STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215258	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Spa Creek	35 Milkshake Lane Annapolis, MD 21403

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record reviews and interviews, it was determined that the facility failed to develop/implement care plans for Residents. This was found to be evident for 5 (Resident # 16, #8, #60, #107, and #82) out of 25 Residents reviewed for care plans during the recertification survey. The findings include: 1) A care plan, as defined by CMS (Centers for Medicare & Medicaid Services), is a formal document outlining a resident's medical and personal care needs, treatments, and preferences within a nursing home or other care setting. It serves as a communication tool for the interdisciplinary team to coordinate services and ensure the resident's highest practicable physical, mental, and psychosocial well-being. During a review of Resident #16's medical records conducted on 08/04/25 at 8:47 AM revealed a diagnosis of Dementia and Schizophrenia. A review of Resident #16's care plan conducted on 08/04/25 at 08:50 AM did not show a care plan for Dementia and Schizophrenia. During an interview conducted on 08/04/25 at 9:09 AM, the Director of Nursing (DON) and this Surveyor reviewed Resident #16's care plan. The DON confirmed the care plan did not include Dementia and Schizophrenia. The DON advised that he would revise the Resident's care plan to include Dementia and Schizophrenia. 2) During an observation on 07/30/2025 at 1:52 PM this Surveyor observed multiple scabs and redness on Resident #8's face. The Resident advised that he/she had been diagnosed and treated for dermatitis. A review of Resident #8's diagnoses conducted on 08/04/25 at 12:32 PM revealed a diagnosis of Dermatitis. A review of Resident #8's Medication Administration Record (MAR) conducted on 08/04/25 at 12:36 PM revealed the following order: Ketoconazole Hydrocortisone External Kit 2 & 1 % (Ketoconazole Hydrocortisone). Apply to Forehead and left cheek topically two times a day for Sebbhoric Dermatitis -Order Date 03/06/2024. A review of Resident #8's care plan conducted on 08/04/25 at 12:42 PM did not reveal a care plan for Dermatitis. Psychotropic medications, also known as psychoactive drugs, are medications that affect the brain's (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activity, impacting mental processes and behavior. They are primarily used to treat mental illnesses like depression, anxiety, and psychosis. These drugs work by altering the levels of neurotransmitters, the chemical messengers in the brain. 3) A review of Resident #60's MAR conducted on 08/05/2025 at 12:55 PM revealed the following psychotropic medication orders: Remeron Oral Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for Depression -Order Date 07/10/2025 1808. Clonazepam Oral Tablet 1 MG (Clonazepam) Give 1 tablet by mouth two times a day for anxiety take with food. -Order Date 06/13/2024 1825. A review of Resident #60's physician order conducted on 08/05/25 at 1:02 PM showed the following order: Enter the number that coincides with observation: 0. None 1. Sedation 2. Drowsiness/dizziness 3. Dry mouth/eyes 4. Constipation 5. Blurred vision 6. Extrapyramidal Reactions (involuntary movements) 7. Weight gain/edema 8. Seizures 9. Urinary Retention 10. Tardive Dyskinesia 11. Cognitive/behavior impairment 12. Akathisia 13. Pseudo Parkinsonism 14. Orthostatic hypotension 15. Unsteady balance 16. Other. Every shift for monitoring potential side effects of psychotropic medications Order Date 08/22/24. During a review of Resident #60's care plan conducted on 08/06/25 at 6:32 AM, did not reveal a care plan for psychotropic medications. 4) 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. Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. On 7/31/2025 at 8:22 AM, during an interview with Resident #107, he/she complained that he/she has not been washed up or received shower for approximately 12 days. The shower schedule that was posted in the resident's room indicated Tuesday and Friday between 7:00AM and 3:00 PM. On 7/31/2025 at 10:40 AM, a review of Resident #107's care plan showed no evidence of a care plan specifically developed to address assistance with ADLs for showering and bathing. A review of the Minimum Data Set with an Assessment Reference Date (ARD) of 6/30/25 indicated that Resident #107 required the following: - Partial/ moderate assistance with Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excluding washing of back and hair). Does not include transferring in/out of tub/shower. - Setup/clean-up help with Tub/shower transfer: The ability to get in and out of a tub/shower. On 8/01/2025 at 12:10 PM, during an interview with the Director of Nursing (DON), he confirmed that the residents' care plans were initiated and updated by Supervisors, Unit Managers (UM), Director of Nursing (DON), Assistant Director of Nursing (ADON), MDS Nurse and the Infection Control nurse. He added that care plans were updated quarterly and as needed when there were changes in condition. The DON was notified of the concern and stated he would inform the MDS nurse immediately to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	update Resident #107's care plan. On 8/01/2025 at 1:01 PM, the surveyor informed the Nursing Home Administrator (NHA) of the concern, and a copy of Resident #107's care plan was requested. On 8/01/2025 at 1:12 PM, the surveyor received a copy of Resident 107's care plan which showed that an intervention was added on 8/1/25: Assist and encourage resident to participate to the fullest extent possible with bathing or Shower. 5) On the initial tour of the facility on 7/30/2025, the surveyor observed Resident #82 who was alert and oriented x4, in no distress and lying in bed. Resident #82 stated that he/she was diabetic and received insulin injections. A comprehensive care plan is a detailed, individualized document outlining a Resident's medical, emotional, and daily living needs, developed by an interdisciplinary team. It serves as a central resource for all healthcare providers, ensuring coordinated, Resident-centered care across various settings. This plan is dynamic, meaning it is updated as the Resident's condition changes, and it helps prevent errors, promote communication, and improve Resident outcomes. The key components of the care plan include medical summary, emergency care, daily care, goals of care, interventions, social and emotional needs, and advanced directives. The purpose and the benefits of the care plan include improved communication and coordination, reduced medical errors, enhanced Resident-centered care, increased efficiency, and better outcomes. The main reasons to complete a comprehensive care plan are Resident-centered care, nursing team collaboration, documentation and compliance, and assessment, diagnosis, outcomes and planning, implementation, and evaluation. During record review of Resident #82's electronic medical record on 8/4/2025 at 9:30 AM it was revealed that the Resident had a medical diagnosis of Diabetes Mellitus and a physician order for Insulin in the morning and at bedtime for diabetes. Further review of the medical record revealed that Resident #82 did not have a comprehensive care plan for insulin and Diabetes Mellitus. In an interview with the Director of Nursing (DON) at 10:25 AM on 8/4/2025 the surveyor conveyed that Resident #82 had a physician order for insulin and a medical diagnosis of Diabetes Mellitus; however, there was not a care plan developed/implemented for the diagnosis of diabetes mellitus or for insulin. The Director of Nursing (DON) reviewed Resident #82's comprehensive care plan and physician orders and acknowledged that Resident did have a physician order for insulin since admission to the facility on 5/6/2025 and did not have a plan of care for the diagnosis of Diabetes Mellitus and insulin. At 11:00 AM on 8/4/2025, the DON provided a copy of Resident #82's care plan which now included a plan of care for diabetes mellitus and an intervention for diabetes medication as ordered by the doctor. The care plan was date stamped 8/4/2025. The DON acknowledged that the care plan was completed after surveyor intervention. At 11:30 AM on 8/4/2025, the Licensed Nursing Home Administrator (LNHA) was notified that Resident #82 had a physician order for insulin and a diagnosis of diabetes but did not have a comprehensive care plan developed/implemented for diabetes and insulin until surveyor intervention. No additional information was provided by the facility at the time of survey exit.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews and record reviews it was determined that the facility failed to ensure staff provided services that met professional standards of practice. This was found to be evident for 5 (Resident #55, #131, #81, #142, and #96) out of 5 Residents reviewed for Services Meet Professional Standards of Practice during the recertification survey.The findings include: 1) During a medication administration observation conducted on 07/31/25 at 7:31 AM, this Surveyor observed License Practice Nurse (LPN) #4 administer Resident #55’s morning medications. The following medications were administered: Amlodipine 10 mg (milligram)1 tab (tablet) Aspirin 81 mg 1 tab, Escitalopram Oxala 5 mg 1 tab, Losartan Potassium 100 mg 1 tab, Metoprolol 25 mg 1 tab, and Vitamin D 25 mcg (microgram) 1000 iu (international unit). During a review of Resident #55’s Medication Administration Record (MAR) conducted on 07/31/25 at 7:41AM, it was discovered that LPN #4 documented that she administered Bio freeze topical to the right foot. However, during the medication administration observation this Surveyor did not observe the LPN administer that medication. 