DATE].<br><br>On [DATE], a GNA license search was conducted using Maryland Board of Nursing license lookup which revealed a license expiration date of [DATE] with a status of not renewed. The surveyor informed the Director of Nursing of the expired license and requested evidence of an active license and documentation of shifts worked since [DATE].<br><br>On [DATE] at 10:04 AM, during an interview with Human Resources (HR) the surveyor inquired about the process for ensuring nursing employee files are up to date. The HR explained that monthly employee file audits are conducted and a tracking system was used to identify employee who are due for license renewal and annual performance review. The surveyor informed HR of GNA #21 expired license and requested evidence of active license.<br><br>On [DATE] at 1:26 PM, the DON and HR provided the surveyor with GNA #21's work schedule. Review of the schedule revealed that GNA #21 worked every weekend from [DATE] until [DATE] with an expired license. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of records, review of complaints and staff interviews, it was determined that the facility failed to 1) ensure narcotic record books were consistently signed by both incoming and outgoing nurses, 2) ensure that drug records were maintained in a manner that accounted for all controlled drugs and allowed for reconciliation of dispensed and administered medication, and 3) ensure that medication was administered in accordance with physician ordered parameters. This was evident for 8 of 8 medication carts observed during the medication storage task, 2 (Complaint #2646715, #2613978 ) of 5 complaints reviewed, and 1 (Resident #71) of 2 residents reviewed for pharmacy services during the annual survey.<br><br>The findings include:<br><br>The MDS (Minimum Data Set) is a federally mandated, standardized assessment tool used in Skilled Nursing Facilities (SNFs) to comprehensively assess a resident's clinical and functional status. The MDS is used to develop individualized care plans, monitor quality of care, and determine Medicare reimbursement.<br><br>Brief Interview for Mental Status (BIMS) is a quick cognitive screening tool used in healthcare (especially long-term care) to check for memory, orientation, and recall (like remembering three words) in patients, scoring 0-15 to flag potential impairment.<br><br>1) On 12/09/2025 at 8:50 AM, during a medication cart observation on unit 2, the surveyor reviewed the narcotic record book and observed multiple missing signatures.<br><br>During an interview with Registered Nurse (RN) #15 who confirmed the missing signatures, when asked whether narcotics were counted at shift change that morning, RN #15 stated, Yes. When asked about expectations for signing the narcotic record book, she stated that the book should be signed by the incoming nurse and the outgoing nurse.<br><br>On 12/09/2025 at 9:28 AM, during a medication administration observation of Licensed Practical Nurse (LPN) #17 on unit 3, the surveyor reviewed the narcotic record book and observed that it had not been signed that morning by the incoming nurse. LPN #17 confirmed that she was the incoming nurse and stated that the lack of signature was an oversight. The surveyor also observed multiple missing signatures in the narcotic record book. When asked about expectations regarding signing the narcotic record book, LPN #17 stated that the outgoing nurse and incoming nurse were expected to sign the narcotic record book every shift after counting the controlled medications together.<br><br>On 12/09/2025 at 9:49 AM, during an observation of medication cart on unit 4, the surveyor reviewed the narcotic record book and observed that it had not been signed that morning. LPN #13 stated that it had been a busy morning and that she had counted the narcotics with the outgoing nurse but forgot to sign the record. The surveyor also observed multiple missing signatures in the narcotic record book. When asked about expectations for signing the narcotic record book, LPN #13 stated that both the outgoing nurse and incoming nurse were required to sign the narcotic record book across all shifts after completing the count together.<br><br>On 12/09/2025 at 11:32 AM, during an interview with the Director of Nursing (DON), the surveyor (continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | asked about expectations regarding signing narcotic record sheets. The DON stated that incoming and outgoing nurses were expected to count and account for all narcotics at shift change and that both nurses were required to sign the narcotic record sheet. The surveyor discussed the concerns identified during medication observations with the DON, who stated that she would provide education for all staff involved.