STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215313	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Glade Valley	56 West Frederick Street Walkersville, MD 21793

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48168 Based on a record review and interview it was determined that the facility failed to report a resident's allegation of missing money. This was evident for 1 (Resident #263) and was discovered during the investigation of the facility reported incident #MD00212599. During the survey 15 facility reported incidents were investigated. The findings include: A review of the facility reported incident (FRI # MD00212599) revealed that Resident #373 alleged that on 12/02/24 money was missing from the locked drawer in his/her room. A review of the facility's investigation file failed to reveal evidence that any other residents were asked if they also had money missing. On 4/30/25 at 9:44 AM an interview was conducted with the Nursing Home Administrator (NHA) to review the facility's investigation of FRI #MD00212599. When the NHA was asked if any other residents had reported missing money, the NHA said, yes, Resident #373's roommate (Resident #263) also reported missing money on the same date as Resident #373's. The NHA said she did not report Resident #263's allegation of missing money to the state authority. When asked why she did not do so, she said that she talked to the resident's family member who questioned whether the resident possessed money in his/her room. When asked to explain the discrepancy between reporting missing money for Resident #373 and not for Resident #263, the NHA acknowledged and affirmed the deficiency.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51489 Based on record reviews and staff interviews, it was determined that the facility failed to conduct thorough investigations of an allegation of abuse. This was evident for 4 (Resident #9, #71, #77, #33) of 10 residents reviewed for abuse. The findings include: 1) On 4/22/25 at 2:06 PM, in an interview with the Director of Nursing (DON), she stated that a thorough investigation of alleged abuse should include real-time documentation in Nurse Progress Note in Point Click Care (PCC- an electronic health record) and notification of the Nursing Home Administrator (NHA) and DON. The nurse should have performed and documented a risk management assessment. The DON stated, I expect these to be documented in PCC and to be part of the investigation file. On 4/28/25 at 12:30 PM, a record review of the facility-initiated incident report revealed: On 1/21/25 at 11:55 AM Resident #9 and her friend, the complainant, made Licensed Practical Nurse (LPN #9) aware of alleged verbal abuse that occurred on 1/19/25 between Geriatric Nurse Assistant (GNA #8), and Resident #9. On 1/21/25 at 12:00 PM, LPN #9 reported the allegation to the NHA and Regional Director of Nursing (Staff #24). GNA #8 was suspended pending investigation. On 1/21/25 at 1:32 PM the NHA initiated a facility self-report with the Office of Health Care Quality (OHCQ). On 1/21/25 the file revealed interviews and statements from Resident #9, GNA #8, three staff statements (Staff #15, #16, and #17) and six residents' statements. On 1/28/25, the NHA concluded the allegation of abuse was not verified because Resident #9 changed the verbiage used by GNA #8 and alleged witnesses were not able to verify alleged comments. On 1/28/25 at 5:23 PM the NHA submitted a final report with OHCQ. On 4/28/25 at 1:05 PM, a record review in PCC lacked any documentation regarding the allegation of abuse. On 4/28/25 at 3:03 PM a review of employee files revealed GNA #8 last completed abuse and neglect training on 12/11/2021 through ShiftMed, a staffing agency. On 4/28/25 at 3:13 PM in an interview, the DON acknowledged GNA #8 did not receive post incident training. On 4/28/25 at 4:03 PM in an interview, the NHA acknowledged that the investigation failed to include a psych evaluation, risk management, updated care plan, and post incident training. The NHA acknowledged that the investigation did not meet facility standards. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 4/29/25 at 11:00 AM a record review of the facility-initiated incident report revealed: On 12/7/24 at 5:25 PM, Resident #71 and a family member made LPN #20 aware of alleged physical abuse that occurred on 12/5/24 between GNA #21and Resident #71. On 12/7/24 at 6:00 PM, LPN #20 informed Registered Nurse (RN) #22 and acting administrator regarding the allegation. GNA #21 was suspended pending investigation. On 12/7/24 at 6:57 PM, RN #22 filed a facility initiate-report (FRI) with OHCQ. The investigation file revealed an inaccurate and incomplete FRI that was submitted to OHCQ. Resident #71 and GNA #21 interviews lacked dates and time. The resident's statements were dated 12/6/24, a day before the initial FRI was filed. The initial facility investigation listed steps to ensure residents are protected: GNA suspension, education with staff, referral to psych services, skin and pain assessment for the resident. On some unknown date and time, RN #22 concluded the allegation of abuse was not verified because Resident #71 has chronic shoulder/arm and Staff #21 may have accidentally moved the resident's arm. An unidentified facility staff filed a final report with OHCQ. On 4/29/25 at 11:24 AM a record review of Resident #71's Medication Administration Record (MAR) revealed Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth one time a day for chronic pain. On 4/29/25 at 11:42 AM a record review of Resident #71's Care Plan revealed chronic pain and polyarthritis. On 4/29/25 at 2:22 PM in an interview with the NHA, the surveyor reviewed the incomplete investigation file. It lacked: interview dates and times, diagnostics related to the resident's history and complaint, follow-up to GNA #21's admission that the resident's arm may have been moved wrong, post incident staff education, psych services, skin and pain assessment for Resident #71. On 4/29/25 at 2:45 PM after reviewing Resident #71's investigation file, the NHA confirmed surveyor's findings and stated, That's unacceptable, I see what you're saying. I know what I need to do going forward. 