2) During a medication administration observation conducted on 07/31/25 at 7:48 AM, this Surveyor observed LPN #4 administer Resident #131’s morning medications. The following medications were administered: Multivitamin Centrum Sil 300 -600 mcg 1 tab, Levothyroxine 125 mcg 1 tab before meal, Gabapentin 300 mg 1-tab, Ferrous Sulfate 325 mg elemental 65 mg 1 tab, Pantoprazole 40 mg 1 tab, 30 cc (cubic centimeter) Lactulose and 1 Lidocaine patch 4%. During the application of the Lidocaine 4% patch, Resident #131 advised LPN #4 that the night shift had placed a Lidocaine patch on his/her lower right back. The LPN removed the Lidocaine patch dated 07/31/25 11p-7a and placed her Lidocaine 4% patch on the Resident. During an interview following the medication administration observation, this Surveyor discussed the concern that the Lidocaine patch would now be applied to Resident #131 for an extended period time. When asked what the facility’s expectation was when there was a discrepancy in a medication administration, the LPN #4 replied that she had to follow the MAR. During a review of Resident #55’s MAR conducted on 07/31/25 at 8:07 AM, it was discovered that LPN #4 signed off on an order for Bio Freeze apply to right foot that she administered the medication. However, this Surveyor did not observe the LPN administer that medication. During a review of Resident #131’s MAR conducted on 07/31/25 at 8:09 AM, it was discovered that LPN #4 signed off that that she administered 1 tab of Entecavir oral. However, during the medication administration observation this Surveyor did not observe the LPN administer that medication. A review of the Lidocaine patch order showed there were two active orders for the Lidocaine patch: Lidocaine External Patch 4% apply to lower right Back topically in the morning for pain remove at PM (after midday) and remove per schedule – Apply 0800 Remove 1959 Order Date - 12/13/24; and Lidoderm External Patch 5% (Lidocaine) apply to lower back topically in the morning for back pain leave on 12 hours only Order date- 07/29/25 Apply 0600. During an interview conducted on 07/31/25 at 8:13 AM, LPN #4 acknowledged that she had not (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	applied Resident #55’s Bio Freeze to the right foot. The LPN further stated that she spoke with her unit manager and had Resident #131’s Lidocaine orders clarified. After clarifying the orders, the order for Lidoderm (Lidocaine) 5% was discontinued. The LPN stated that she believed that she administered the Resident #131’s 1 tab of Entecavir oral medication. However, the LPN admitted that prior to administering the medications this Surveyor and the LPN reviewed each medication that was to be administered and Entecavir was not included in the medications reviewed. 3) During Resident #81’s medication administration observation conducted on 07/31/25 at 8:18 AM, LPN #11 administered the following medications: Aspirin 81 mg 1 tab, Amlodipine 10 mg 1 tab, Carvedilol 3.125mg 1 tab, Escitalopram Oxalate 10 mg 1 tab, Hydralizam HCL 25 mg 1 tab, and Multivitamin. During a review of Resident #81’s MAR it was discovered that LPN #11 signed off that she administered 1 tab of Brillanta Oral tab 90 mg. However, this Surveyor did not observe this medication administered. 4) A PEG tube, or Percutaneous Endoscopic Gastrostomy tube, is a feeding tube inserted through the abdominal wall into the stomach, providing direct access for nutrition, hydration, and medication. It's used when a person can't safely swallow or eat enough to meet their nutritional needs. During Resident #142’s medication administration observation conducted on 07/31/25 at 8:32 AM. This Surveyor observed LPN #11 crush each of the following medications individually and place each medication in a separate medication cup in preparation to administer them in the Resident’s PEG tube. The following medications were crushed: Clopidogrel 75 mg 1 tab, Metformin HCL 100 mg 1-tab, Ferrous Sulfate 325 mg 1 tab, Lisinopril 2.5 mg 1 tab, Aspirin 81 mg 1 tab, and Senna enteric coated 5 mg. The bottle of Senna reads enteric coated do not crush. This Surveyor observed LPN #11 fill each medication cup with 30 ml (millimeters) of warm water and then flushed the Peg tube with 30 ml of water. The LPN began to administer each medication separately. The LPN flushed the PEG tube after each medication alternating the amount of water between 10 ml, 20 ml, and 30 ml. Once the medications were administered this Surveyor observed undissolved medication in each medication cup. During an interview with LPN #11 following the medication administration, this Surveyor expressed concern that Resident #142 had not received the full dosage of each medication. The LPN agreed and stated that “it’s impossible to dissolve the medications.” During a review of Resident’s #142’s MAR, it was discovered that LPN #11 signed off on an order for Omeprazole Oral Tablet Release 20 mg Order Date- 07/25/25 at 2139. However, this Surveyor did not observe LPN #11 administer that medication. A continued review of the MAR showed an order that stated: “Enteral Feed: Flush tube with 15 ml of water before each medication pass every shift Order Date – 07/25/25 at 2040.” Another order stated: “Flush tube with at least 15 ml of water after final medication every shift Order date- 07/25/25 at 2040.” During a follow up interview conducted on 07/31/25 at 12:09 PM, LPN #11 reviewed Resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	81’s MAR and confirmed that she had not administered Brillanta 90 mg. During a review of Resident #142’s MAR, LPN #11 confirmed that she had not administered Omeprazole Oral Table 20 mg. She also reviewed the order for flushing before each medication administration and acknowledged that she did not follow the order to flush with 15 ml of water before each medication. An interview was conducted on 07/31/25 at 1:07 PM with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). During the interview the DON stated he would notify the physician of the missed medications and incomplete dosages of medications administered. He further stated that he would provide an in-service on the education of proper medication administration and following physician orders. 5) During an interview conducted on 08/04/25 at 2:14 PM, Resident #96 reported that on the evening of 08/01/25 he/she felt anxious. The Resident explained that his/her anxiety had been previously treated with 1 mg of Lorazepam. The Resident stated that he/she advised License Practice Nurse (LPN) #12 of his/her anxiety and requested Lorazepam. The Resident further stated that LPN #12 returned and advised that the Lorazepam order had been discontinued and she would need to contact the physician. The LPN returned and informed the Resident that the Physician ordered 0.5 mg (milligram) of Lorazepam. The Resident reported that he/she told the LPN that the dose was incorrect and that his/her anxiety had been previously treated effectively with 1 mg of Lorazepam. According to the Resident the LPN did not administer the medication nor communicate that she would contact the Physician. The Resident advised as a result his/her anxiety was not treated. On 08/04/2025 at approximately 3:00 PM, this surveyor conducted a record review of Resident #96’s Medication Administration Record (MAR) for July and August 2025. The July 2025 MAR showed that Resident #96 had an order for Lorazepam Oral Tablet 0.5 MG with instructions to “Give 0.5 tablet by mouth every 12 hours as needed for anxiety for 14 days. May give two ½ tabs of (0.5 mg) to equal 1 mg dosing until med supply complete, then can switch to full tab of 1 mg.” This order was placed on 07/17/2025 at 12:22 PM. The MAR indicated that Resident #96 had received this medication and that it had been effective on July 19th, 20th, 25th, 27th, and 28th. On 08/04/2025 at approximately 3:10 PM, this surveyor conducted a continued review of Resident #96’s Medication Administration Record (MAR) for August 2025. The MAR showed that Lorazepam Oral Tablet 0.5 mg was ordered on 07/31/2025 at 11:45 PM to “Give 2 tablets by mouth every 12 hours as needed for anxiety for 1 day,” which was discontinued on 08/01/2025 at 4:34 PM. A subsequent order for Lorazepam 0.5 mg was started on 08/01/2025 at 4:32 PM to “Give 0.5 tablet by mouth every 12 hours as needed for anxiety for 14 days.” According to the MAR, there was no documentation showing that this medication was administered to Resident #96 on 08/01/2025. This order was discontinued on 08/04/2025 at 11:47 AM, and a new order was initiated at that time to “Give 2 tablets by mouth every 12 hours as needed for anxiety for 14 days.” On 08/04/2025 at approximately 3:30 PM, this surveyor conducted a record review of #96’s progress notes. A note documented by the Advanced Practice Nurse (APN) on 08/01/2025 at 12:46 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM stated, “Communication from patient received via nurse requesting a medication. Counseled that bridge supply will be ordered until evaluated by the primary team. Patient was prescribed 0.5 mg Lorazepam tablet, take 2 tablets by mouth twice daily for anxiety. This fell off the MAR this evening. Patient requesting a dose. No previous side effects reported.” At this time, there were no progress notes found that discussed Resident #96 requesting the lorazepam dose be changed to 1 mg instead of 0.5 mg. On 08/05/2025 at 9:00 AM, this surveyor attempted to contact LPN #12, who cared for Resident #96 on 08/01/2025, for an interview. There was no answer, and a voicemail was left. On 08/05/2025 at 10:00 AM, this surveyor conducted an interview with the Director of Nursing (DON) to discuss his expectations when a resident refuses medication. The DON stated that if a resident refuses any medication, the nurse is expected to notify the physician by calling the on-call doctor and documenting the notification in a progress note. When asked about the procedure if the medication offered is not the correct dose or if the resident requests a different dose, the DON responded that the nurse should notify the physician, who will then decide how to proceed. During the interview, the surveyor informed the DON of concerns that Resident #96 did not receive the lorazepam needed for anxiety. Specifically, Resident #96 had requested a 1 mg dose instead of 0.5 mg, and there was no documentation indicating that LPN #12 had contacted the physician to report the resident’s refusal or to request a medication change. The DON stated he would need to speak with the nurse to clarify what had occurred. On 08/05/2025 at 12:00 PM, this surveyor conducted record review of the narcotic book, which showed an order for Lorazepam 0.5 mg under Resident #96’s name. For the date 08/01/2025, the entry stated “Wasted 1 tablet,” signed with a signature bearing the same first initial and full last name as LPN #12. A photograph of this page in the narcotic book was taken at that time.