<br><br>2) On 12/10/2025 at 12:47 PM, review of Complaint #2646715 revealed that on 10/17/2025, a complaint was filed with the State Agency alleging that on 10/04/2025 and/or 10/05/2025, the facility's narcotic record sheet reflected that a controlled substance had been administered to the complainant's loved one; however, the resident reported that he had not received the medication. The complainant further stated that review of the resident's chart did not show documentation that the medication was administered during that period.<br><br>On 12/10/2025 at 12:52 PM, review of Resident #91's clinical record revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 on the Minimum Data Set (MDS) assessment dated [DATE], indicating that the resident was cognitively intact at the time of the alleged incident.<br><br>On 12/11/2025 at 7:15 AM, review of Resident #91's physician orders in the electronic health record revealed an active order dated 09/29/2025 for Oxycodone HCl 5 mg oral tablet, to be administered 5 mg by mouth every six (6) hours as needed for pain rated 5–10.<br><br>On 12/11/2025 at 7:28 AM, review of the controlled drug administration record provided by the pharmacy revealed that Oxycodone HCl 5 mg was removed from the narcotic supply on the following dates and times:<br><br>10/04/2025 (no time documented)<br><br>10/05/2025 at 8:15 AM<br><br>10/05/2025 at 1:56 PM<br><br>10/05/2025 at 9:00 PM<br><br>10/12/2025 at 9:50 AM<br><br>On 12/11/2025 at 7:39 AM, review of the resident's Medication Administration Record (MAR) for October 2025 failed to show documentation that Oxycodone HCl 5 mg was administered to the resident on the above-listed dates, despite the medication being removed from the controlled drug supply.<br><br>On 12/11/2025 at 9:49 AM, during an interview with the Director of Nursing (DON), the surveyor asked about expectations regarding the administration and documentation of controlled substances. The DON stated that the nurse administering a controlled medication was expected to sign the pharmacy-provided controlled drug record to indicate removal of the medication from the narcotic supply and document the remaining count and then sign the MAR to indicate that the medication was administered to the resident. When informed of the discrepancy between the controlled drug removal record and the lack of documentation on the MAR, the DON stated that such practice was not acceptable. The DON further stated that all licensed nursing staff would be educated on proper<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | documentation of controlled substances and that random audits would be conducted to prevent recurrence.<br><br>3a) On 12/10/2025 at 8:50 AM, review of Complaint #2613978 revealed that on 09/10/2025, a complaint was filed with the State Agency alleging that Resident #87 reported experiencing increased pain due to missed pain medication on multiple occasions, which reportedly interfered with the resident's ability to participate in therapy services.<br><br>On 12/10/2025 at 8:57 AM, review of Resident #87's clinical record revealed a MDS discharge assessment dated [DATE], which documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating that the resident was cognitively intact at the time of the complaint.<br><br>On 12/10/2025 at 9:34 AM, review of Resident #87's physician orders revealed an order dated 08/18/2025 for Oxycodone HCl 5 mg oral tablet as follows:<br><br>Give three (3) tablets by mouth every four (4) hours as needed for pain rated 7 to 10, and<br><br>Give two (2) tablets by mouth every four (4) hours as needed for pain rated 4 to 6.<br><br>On 12/10/2025 at 9:59 AM, review of the Medication Administration Record (MAR) revealed that Oxycodone HCl 5 mg, two (2) tablets, prescribed for pain rated 4 to 6, was administered on the following dates and times when the documented pain level did not meet the ordered parameters:<br><br>08/28/2025 at 5:07 AM with pain level of 0<br><br>08/29/2025 at 7:33 PM with pain level of 0<br><br>08/30/2025 at 5:50 AM with pain level of 0<br><br>09/04/2025 at 7:31 PM with pain level of 8<br><br>09/05/2025 at 6:36 AM with pain level of 10<br><br>09/09/2025 at 6:02 AM with pain level of 8<br><br>09/12/2025 at 10:22 AM with pain level of 0<br><br>09/15/2025 at 5:35 PM with pain level of 7<br><br>Further review of the MAR revealed that Oxycodone HCl 5 mg, three (3) tablets, prescribed for pain rated 7 to 10, were administered on the following dates and times when the documented pain level did not meet the ordered parameters:<br><br>08/28/2025 at 00:04 AM with pain level of 0<br><br>08/31/2025 at 6:34 AM with pain level of 0<br><br>08/31/2025 at 10:00 PM with pain level of 5<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 09/05/2025 at 11:45 AM with pain level of 5<br><br>04/06/2025 at 8:16 PM with pain level of 6<br><br>09/09/2025 at 1:31 PM with pain level of 6<br><br>09/10/2025 at 6:00 PM with pain level of 5<br><br>09/11/2025 at 8:34 PM with pain level of 6<br><br>09/12/2025 at 00:37 AM with pain level of 