3) On 4/25/25 at 10:05 AM, a record review of the facility-initiated incident report revealed: On 10/30/24 at 10:45 AM, Resident #77 informed the Regional Director of Nursing (Staff #24) of an encounter this week, in the last day or two, with a staff member alleging abuse. On 10/30/24 at 10:54 AM, the RDON documented knowledge of the incident report. On 10/30/24 at 12:07 PM, the NHA filed a FRI with OHCQ. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The investigation file revealed that LPN #9 and NHA attempted an interview with Resident #77, in which the resident stated, not right now. No date or time was indicated. The alleged perpetrator, GNA #29's written statement and other staff (#26, #27, #28, #31) witness statements substantiated physical contact had occurred between Resident #77 and GNA #29. A social worker designee (Staff #30) conducted ten resident interviews. No documentation was found that the GNA was immediately removed from resident care. On an unknown date and time, the NHA and RDON concluded the abuse allegation was not verified because the resident kept changing the event's account. On 11/6/24 at 3:29 PM RN #22 filed the final report with the OHCQ. On 4/28/25 at 8:42 AM in an interview with the NHA, she acknowledged that the staff statements indicated some type of contact between GNA #29 and Resident #77. She also agreed that Resident #77 was never directly interviewed by her. On 4/28/25 at 9:00 AM the NHA provided a sign-in sheet for Resident Abuse Prevention and Reporting in-service that was dated 11/4, 11/5, 11/8, and 11/9/24; however, GNA #29 did not sign-in. On 4/28/25 at 9:20 AM, in a subsequent interview with the NHA, the surveyor shared concern that the abuse investigations always seemed to conclude not verified using a similar rationale that the involved residents were confused, and not as a result of thorough investigation. The NHA acknowledged that although abuse was not substantiated, the facility staff failed to investigate these allegations thoroughly. 45139 4) On 4/24/25 at 2:43 PM, a review of Intake # MD00211246 revealed an allegation of employee to resident abuse. Further review revealed that Resident #33 alleged that an employee abused him/her in their room. On 4/24/25 at 3:00 PM, a review of the facility's investigation revealed that Resident #79 is a long-term resident and the roommate of the Resident alleging abuse. Further review revealed a document interviewing Resident #79, regarding the alleged abuse. The documented interview was signed and dated 5 days after the incident. The interview documented that the resident was unable to recall anything regarding the alleged abuse. On 4/30/25 at 9:47 AM, a review of the annual MDS dated [DATE] revealed the roommate Resident #79 did not have any cognitive decline. On 4/24/25 at 3:47 PM, the Nursing Home Administrator(NHA) was interviewed. During the interview she confirmed she was the facility abuse coordinator. The concern that a potential witness was not promptly interviewed was shared. The NHA reported that the resident does not like to leave his/her room, making it difficult to have private a conversation with him/her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/30/25 at 11:37 AM, Resident #79 was interviewed. During the interview s/he reported that s/he enjoys getting out of bed for short periods of time. S/he reported that s/he requires the help of the staff to get out of bed. Resident #79 has no recollection of being interviewed regarding any abuse allegation involving his/her roommate. On 5/01/25 at 10:50 AM, the above concerns regarding the delay in interviewing a witness was shared with the NHA and no additional information was provided prior to the end of the survey.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51900 Based on record reviews and interviews, it was determined that the facility failed to develop and implement a baseline care plan. This was evident for 1 (Resident #369) of 4 residents reviewed for pressure ulcers and injuries. The findings include: Resident #369 was admitted to the facility for short-term managed care rehabilitation following hospitalization due to weakness related to a recent COVID-19 infection and chemotherapy treatment for cancer. The resident also presented with unstageable sacral wounds and history of depression, anxiety, and pain. A baseline care plan is a detailed, initial plan developed for each resident within 48 hours of their admission. It outlines the essential care instructions needed to provide effective and person-centered care. This plan serves as a foundation for the residents' overall care, ensuring continuity and staff communication. On 4/29/25 at 8:50 AM, in response to complaint MD00204145, the surveyor reviewed Resident #369's medical record which revealed that the resident was admitted on [DATE] and that a comprehensive Minimum Data Set (MDS) assessment had been completed on 3/02/24. Further review of the medical record Care Plan Report, revealed there was a one-page document that had been initiated on 5/10/24-despite the resident being discharged in late March 2024. This document included a single intervention: The resident has potential/actual impairment to skin integrity r/t-after which it was marked canceled. No additional evidence was found to indicate that a care plan had been created. On 4/29/25 at 10:39 AM, the surveyor spoke with the Director of Nursing (DON) and expressed concern that a care plan was not created for Resident #369. The DON stated that she would investigate the matter. On 4/29/25 at 1:14 PM, the surveyor spoke again with the DON and inquired whether she had found evidence of a completed care plan. The DON responded, No, this is all I found, and I am embarrassed, as she handed the surveyor a printed copy of a one-page, incomplete care plan that had been created and subsequently canceled in May 2024. (The resident had been discharged from the facility in March 2024.) On 5/1/25 at 10:55 AM, the surveyor spoke with the Nursing Home Administrator (NHA) regarding concerns that Resident #369 did not receive either a baseline care plan. The NHA acknowledged awareness of the issue and emphasized that she did not want the surveyor to believe she was attempting to alter the medical record. She explained that while it may appear the facility tried to create a care plan after the resident's discharge, her access to the record was only to review the issue and not to initiate a new care plan. She stated she was aware of the deficiency in care planning, which prompted her to access the resident's record.