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews and record reviews it was determined that the facility failed to ensure medications were administered with a 5% or less error rate. This was found to be evident for 12 errors out of 31 medication administration opportunities that resulted in an error rate of 38.71% during the recertification survey. The findings include: 1) During a medication administration observation conducted on 07/31/25 at 7:31 AM, this Surveyor observed License Practice Nurse (LPN) #4 administer Resident #55's morning medications. The following medications were administered: Amlodipine 10 mg (milligram)1 tab (tablet) Aspirin 81 mg 1 tab, Escitalopram Oxala 5 mg 1 tab, Losartan Potassium 100 mg 1 tab, Metoprolol 25 mg 1 tab, and Vitamin D 25 mcg (microgram) 1000 iu (international unit). During a review of Resident #55's Medication Administration Record (MAR) conducted on 07/31/25 at 7:41AM, it was discovered that LPN #4 documented that she administered Bio freeze topical to the right foot. However, during the medication administration observation this Surveyor did not observe the LPN administer that medication. 2) During a medication administration observation conducted on 07/31/25 at 7:48 AM, this Surveyor observed LPN #4 administer Resident #131's morning medications. The following medications were administered: Multivitamin Centrum Sil 300 -600 mcg 1 tab, Levothyroxine 125 mcg 1 tab before meal, Gabapentin 300 mg 1-tab, Ferrous Sulfate 325 mg elemental 65 mg 1 tab, Pantoprazole 40 mg 1 tab, 30 cc (cubic centimeter) Lactulose and 1 Lidocaine patch 4%. During the application of the Lidocaine 4% patch, Resident #131 advised LPN #4 that the night shift had placed a Lidocaine patch on his/her lower right back. The LPN removed the Lidocaine patch dated 07/31/25 11p-7a and placed the Lidocaine 4% patch on the Resident. During an interview following the medication administration observation, this Surveyor discussed the concern that the Lidocaine patch would now be applied to Resident #131 for an extended period time. When asked what the facility's expectation was when there was a discrepancy in a medication administration, the LPN #4 replied that she had to follow the MAR.During a review of Resident #55's MAR conducted on 07/31/25 at 8:07 AM, it was discovered that LPN #4 signed off on an order for Bio Freeze apply to right foot that she administered the medication. However, this Surveyor did not observe the LPN administer that medication. During a review of Resident #131's MAR conducted on 07/31/25 at 8:09 AM, it was discovered that LPN #4 signed off that that she administered 1 tab of Entecavir oral. However, during the medication administration observation this Surveyor did not observe the LPN administer that medication. A review of the Lidocaine patch order showed there were two active orders for the Lidocaine patch: Lidocaine External Patch 4% apply to lower right Back topically in the morning for pain remove at PM (after midday) and remove per schedule - Apply 0800 Remove 1959 Order Date - 12/13/24; and Lidoderm External Patch 5% (Lidocaine) apply to lower back topically in the morning for back pain leave on 12 hours only Order date- 07/29/25 Apply 0600. During an interview conducted on 07/31/25 at 8:13 AM, LPN #4 acknowledged that she had not applied Resident #55's Bio Freeze to the right foot. The LPN further stated that she spoke with her unit manager and had Resident #131's Lidocaine orders clarified. After clarifying the orders, the order for Lidoderm (Lidocaine) 5% was discontinued. The LPN stated that she believed that she administered the Resident #131's 1 tab of Entecavir oral medication. However, the LPN admitted that prior to administering the medications this Surveyor and the LPN reviewed each medication that was to be administered and Entecavir was not included in the medications reviewed. 3) During Resident #81's medication administration observation conducted on 07/31/25 at 8:18 AM, LPN #11 administered the following medications: Aspirin 81 mg 1 tab, Amlodipine 10 mg 1 tab, Carvedilol 3.125mg 1 tab, Escitalopram Oxalate 10 mg 1 tab, Hydralizam HCL 25 mg 1 tab, and Multivitamin. During a review of Resident #81's MAR it was discovered that LPN #11 signed off that she administered 1 tab of Brillanta Oral tab 90 mg. However, this Surveyor did not observe this medication administered. 4) A PEG tube, or Percutaneous Endoscopic Gastrostomy tube, is a feeding tube inserted through the abdominal wall into the stomach, providing direct access for nutrition, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hydration, and medication. It's used when a person can't safely swallow or eat enough to meet their nutritional needs. During Resident #142's medication administration observation conducted on 07/31/25 at 8:32 AM. This Surveyor observed LPN #11 crush each of the following medications individually and place each medication in a separate medication cup in preparation to administer them in the Resident's PEG tube. The following medications were crushed: Clopidogrel 75 mg 1 tab, Metformin HCL 100 mg 1-tab, Ferrous Sulfate 325 mg 1 tab, Lisinopril 2.5 mg 1 tab, Aspirin 81 mg 1 tab, and Senna enteric coated 5 mg. The bottle of Senna reads enteric coated do not crush. This Surveyor observed LPN #11 fill each medication cup with 30 ml (millimeters) of warm water and then flushed the Peg tube with 30 ml of water. The LPN began to administer each medication separately. The LPN flushed the PEG tube after each medication alternating the amount of water between 10 ml, 20 ml, and 30 ml. Once the medications were administered this Surveyor observed undissolved medication in each medication cup. During an interview with LPN #11 following the medication administration, this Surveyor expressed concern that Resident #142 had not received the full dosage of each medication. The LPN agreed and stated that it's impossible to dissolve the medications.During a review of Resident's #142's MAR, it was discovered that LPN #11 signed off on an order for Omeprazole Oral Tablet Release 20 mg Order Date- 07/25/25 at 2139. However, this Surveyor did not observe LPN #11 administer that medication. A continued review of the MAR showed an order that stated: Enteral Feed: Flush tube with 15 ml of water before each medication pass every shift Order Date - 07/25/25 at 2040. Another order stated: Flush tube with at least 15 ml of water after final medication every shift Order date- 07/25/25 at 2040.During a follow up interview conducted on 07/31/25 at 12:09 PM, LPN #11 reviewed Resident 81's MAR and confirmed that she had not administered Brillanta 90 mg. During a review of Resident #142's MAR, LPN #11 confirmed that she had not administered Omeprazole Oral Table 20 mg. She also reviewed the order for flushing before each medication administration and acknowledged that she did not follow the order to flush with 15 ml of water before each medication. An interview was conducted on 07/31/25 at 1:07 PM with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). During the interview the DON stated he would notify the physician of the missed medications and incomplete dosages of medications administered. He further stated that he would provide an in-service on the education of proper medication administration and following physician orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews it was determined that the facility failed to ensure that 1) the medication refrigerator was used to store only medications and 2) medications were stored properly in the medication carts. This was found to be evident for 1 (1st floor medication refrigerator) out of 2 medication refrigerators and 3 out of 4 medication carts observed for medication storage during the recertification survey. The findings include: 1) An observation was conducted on 08/05/25 at 6:06 AM in the first-floor storage room. This Surveyor and License Practical Nurse (LPN) Supervisor #1 observed 1 16-ounce cup full of half and half creamers in the medication refrigerator.2) According to the National Institute of Health diabetes is a disease that occurs when your blood glucose, also called blood sugar, is too high. Glucose is your body's main source of energy. Your body can make glucose, but glucose also comes from the food you eat.An insulin pen is an injection device that you can use to deliver preloaded insulin into your subcutaneous tissue - the innermost layer of skin in your body. These pens are one form of insulin therapy for people with diabetes.An observation of the medication cart Prospect Bay 1 PO was conducted on 08/05/25 at 6:22 AM. This Surveyor and LPN Supervisor #1 discovered Resident #77's Glargine insulin pen that was dated 07/20/25 however the insulin pen was unopened and in a pharmacy bag with a label that said refrigerate until opened. Another insulin pen was discovered for Resident #123, a Lantus Solostar insulin pen was found to be undated and unopened in pharmacy bag with a label that read refrigerate until opened. An observation was conducted