6<br><br>09/18/2025 at 6:33 PM with pain level of 0<br><br>09/19/2025 at 6:49 AM with pain level of 5<br><br>On 12/10/2025 at 12:16 PM, during an interview with the Director of Nursing (DON), the surveyor asked about expectations regarding administration of pain medications. The DON stated that pain medications were to be administered strictly in accordance with physician orders and the prescribed pain scale parameters. When informed of the findings related to both under-medication and over-medication of Resident #87, as well as administration of pain medication when not clinically indicated, the DON acknowledged the concern and stated that the staff involved would be reeducated. The DON further stated that all nursing staff on the unit would receive reeducation regarding adherence to physician orders and proper pain assessment and medication administration.<br><br>3b) On 12/09/2025 at 12:57 PM, a review of Resident #71's Medication Administration Record (MAR) for November and December 2025 revealed that the following medications were administered outside of the physician ordered parameters:<br><br>Doxazosin Mesylate 4mg was ordered to be held for systolic blood pressure (SBP) less than 110mmHg, however, the medication was administered on the following dates:<br><br>11/08/25 SBP of 104/73<br><br>11/11/25 SBP of 99/58.<br><br>12/08/25 SBP of 101/56<br><br>Losartan Potassium-Hydrochlorothiazide 100-25mg was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates:<br><br>11/09/25 SBP of 104/57<br><br>11/11/25 SBP of 99/58.<br><br>Nifedipine 60mg was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates:<br><br>11/10/25 SBP of 102/60<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215226 | A. Building<br>B. Wing | 12/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Advanced Rehab at Autumn Lake Healthcare | 515 Brightfield Road<br>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.

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 11/20/25 SBP of 83/56<br><br>12/05/25 SBP of 106/59<br><br>Carvedilol 25mg, was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates:<br><br>11/10/25 SBP of 102/60<br><br>11/14/25 SBP of 92/57<br><br>12/05/25 SBP of 106/59<br><br>Clonidine 0.1mg, was ordered to be held for SBP less than 110mmHg, however, the medication was administered on the following dates:<br><br>11/05/25 SBP of 106/72<br><br>11/09/25 SBP of 104/57<br><br>11/10/25 SBP of 102/60<br><br>11/20/25 SBP of 97/48<br><br>12/05/25 SBP of 106/59<br><br>Oxycodone 5mg was ordered on 10/27/25, for staff to administer three tablets as needed (PRN) for severe pain rated 7-10 and was discontinued on 11/07/25. The medication was administered on the following dates:<br><br>11/03/25 pain score of 5- medication administered.<br><br>11/04/25 pain score of 6-medication administered.<br><br>11/05/25 pain score of 5-medication administered.<br><br>11/06/25 pain score of 5-medication administered<br><br>11/07/25 at 12:33 AM, pains score of 5-medication administered.<br><br>11/07/25 at 06:31 AM, pain score of 5-medication administered.<br><br>Oxycodone 5mg was ordered on 11/07/25, for staff to administer three tablets PRN for severe pain rated 7-10 and was discontinued on 11/19/25. The medication was administered on the following dates:<br><br>11/10/25 pain score of 4-medication administered.<br><br>11/14/25 pain score of 4-medication administered.<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 11/17/25 pain score of 1-medication administered.<br><br>Oxycodone 5mg was ordered on 11/19/25 for staff to administer three tablets PRN for severe pain of 8-10 and was discontinued on 11/28/2025. The medication was administered on the following dates:<br><br>11/22/25 at 6:30 PM, pain score of 0-medication administered.<br><br>11/22/25 at 9:30 PM, pain score of 0-medication administered.<br><br>11/23/25 pain score of 0-medication administered.<br><br>11/24/25 pain score of 2-medication administered.<br><br>11/27/25 pain score of5-medication administered.<br><br>Oxycodone 5mg was ordered on 11/28/2025 for staff to administer two tablets PRN for pain rated 5-10. The medication was administered on the following dates:<br><br>12/04/25 at 3:03 AM, pain score of 1-medication administered.<br><br>12/04/25 at 6:08 AM, pain score of 0-medication administered.<br><br>12/04/25 at 1:11 PM, pain score of 3-medication administered.<br><br>12/06/25 pain score of 0-medication administered.<br><br>The November 2025 MAR included an order to offer non-pharmacological interventions including repositioning, food or drink, and back rubs prior to administering PRN medication and to document interventions. A review of records from 11/01/2025-11/30/2025 showed these services were not documented as offered prior to medication administration.<br><br>On 12/09/2025 at 1:26 PM, during an interview, the Director of Nursing (DON) explained that staff are expected to administer medications as ordered by the physician's parameters and document when medications are held if the order parameters are not met. The surveyor review Resident #71's MAR for November and December 2025 with the DON which showed medications were administered outside of the physician's parameters. The DON acknowledged the findings and stated staff education would be provided. |