on 08/05/25 at 6:53 AM on the 2nd floor Lighthouse medication cart. This Surveyor and Unit Manager #9 observed an insulin pen for Resident #58. The Basaglar Kwik insulin pen was undated and unopened in a pharmacy bag labeled refrigerate until opened. In another medication cart on the 2nd floor nursing unit there was an undated opened Tresiba FlexTouch insulin pen for Resident #113 and a Basaglar Kwikpen insulin pen for Resident # 111 that was undated but opened. The UM advised that Resident #111 no longer resided in the facility, and the insulin pen should have been removed from the medication cart and destroyed. During an interview with the Director of Nursing (DON) conducted on 08/05/25 at 7:33 AM, the DON stated that he would provide in-services on the storage of insulin pens, proper use of the medication refrigerators and discarding of medications for discharged residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility staff interviews and surveyor record review, it was determined that the facility failed to maintain proper sanitation for storage of food on the nursing units and in the kitchen. This was found to be evident on 2 out of 3 nursing units and on the initial and follow-up tours of the kitchen during review of food storage and sanitation.The findings include:During the initial tour of the kitchen on 7/30/2025 at 07:50 AM with the Food Services Director (FSD) in attendance, the surveyor observed the following sanitation concerns: several cardboard boxes directly on the floor in the dry storage room; employee personal items (green bag with water bottle) on the top shelf in the dry storage room; no label on the angel food cake in the walk-in freezer; 2 water bottles 1/2 full in the walk-in refrigerator on the 2nd shelf in a metal container labeled staff; and a dented lid on a can of beef stew that was not stored on the designated shelf for dented food items in the dry storage room.In an interview during the initial tour of the kitchen on 7/30/2025 with the Food Services Director (FSD) he acknowledged the surveyor's sanitation concerns and removed the employee water bottles and personal items from the walk-in refrigerator and the dry storage room, labeled/dated the angel food cake in the walk-in freezer, and placed the can of beef stew with the dented lid on the designated shelf for dented food items in the dry storage room.In a follow-up visit to the kitchen at 11:00 AM on 7/30/2025, the surveyor reviewed the sanitation concerns with the Director of Operations (DOO) for Healthcare Services Group that were identified by the surveyor during the initial tour of the kitchen with the FSD. The DOO acknowledged the surveyor's sanitation concerns. Healthcare Services Group was a contract company that the facility used for the dietary department.At 6:45 AM on 7/31/2025 the surveyor conducted an observation of the nourishment refrigerator in the 1st floor Pantry room of the facility with the 1st floor Unit Manager (employee #1) in attendance. The surveyor observed that the 1st floor nourishment refrigerator was broken and there was a sign on the door that indicated Do Not Use. There was a small freezer in the 1st floor pantry room and in the freezer was a 32-ounce jar of applesauce 1/2 full with no date when the applesauce was opened. The 1st floor Unit Manager (employee #1) discarded the applesauce in the trash. The surveyor conducted an observation of the 2nd floor Pantry room on 7/31/2025 at 6:55 AM with the Director of Nursing (DON) in attendance. The surveyor observed the following in the 2nd floor nourishment refrigerator located in the Pantry room: multiple food items that were not labeled and dated with Resident names; 3 1/2 full water bottles not labeled and dated; take-out entree of food not labeled and dated; plastic cup with lid and straw 1/2 full of a red-colored liquid not labeled and dated; and several food items stored in a brown leather bag not labeled and dated.In an interview with the Director of Nursing (DON) following the observations of the nourishment refrigerators in the Pantry rooms on 7/31/2025, the surveyor asked what the expectation was for labeling and dating the food items. The DON stated that the items in the nourishment refrigerators were to be labeled and dated with Residents' names and discarded after 72 hours, and the nourishment refrigerators in the Pantry rooms were for Residents' food/beverage items and not for the staff.On 7/31/2025 at 1:30 PM the surveyor reviewed the facility's policy for Food: Safe Handling for Foods from Visitors dated 2/2023 from the Dining Services Policy and Procedure Manual for Healthcare Services Group. The policy indicated that the food items were to be labeled and dated with the Resident name and the current date, and food items were to be discarded if stored for 7 days or greater. Additionally, the policy indicated that the Residents' food items were stored separately or easily distinguishable from the facility food.In a follow-up visit to the kitchen on 8/5/2025 at 11:00 AM the surveyor observed the lunch meal tray line service with the District Food Service Manager (DFSM). During the observation of the meal tray line service, the surveyor observed a water bottle and a plastic cup with a straw 1/2 full of an orange-colored liquid on the shelf above the sink, and an employee backpack and a water bottle on the shelf above the other sink. In an interview with the DFSM during the meal tray line (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	service on 8/5/2025, the DFSM acknowledged the surveyor's sanitation concerns and removed the 2 water bottles, plastic cup with the orange-colored liquid, and the employee backpack from the shelves above the sinks.No additional information was provided by the facility at the time of survey exit.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record reviews and interview, it was determined that the facility failed to ensure 1) immunization education was provided to Residents and 2) an immunization was offered. This was found to be evident for 5 (Resident #33, #14, #16, #10, and #58) out of 5 Residents reviewed for immunizations during the recertification survey.The findings include: 1)A review of Resident #33's immunization record conducted on 08/05/2025 at 9:08 AM revealed the resident received Pneumococcal conjugate vaccine 20-valent (PCV20) (216) on 07/10/2025. However, the medical record review confirmed the education regarding the Pneumococcal conjugate vaccine 20-valent (PCV20) (216) was not provided to the Resident or Resident Representative if applicable. A review of Resident #14's immunization record conducted on 08/05/25 at 9:17 AM revealed the Resident received TB step Mantoux Skin Test - Step 1 & 2. However, education was not provided. During a review of Resident # 16's immunization record conducted on 08/05/25 at 9:35 AM revealed the Resident received Pneumococcal conjugate vaccine 20-valent (PCV20) (216). However, education was not provided to the Resident's Representative. During a review of Resident #10's immunization record conducted on 08/05/25 at 9:47 AM revealed the resident's family refused SARS-COV-2 (COVID-19) Spikevax (Moderna) Fall 2024 (312). However, no education was provided for the Resident's family. A review of Resident's #58's immunization record conducted on 08/05/25vat 10:07 AM revealed that the Resident Influenza (standard dose syringe) (171) on 10/17/24 but was not provided education. On 08/05/25 at 11:37 AM an interview with the Infection Control Preventionist (ICP) conducted. The ICP reviewed the immunizations of Resident #33, #14, #16, and #10 and confirmed the Residents had not received immunization education.2)During a review of Resident #58's immunization record was conducted on 08/05/25 at 11:42 AM. The review revealed that Resident #58 was due for the pneumococcal vaccine on 11/19/24 and now was overdue. Additionally, the ICP reviewed Resident #58's immunization record and confirmed that the Resident had not received the pneumococcal vaccine since 11/19/24.During an interview conducted on 08/05/25 at 11:46 AM, the ICP confirmed that Resident #58 was overdue for the facility to offer the pneumococcal vaccine.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on surveyor observations, staff interviews and surveyor record reviews, it was determined that the facility failed to ensure the dignity of Residents. This finding was found to be evident in 2 (Resident #99 and #143) out of 2 Residents reviewed for Resident Rights.The findings include:An indwelling Foley catheter is a flexible tube inserted through the urethra (the tube that carries urine from the urinary bladder to the outside of the body) into the bladder to drain urine. A small balloon inflated with sterile water secures it in place. The indwelling Foley catheter is connected to a drainage bag for urine collection.On tour of the facility at 9:30 AM on 7/30/2025 the surveyor observed Resident #143 in bed, and a Foley catheter drainage bag was attached to the Resident's bed frame. The Foley catheter drainage bag was not covered with a privacy barrier/covering and urine was visible in the Foley catheter drainage bag.The surveyor conducted a record review of Resident #143's electronic medical record on 7/31/2025 at 7:35 AM. Review of the medical record revealed that Resident #143 had a physician order dated 7/28/2025 for a Foley catheter and to empty the catheter drainage bag at least once every eight hours. Resident #143 observed at 7:15 AM on 8/4/2025 in bed with Foley catheter drainage bag hanging on the bed frame. The Foley catheter drainage bag did not have a privacy barrier/covering on the drainage bag, and the drainage bag had urine in the bag which was visible from the hallway.On 8/4/2025 at 2:45 PM the surveyor reviewed that facility's policy and procedure for catheter care dated 1/26/2023 from The Compliance Store platform. The policy indicated that the facility was to ensure that Residents with indwelling catheters received appropriate catheter care and maintained their dignity and privacy when indwelling catheters were in use. The policy further indicated that privacy bags would be available, catheter drainage bags would be covered at all times while in use, and drainage bags would be emptied when bag was half-full or every 3 to 6 hours.In an interview with the Director of Nursing (DON) at 3:15 pm 8/4/2025, the surveyor asked what the expectation was for Foley catheter drainage bags to be covered with a privacy barrier/covering. The DON stated that the facility had Foley catheter drainage bags that had a grayish-blue color privacy barrier that covered the Foley catheter drainage bag. The surveyor conveyed to the DON that Resident #143 did not have the Foley catheter drainage bag that had a protective barrier/covering. DON acknowledged surveyor. On 7/30/2025 at 12:45 PM Resident #99 was observed sitting in the wheelchair in the vending machine room which was located near the lobby of the facility. Resident #99 was dressed in shorts and had a urinary drainage leg bag secured to his/her right leg with urine visible in the leg bag. At 2:15 PM on 7/30/2025 Resident #99 was observed sitting in the wheelchair at the 1st floor nursing station with the urinary drainage leg bag secured to his/her right leg with urine visible in the leg bag.The surveyor conducted a record review of Resident #99's electronic medical record on 7/31/2025 at 7:55 AM and the review revealed that Resident #99 had physician orders dated 7/4/2025 for a Foley catheter, to empty the catheter drainage bag at least once every eight hours and may use leg bag if desired when out of bed.In the interview with the Director of Nursing (DON) at 3:15 pm on 8/4/2025 the surveyor conveyed to the DON that Resident #99 was observed in the vending machine room and at the 1st floor nursing station on 7/30/2025 with the urinary drainage leg bag attached to his/her leg with urine visible in the leg bag. The DON stated that the facility does not have a protective barrier/covering for the leg bags; however, the expectation for Residents with leg bags was that the Residents should have a sheet covering placed over their legs when out of bed to protect the Resident's privacy and dignity. The surveyor conveyed that Resident #99 was not observed with a sheet covering on his/her legs at either time of the surveyor observations. DON acknowledged the surveyor and stated that he was aware.No additional information was provided by the facility at the time of survey exit.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, it was determined that the facility failed to provide access to resident's funds during non-banking hours. This was found to be evident for 1 (Resident #41) out of 1 resident reviewed for personal funds. The findings include:On 07/30/2025 at 03:12 PM, during an interview with Resident #41, he/she reported that residents were not able to access their personal funds on the weekends. On 08/01/2025 at 11:53 AM, during an interview with the Business Office Manager (BOM), she stated that residents can obtain money on the weekends. She reported that the front desk staff have access to the safe during banking hours, and when they are not present, the nurse supervisor can access the safe 24/7. However, she explained that this has never occurred, as residents have not requested money on weekends, and all residents typically receive their money for the weekends on Fridays. The BOM confirmed that resident banking hours are Monday through Friday from 9:00 AM to 4:00 PM, and residents can withdraw money during these hours. She stated that after these hours, the nurse supervisor is able to access the safe, but reiterated that this has never been necessary. She further stated that the solution would be to provide the night supervisors with the code in the event they need to access the safe.On 08/01/2025 at approximately 1:00 PM, this surveyor conducted an interview with Unit Manager #9. It was confirmed that the Unit Manager position is the same as the nurse supervisor role. This surveyor then asked her to confirm whether the nurse supervisor/unit manager is able to access the safe containing residents' personal funds during non-banking hours, such as evenings and weekends. Unit Manager #9 stated that she was not sure, as she is only present during banking hours. She added that she did not believe this was the case, but would need to confirm with the BOM first.On 08/01/2025 at 2:12 PM, during an interview with the Administrator, the topic of residents' access to their personal funds was discussed. The Administrator stated that the facility does not typically give money to residents on weekends. She reported that the hours during which residents can obtain their money are posted at the front desk. When asked about residents' access to their personal funds during non-banking hours, such as weekends, she confirmed that residents usually do not have access to their funds at those times. She further confirmed that the facility does not have a designated person who can access the safe outside of regular hours. When asked if residents would be able to access their funds when the Administrator, the Director of Nursing, the BOM and the front desk attendant were not in the building, she stated they would not.On 08/01/2025 at 2:26 PM, this surveyor reviewed the copy of a sign provided by the Administrator, which was posted at the front desk. The sign stated, Residents only banking hours: Monday-Friday, 9:00 AM to 4:00 PM.On 08/01/2025 at approximately 4:30 PM, this surveyor conducted an interview with the Administrator and the Regional Director of Nursing to explain the concern that residents do not have access to their personal funds outside of the posted banking hours and not on weekends.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observations and facility staff interview it was determined that the facility failed to provide a safe, clean, comfortable homelike environment for Residents. This finding was found to be evident in 5 (Resident #5, #9, #99, #119 and #141) out of 5 Resident rooms reviewed for safe/clean/comfortable/homelike environment.The findings include:On 07/30/2025 at 8:45 AM during the initial tour of the facility the surveyor observed items in Resident rooms that were not in good repair. The following rooms were observed with items that were not in good repair: room [ROOM NUMBER] - the bedside table, dresser, closet, bathroom door and bathroom doorframe were marred/chipped; room [ROOM NUMBER] - the bedside table and the bed headboard were marred/chipped; room [ROOM NUMBER] - the bedside table was marred/chipped; room [ROOM NUMBER]A - the bedside table, closet, bathroom doorframe and bathroom door were marred/chipped; and room [ROOM NUMBER]B - the dresser was marred/chipped.In an interview with the Maintenance Director at 9:50 AM on 8/4/2025 the surveyor asked what the expectation was for repair of the items in the Resident rooms on the 1st floor of the facility that were not in good repair. The surveyor further stated that several of the Resident rooms were observed with marred/chipped furniture (dressers, closets, headboards), and marred/chipped doors and doorframes to Resident rooms and bathrooms. The Maintenance Director acknowledged the surveyor and stated that he was aware the furniture and doors/doorframes in the Resident rooms on 1st floor were not in good repair and the plan was to replace the furniture in the Resident rooms on the 1st floor with the renovation of the 1st floor of the facility in September.No additional information was provided by the facility at the time of survey exit.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews it was determined that the facility failed to ensure that the required parties were notified appropriately. This was found to be evident for 1 (Resident #16) out of 3 Residents reviewed for discharge during the recertification survey.The findings include: During a review of Resident #16's medical record conducted on 08/04/25 at 9:46 AM, it was discovered that the Resident was transferred to a local hospital's emergency room on [DATE] where he/she was later admitted . Further review of the Resident's medical record revealed a change in condition/concurrent form. The form did not show that the Resident Representative had received a bed hold or transfer summary. During an interview conducted on 08/04/2025 at 11:31 AM, the Nursing Home Administrator (NHA) provided this surveyor with the bed hold notice dated 07/10/25, a list sent to the ombudsman, and the change in condition/current form.A review of the Ombudsman weekly list for discharge notifications did not show that the Ombudsman was notified of Resident #16's transfer to the hospital on [DATE]. The NHA reviewed the list and confirmed that the Resident's name was not listed. The NHA advised that she would have the first floor Social Service staff member investigate it further. During the review of the change in condition/concurrent form, the NHA confirmed the form did not indicate that the transfer summary was provided to the Resident Representative. The NHA stated that she would have the Director of Nursing (DON) look in into it further. During an interview conducted on 08/04/25 at 1:07 PM, the NHA stated that the Ombudsman was not notified of Resident#16's transfer to the hospital on [DATE]. During an interview conducted on 08/05/25 at 7:14 AM, the DON stated that Resident #16's representative was not notified in writing of the transfer summary. He further stated that the facility's practice is that the Business Office Manager (BOM) or nurse would mail the transfer summary. The DON reported that the facility had not recorded when a transfer summary had been sent out. The DON stated going forward the facility will implement a new process that would capture when and to who the transfer summary is sent out to.