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| | 215226 | A. Building<br>B. Wing | 12/11/2025 |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on record review and interview, it was revealed that the facility failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) form was completed entirely. This was evident for 1 (Resident #26) out of 3 residents reviewed for beneficiary notification.<br><br>The findings include:<br><br>In a nursing home, beneficiary notifications are required notices given to residents or their representatives to inform them of changes in Medicare or Medicaid coverage, services or financial responsibility. These notices explain when covered services are ending, when services may not be covered, any potential costs to the resident, and the resident's right to appeal. Providing timely beneficiary notifications helps protect resident rights and ensures regulatory compliance.<br><br>On 12/11/2025 at 10:12 AM, record review of the SNFABN document revealed that Resident #26's SNFABN form was incomplete. The section which asked the resident which option they would like regarding the billing of Medicare was left blank.<br><br>On 12/11/2025 at 10:12 AM, an interview with Staff #7 revealed that the expectation was that the form should be completely filled out. During the interview, the surveyor reviewed the document noted above with Staff #7, she indicated she was unable to indicate which option the resident chose as none were checked off. She further indicated it should have been filled out entirely including an option marked.<br><br>On 12/11/2025 at 10:30 AM, the concern was addressed with the Director of Nursing and she indicated that she understood. |

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| | 215226 | A. Building<br>B. Wing | 12/11/2025 |

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| Advanced Rehab at Autumn Lake Healthcare | 515 Brightfield Road<br>Lutherville, MD 21093 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, it was determined that facility staff failed to establish infection control interventions to prevent the transmission of infection to residents. This deficient practice was evident for 3 (Resident #55, #3, and #95) of 5 residents reviewed for the infection control task during the annual survey.<br><br>The findings include:<br><br>On 12/04/2025, observations were made of Resident #3 at 9:07 AM, Resident #95 at 11:10 AM, and Resident #55 at 11:43 AM in their assigned rooms. During the observations, the surveyor noted that enhanced barrier precautions (EBP) signage was not posted on the residents' doors, and personal protective equipment (PPE) was not available outside of the residents' rooms.<br><br>A review of Resident #3 medical record revealed an admission to the facility on [DATE], with multiple diagnosis, including orthopedic aftercare. The medical record included an order for daily wound dressing changes, however, further review failed to show an order for EBP.<br><br>A review Resident #95 medical record revealed an admission to the facility on [DATE], with a left femur fracture. The medical records included an order for left lower extremity dressing changes, however, further review failed to show an order for EBP.<br><br>A review of Resident #55's medical record revealed the resident was admitted to the facility on [DATE]. In October 2025, the resident had physician orders for PICC line dressing change, daily wound dressing change, and foley catheter care. Further review of the medical records failed to show an order for EBP. Additionally, on 10/20/2025 the resident was ordered Vancomycin four times daily for Clostridioides Difficile infection; however, the medical records failed to show evidence that transmission-based precautions were ordered.<br><br>On 12/08/2025 at 7:30AM, a review of the medical records for Resident #3, Resident #95, and Resident #55, revealed that the Director of Nursing (DON) entered an order on 12/07/2025, for EBP.<br><br>During an interview on 12/08/2025 at 9:30 AM, the DON stated that EBP are required for residents with tube feedings, foley catheters, and wounds requiring dressing changes. The DON stated that the admitting nurse or unit manager were responsible for ensuring EBP orders were entered. When asked about the lack of EBP orders prior to 12/07/2025 for Resident # 3, Resident #95, and Resident #55, the DON was unable to provide an explanation. Additionally, the DON could not explain why transmission-based precautions were not initiated in October 2025 for Resident #55. |