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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** Based on observation, Resident and staff interviews and surveyor record review it was determined that the facility failed to accurately complete a Minimum Data Set (MDS) assessment on a Resident. This finding was found to be evident in 1 (Resident #82) out of 2 Residents reviewed for accuracy of MDS assessments. The findings include:On the initial tour of the facility on 7/30/2025, the surveyor observed Resident #82 who was alert and oriented x4, in no distress and lying in bed. Resident #82 stated that he/she was diabetic and received insulin injections.Minimum Data Set (MDS) assessment is a standardized assessment tool used to evaluate the health and functional capabilities of nursing home Residents. It is a federally mandated process for all Medicare and Medicaid certified nursing homes. MDS assessments are performed by trained clinicians at admission, discharge, and other intervals, such as quarterly or annually. The MDS gathers information on physical, psychological and psychosocial functioning, comorbidities, medical diagnoses, treatments, medications, and therapies. It also covers aging-related areas like cognitive status, geriatric syndromes, and life care wishes. MDS assessments help nursing home staff identify health issues and provide a valuable resource for studying disability and function in older adults. The Centers for Medicare and Medicaid Services (CMS) collect and make MDS data available. During record review of Resident #82's electronic medical record on 8/4/2025 at 9:30 AM it was revealed that the Resident had a physician order for Insulin in the morning and at bedtime for diabetes. Resident #82 had an order for Insulin on admission to the facility in May of 2025. Further review of the medical record for Resident #82 revealed that the admission Minimum Data Set (MDS) assessment dated [DATE] section N0415 High-Risk Drug Classes: Use and Indication was coded no for taking hypoglycemic drug (including insulin). In an interview with the Lead MDS Coordinator at 11:20 AM on 8/4/2025 the surveyor conveyed that Resident #82's admission MDS dated [DATE] was coded no for Resident taking a hypoglycemic drug (insulin) under section N0415 High-Risk Drug Classes: Use and Indication. The Lead MDS Coordinator reviewed Resident #82's admission MDS dated [DATE] and acknowledged the surveyor and stated that she would make the correction to the admission MDS. The Licensed Nursing Home Administrator (LNHA) was notified at 11:30 AM on 8/4/2025 of the inaccurate coding on Resident #82's admission MDS dated [DATE].During a follow-up record review on 8/6/2025 at 7:30 AM of Resident #82's medical record it revealed that the Lead MDS Coordinator completed a Modification of admission MDS dated [DATE] for Resident #82 on 8/4/2025 at 12:01 PM which was now coded yes for Resident taking a hypoglycemic drug (insulin) under section N0415 High-Risk Drug Classes: Use and Indication.No additional information was provided by the facility at the time of survey exit.

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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 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. Based on interviews and record reviews it was determined that the facility failed to ensure care plan meetings were held in a timely manner. This was found to be evident for 1 (Resident #3) out of 1 Resident reviewed for care plan meetings during the re-certification survey.The findings include: According to CMS (Centers for Medicare & Medicaid Services) care plan meetings, which are part of the comprehensive care planning process for long-term care facilities, require regular review and revision based on resident assessments. These meetings ensure that residents receive person-centered care that meets their individual needs and preferences. A comprehensive care plan meeting should be held within seven days of completing the MDS (Minimum Data Set) assessment. This applies to all comprehensive assessments, including admission, annual, and significant change assessments, but not discharge assessments. The care plan must be reviewed and revised after each subsequent assessment. During an interview conducted on 07/30/2025 at 11:29 AM, Resident #3 stated that he/she did not recall attending care plan meetings routinely.On 08/05/2025 at 4:42 PM a review of Resident #3's Social Service notes revealed care plan meetings for the following dates: 1/31/24, 06/04/24, 10/31/24, 03/03/25. A Social Service note dated 08/05/25 stated care plan meeting is scheduled for Monday August 18th at 12PM. This writer left a detailed VM (voicemail) for the family, requesting a call back.During an interview conducted on 08/06/2025 at 7:36 AM, the second floor Social Service staff member acknowledged the delay in providing Resident #3's care plan meetings. The Social Service staff member stated that she was not aware at first that Minimum Data Set department (MDS) had a calendar, but once discovered she began using the MDS calendar. This Surveyor asked was MDS behind with Resident assessments the Social Service staff member replied no. She reported that the continued delay in holding care plan meetings was on her end but was unable to provide a reason for the delay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews it was determined that the facility failed to ensure Activities of Daily Living (ADL) were provided to a Resident. This was found to be evident for 2 (Resident #108 and #42) out of 5 Residents reviewed for ADL care during the recertification survey.The findings include: 1) According to Centers of Medicare and Medicaid Services (CMS) Activities of Daily Living (ADLs) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. If a sample person has difficulty performing an activity by himself/herself and without special equipment or does not perform the activity at all because of health problems, the person is deemed to have a limitation in that activity. During a random observation conducted on 07/30/25 at 12:18 PM, Resident #108 appeared uncleaned, hair disheveled and in a night gown. The Resident also had an odor of urine. During an interview conducted on 7/30/2025 at 12:19 PM, Resident #108 stated that he/she had not been cleaned all morning. The Resident reported that an Aide (unsure of who the aide was) came into the Resident's room this morning and provided care to the Resident's roommate but never returned. The Resident stated that his/her diaper had been soiled since early this morning. During an interview conducted on 07/30/2025 at 12:49 PM, the Unit Manager (UM) #9 advised that the staffing agency cancelled all the Geriatric Nursing Assistants (GNA) that were scheduled for this morning, and as a result they were short staffed. During the interview, the UM sent GNA #13 into Resident #108's room to provide ADL care. During an interview conducted on 07/30/25 at 1:32 PM, the Nursing Home Administrator (NHA) confirmed that the staffing agency cancelled all the GNAs that were assigned to work that morning. The NHA further stated that she had been in communication with corporate regarding this issue. The Minimum Data Set (MDS) in long-term care is a standardized assessment used in nursing homes certified by Medicare and Medicaid. It's a core set of screening, clinical, and functional status elements used to assess residents' needs and develop individualized care plans. The MDS is used for all residents, regardless of payer source, and is completed upon admission, periodically, and upon discharge. A review of Resident #108's MDS assessment dated [DATE] was conducted on 08/04/2025 at 1:02 PM. The MDS assessment identified the Resident as being dependent on personal hygiene and toileting. A review of Resident #108's care plan conducted on 08/04/2025 at 1:05 PM, revealed a Care Plan for bladder incontinence and ADL Self Care Performance Deficit. The Care Plans had goals and interventions. 2) 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. On 7/30/2025 at 9:11 AM, Resident #42 was observed lying in bed with facial hair noticeable on (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her chin and upper lip. The Resident stated, I have informed the aides and asked for a razor. On 8/05/2025 at 6:55 AM, a review of Resident #42's medical record showed a BIMS score of 15 out of 15, indicating the resident is cognitively intact. (Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities.) On 8/05/2025 at 7:18 AM, review of the MDS with an Assessment Reference Date (ARD) of 7/19/2025 revealed that Resident #42 had Functional Limitation in Range of Motion- impairment on one side- upper and lower extremity, and required assistance with personal hygiene. (Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). On 8/05/2025 at 7:20 AM, a care plan initiated on 7/15/2025 confirmed that Resident #42 had an ADL Self Care Performance Deficit. On 8/05/2025 at 10:19 AM, a follow up visit to Resident #42 revealed facial hair still visible on Resident #42's chin (approximately 1/2 inch) and upper lip (approximately 1/4 inch). On 8/05/2025 at 10:24 AM, the surveyor notified Unit Manager (UM #1) about the concern, who then immediately shaved the resident. On 8/05/2025 at 12:15 PM, the Nursing Home Administrator was informed of this concern.

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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. Based on observation, interview and record review, it was determined that the facility failed to follow the physician orders for the management of constipation. This was evident for 1 (Resident #33) of 1 resident reviewed for constipation/ diarrhea during the recertification survey.The findings include:Milk of Magnesia (MOM) is an over-the-counter laxative that can be used to treat occasional constipation.Dulcolax suppository is a type of laxative that is inserted into the rectum to relieve constipation.An Enema is the process of introducing liquid through the anus to relieve constipation.On 7/30/2025 at 9:26 AM, Resident #33 was observed grimacing, sitting in the wheelchair inside his/her room with lights off. The resident stated that he/she wanted the lights off because he/she was feeling terrible. He/she added that he/she had not slept during the night due to abdominal discomfort. He/she revealed that he had been having constipation for a week now and stated that the staff have been informed about it, however, he/she claimed to have received only Milk of Magnesia. At 9:36 AM, Licensed Practical Nurse (LPN) entered the resident's room and informed Resident #33 that an Enema was ordered for him/her. On 8/04/2025 at 6:55 AM, a review of Resident #33's medical record showed a BIMS score of 15 out of 15, indicating the resident is cognitively intact. (Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities.) On 8/04/2025 at 9:34, a review of the active physician orders revealed that Resident #33 was ordered the following as needed medications for bowel management: 1. Milk of Magnesia(MOM) Suspension 400 MG/5ML (Magnesium Hydroxide) Give 30 ml by mouth every 24 hours as needed for Constipation give at bedtime if no bowel movement in 3 days2. Dulcolax Suppository 10 MG (Bisacodyl) Insert 1 suppository rectally every 24 hours as needed for Constipation if no result from MOM, Miralax by next shift 3. Fleet Enema 7-19 GM/118ML (Sodium Phosphates) Insert 1 dose rectally every 24 hours as needed for Constipation if no result from Dulcolax within 2 hours. If no results from Fleet enema, call MD/advanced practice provider (APP) for further orders On 8/04/2025 at 9:56 AM, a review of the July Medication Administration Record (MAR) revealed that Resident #33 did not receive MOM and Dulcolax Suppository from July 2- 31, 2025, prior to receiving a Fleet enema on 7/30/25 at 1:00 PM.On 8/04/2025 at 10:54 AM, during an interview with LPN #7, he/she confirmed that the nurses were expected to follow the bowel protocol ordered for the management of constipation. He/she stated that if the resident had no bowel movement x 3 days, the nurse would administer Miralax, and if not effective, they would proceed to administering MOM and if no result, the Dulcolax suppository would be administered. He/she confirmed that the last step was Enema. He also added that if everything would fail, the nurses should call the doctor.On 8/04/2025 at 11:05 AM, In an interview with LPN #6, he/she stated that the nurses were expected to follow the bowel protocol as ordered by the Physician. He/she enumerated the steps as: step 1, administer Miralax, if no bowel movement, proceed to step 2, MOM, if no BM, proceed to step 3, Dulcolax suppository and lastly Enema. He/she added that the nurses were expected to document the result in the MAR and in the progress notes if the as needed bowel protocol was given.On 8/04/2025 at 11:13 AM, the Director of Nursing (DON) was notified of this concern. A policy for Bowel Regimen was also requested from the Nursing Home Administrator (NHA).On 8/04/2025 at 12:30 PM, the NHA confirmed that the facility had no specific bowel regimen policy and stated that they followed the physician's orders.On 8/04/2025 at 12:32 PM, the DON stated that he called LPN #10 about the concern. Per DON, LPN #10 claimed that Resident #33 refused the MOM and Dulcolax, however, there was no evidence in the medical record that the resident complained of constipation and that the bowel protocol was offered and declined.

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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. Based on record reviews and interviews, it was determined that the facility failed to ensure Pharmacy Recommendations were 1) reviewed in a timely manner and 2) implemented accurately. This was found to be evident for 2 (Resident #60 and #9) out of 5 Residents reviewed for Medication Regimen Review during the recertification survey. This deficient practice was identified as past non-compliance.The findings include: 1) A pharmacy medication review, also known as medication therapy management (MTM), is a service where a pharmacist evaluates a patient's medications to optimize their use and improve health outcomes. It involves identifying potential medication-related problems, such as adverse drug events, drug interactions, or adherence issues, and recommending solutions to the patient and their prescriber. CRCL stands for Creatinine Clearance Rate. It is a measure of kidney function that indicates how effectively the kidneys remove creatinine, a waste product, from the blood. A review of Resident #60's Consultation Report from Omnicare was conducted on 08/06/25 at 9:42 AM. The report dated 08/14/24 stated CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED. The recommendation stated, It seems resident receives Rivaroxaban (Xarelto) 20 mg daily for atrial fibrillation per PCC (point click care is an electronic health record system). The manufacturer recommends 15 mg [milligram] PO [by mouth] once daily with the evening meal for CrCl 50 mL/min or less when used for nonvalvular atrial fibrillation. Their estimate of kidney function is: CrCl of 48 mL/min on 7/31/24 eGFRcr of 50 mL/min/1.73m2 on 7/31/24. Recommendation: If being used for atrial fibrillation, please evaluate if Rivaroxaban dose should be decreased to 15 mg once daily with the evening meal. A further review of the report showed the physician approved and signed the recommendation on 09/17/24 which was 34 days from the time of pharmacy recommendation. Orthostatic hypotension is a form of low blood pressure that happens when standing up from sitting or lying down. Fludrocortisone is a corticosteroid drug used for managing hormone imbalance and can be used to treat low blood pressure upon standing. The surveyor conducted a record review of Resident #9's electronic medical record on 8/5/2025 at 3:15 PM. Review of Resident #9's medical record revealed that the Resident had a pharmacist drug regimen review (DRR) report date stamped 5/19/2025 that had not been acted on by the Resident's physician until 6/23/2025. The pharmacist DRR report indicated that Resident #9 was ordered Fludrocortisone 0.3 mg daily for orthostatic hypotension by the physician, and the pharmacist recommended that this dose be adjusted as the usual maximum maintenance dose for Fludrocortisone was 0.2 mg daily. At 7:15 AM on 8/6/2025 the surveyor conducted a review of the facility's policy and procedure for Medication Regimen Review (MRR) dated 12/14/2022 from The Compliance Store platform. The policy (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that the facility shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Further review of the facility policy indicated that the pharmacist shall communicate any irregularities to the facility with verbal communication of any urgent needs, and written communication to the attending physician, the facility's Medical Director, and the Director of Nursing (DON). Written communications from the pharmacist shall become a permanent part of the Resident's medical record. In an interview with the Director of Nursing (DON) at 8:50 AM on 8/6/2025 the surveyor asked what the expectation was for completing the pharmacist recommendations and identified irregularities for the monthly drug regimen review (DRR). The DON stated that the recommendations on the pharmacist DRR report should be completed by the physicians within a week of receiving the reports from the pharmacist. The surveyor conveyed that Resident #9 had a pharmacist DRR report date stamped 5/19/2025 with a recommendation to evaluate continued use of Fludrocortisone 0.3 mg daily as the usual maximum maintenance dose for Fludrocortisone was 0.2 mg daily. On 6/23/2025, the physician acted on the pharmacist recommendation and decreased the Fludrocortisone from 0.3 mg daily to 0.2 mg daily. The Director of Nursing (DON) acknowledged the surveyor and stated that facility was working with the physicians and Medical Director on the pharmacist DRR reports. Voltaren Gel (Diclofenac) is a type of nonsteroidal anti-inflammatory drug (NSAID) that treats joint pain caused by arthritis. The medication in Voltaren Gel is Diclofenac and it works by decreasing inflammation. Further review of Resident #9's medical record on 8/6/2025 revealed that Resident had an additional pharmacist drug regimen review (DRR) report date stamped 6/16/2025 that was not acted on by the Resident's physician until 6/24/2025, and the order date and start date on the Resident's drug regimen was not until 6/28/2025. The pharmacist DRR report indicated that Resident #9 was ordered Voltaren Gel to the left knee without a specific quantity to be applied in the directions, and the indication for the medication was for edema not for pain. The pharmacist recommended that the directions be updated to include a specific quantity to be applied and to clarify the indication for the medication, as the manufacturer recommends specific dosing guidance for this medication and the indication should be for pain. As of 6/28/2025 the physician order was Diclofenac Gel 4 gm two times a day to left knee for edema. At 12:55 PM on 8/6/2025 the Licensed Nursing Home Administrator (LNHA) was notified of the concerns with completion of the pharmacist drug regimen review (DRR) reports. The LNHA stated that this was being addressed in a PIP (performance improvement plan) by the facility and shared the PIP with the surveyor. No additional information was provided by the facility at time of survey exit. 2) A review of the Omincare Consultation Report conducted on 08/06/25 at 9:45 AM revealed a section labeled Physician's Response: I accept the recommendation (s) above, please implement as written I accept the recommendation (s) above WITH THE FOLLOWING MODIFICATIONS: I decline the recommendation (s) above and do not wish to implement any changes due to the following reasons below. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician checked I accept the recommendation (s) above, please implement as written. The physician wrote above the signature line change to 15 mg at bedtime. However, the recommendation stated, If being used for atrial fibrillation, please evaluate if Rivaroxaban dose should be decreased to 15 mg once daily with the evening meal. On 08/06/25 at 10:00 AM, a review of Resident #60's Medication Administration Record (MAR) showed the following order: Xarelto Oral Tablet 15 MG (Rivaroxaban) Give 1 tablet by mouth at bedtime for Afib -Order Date 09/19/2024 at 1134. A Process Improvement Plan (PIP) is a structured document outlining how to enhance the efficiency and effectiveness of a specific business process. It acts as a roadmap, guiding teams through the steps needed to identify areas for improvement, implement changes, and monitor results. Essentially, it's a strategic approach to making existing processes better. During an interview conducted on 08/06/25 at approximately 12:45 PM the Nursing Home Administrator (NHA) advised that a PIP was created for the concerns of the pharmacy recommendations. A Review of the PIP dated 06/24/25 conducted on 08/11/25 at 2:01 PM revealed the following: Problem Statement: Decrease and lack of completion of Pharmacy recommendations on time by the Attending Physician. Goal: To increase the pharmacy recommendation completion rate. ROOT CAUSE(S): 1. Lack of urgency from the new Attending Physician to review the recommendations. 2. Decrease number of days that the attending physician is in the facility. 3. The attending Physician delay in reviewing, signing and returning it to the managers. BARRIER(S): External Attending Physician do not attend morning clinical meeting between nursing and the medical group. A review of the facility's Quality Assessment & Performance Improvement (QAPI) plan was conducted on 08/11/25 at 2:10 PM. The QAPI plan dated 6/24/2025 report stated the following: Topic/metrics: Review of all new Pharmacy recommendations for proper completion with the Medical Director during the At-Risk meeting. Process the complete: Unit manager/designee will notify the Attending Physician of any new pharmacy recommendations. Unit manager/designee will notify the Medical Director for any incomplete pharmacy recommendations for her to review after the At-Risk meeting

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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. Based on observation, record review and interview, it was determined that the facility failed to provide adequate monitoring for resident on anticoagulant medication. This was evident for 1 (Resident #33) of 2 residents reviewed for Anticoagulants during the recertification survey.The findings include:The Mayo Clinic describes anticoagulants or blood thinners as medications that help prevent blood clots from forming. Anticoagulant medications increase the risk of bleeding, and patients taking these medications need to be carefully monitored. On 7/30/2025 at 9:28 AM, Resident #33 was observed with bruising on both posterior hands and arms. He/she stated that it was caused by the blood thinner that he/she was taking. On 8/04/2025 at 6:55 AM, a review of the active physician orders revealed that Resident #33 was prescribed an anticoagulant, Xarelto Oral Tablet 10 MG (Rivaroxaban) Give 10 mg by mouth one time a day for Deep Vein Thrombosis (DVT) prophylaxis. Take 1 tablet by mouth daily after dinner. On 8/04/2025 at 7:16 AM, a review of the progress notes written on 7/2/2025 by the Advanced Practice Nurse (APN) specified, Patient is on newly initiated anticoagulation therapy. Monitor for bleeding related to anticoagulation therapy. However, further review of Resident #33's July and August Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no evidence that a monitoring was put in place for anticoagulant use. On 8/04/2025 at 7:47 AM, in an interview with Unit Manager (UM #1), he/she confirmed that the nurses were expected to enter orders/ interventions in the electronic medical record for residents receiving anticoagulant medications such as monitor bleeding, bruising and black tarry stool. The monitoring should appear in the MAR or in the TAR for nurses to know and implement every shift. UM #1 pulled the MAR and TAR of Resident #33 and verified the absence of the anticoagulant monitoring task and stated that an immediate action would be taken to add the order. On 8/04/2025 at 7:59 AM, Resident #33's medical record revealed that an order was written on 8/04/2025 after surveyor intervention. Anticoagulant Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath, nose bleeds. On 8/04/2025 at 8:47, the Nursing Home Administrator (NHA) was notified of the concern.

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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. Based on observation and interviews it was determined that the facility failed to ensure staff practiced infection control. This was evident for 2 (LPN # 4 & LPN#11) staff out of 2 staff observed for infection control during the recertification survey.The findings include: During a medication administration observation conducted on 07/31/25 at 7:31 AM, this Surveyor observed Licensed Practice Nurse (LPN) #4 obtain the Resident's blood pressure. After the LPN obtained Resident #55's blood pressure the LPN failed to sanitize the blood pressure equipment and cuff. Following obtaining the blood pressure, the LPN returned to the medication cart and prepared the Resident's medication without practicing hand hygiene. The LPN entered the Resident's room and administered the medication again without first practicing hand hygiene.During an interview conducted on 07/31/25 at 7:37 AM, LPN #4 advised that the facility's expectation was to always practice infection control which included sanitizing shared medical equipment and hand hygiene when delivering direct care to the Resident.During an interview with the Infection Control Preventionist (ICP) on 08/05/25 at 11:50 AM. The ICP confirmed that shared medical equipment was to be sanitized after each use and hand hygiene is required when delivering direct care which included medication administration. The ICP further stated that she recently held an infection control in-service that included hand hygiene and shared medical equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215258	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Spa Creek	35 Milkshake Lane Annapolis, MD 21403

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 0680 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on interview and record review, it was determined that the facility failed to ensure the activities program was directed by a qualified professional. This deficiency was identified during the review of the activities program conducted during the survey and has the potential to affect all residentsThe findings include:On 08/04/2025 at 3:06 PM, this surveyor interviewed the Activities Director, who stated she had been employed at the facility for three years in that role.On 08/05/2025 at 5:00 PM, the Administrator provided this surveyor with the requested documents for the Activities Director's credentials. The documentation provided was proof of a Bachelor of Science degree. A review of these records showed they did not include the credentials required for an Activities Director per federal guidelines.On 08/05/2025 at 4:40 PM, this surveyor conducted an interview with the Administrator, during which she discussed-and provided documentation showing-that she had submitted a form to the National Certification Council for Activity Professionals (NCCAP) applying for the facility's Activities Director to receive the Activity Director Certified (ADC) credential. However, at this time, the Administrator confirmed there was no other education, training, or documentation the facility could provide regarding the Activities Director's credentials.On 08/06/2025 at approximately 12:30 PM, this surveyor conducted an interview with the Administrator and again inquired if any additional credentials could be provided for the Activities Director. The Administrator confirmed there were none. At this time, the surveyor informed the Administrator that this would be a concern, and the Administrator acknowledged understanding.No additional information was provided by the facility at the time of survey exit.