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51900 Based on record reviews and interviews, it was determined that the facility failed to develop and implement a comprehensive care plan. This was evident for 1 (Resident #369) out of 4 residents reviewed for pressure ulcers and injuries. The findings include: Resident #369 was admitted to the facility for short-term managed care rehabilitation following hospitalization due to weakness related to a recent COVID-19 infection and chemotherapy treatment for cancer. The resident also presented with unstageable sacral wounds and history of depression, anxiety, and pain. A comprehensive care plan is a detailed, individualized document that outlines a resident's goals, needs, and the services they will receive to achieve those goals. It's a collaborative effort involving the residents (if able), their family, and the care team, and it's designed to improve their overall well-being. Facilities are required to complete a comprehensive MDS assessment within 14 days of the resident's admission, and the care plan must be developed within 7 days after that assessment is completed. A Minimum Data Set (MDS) is a standardized assessment tool that helps to evaluate the health status of residents in long-term care facilities. The information gathered helps facilities to develop patient centered care plans based on the resident's unique needs. On 4/29/25 at 8:50 AM, in response to complaint MD00204145, the surveyor reviewed Resident #369's medical record which revealed that the resident was admitted on [DATE] and that an MDS assessment had been completed on 3/02/24. Further review of the medical record Care Plan Report, revealed there was a one-page document that had been initiated on 5/10/24-despite the resident being discharged in late March 2024. This document included a single intervention: The resident has potential/actual impairment to skin integrity r/t-after which it was marked cancelled. No additional evidence was found to indicate that a care plan had been created. On 4/29/25 at 10:39 AM, the surveyor spoke with the Director of Nursing (DON) and expressed concern that a care plan did not appear to have been created for Resident #369. The DON stated that she would investigate the matter. The surveyor also requested a copy of the facility Care Planning Policy. On April 29, 2025, at 1:14 PM, the surveyor spoke again with the DON and inquired whether she had found evidence of a completed care plan. The DON responded, No, this is all I found, and I am embarrassed, as she handed the surveyor a printed copy of a one-page, incomplete care plan that had been created and subsequently canceled in May 2024. (The resident had been discharged from the facility in March 2024.) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON also provided a copy of the facility's policy and procedure titled Comprehensive Care Plan, revised on April 28, 2025, which stated: The comprehensive care plan will be developed within seven days after the completion of the comprehensive MDS assessment. All care areas triggered by the MDS will be considered in developing the plan of care. On 5/1/25 at 10:55 AM, the surveyor spoke with the Nursing Home Administrator (NHA) regarding concerns that Resident #369 did not receive either a comprehensive care plan. The NHA acknowledged awareness of the issue and emphasized that she did not want the surveyor to believe she was attempting to alter the medical record. She explained that while it may appear the facility tried to create a care plan after the resident's discharge, her access to the record was only to review the issue-not to initiate a new care plan. She stated she was aware of the deficiency in care planning, which prompted her to access the resident's record. The NHA reiterated that it was not her intent to create documentation post-discharge and confirmed that the resident never received a comprehensive care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48259 Based on record review and interviews, it was determined that the facility failed to ensure that care plans were reviewed and revised after a change in a resident's condition. This was evident for 1 (Resident #48) of 2 residents reviewed for care planning. The findings include: A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. They must be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The Minimum Data Set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each Resident's strengths and needs. The information collected is used in the Resident's care planning decisions. The facility must have care plans developed and revised by an interdisciplinary team (IDT), including the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the Resident, and the Resident's representative (as practicable). A record review on 4/21/25 at 11:53 AM showed that Resident #48 had been residing in the facility since March 2022. The continued review revealed a referral by a nurse to therapy dated 9/12/24 that indicated Resident #48's right hand was contracted and needed to be evaluated for splinting. Further review of therapy evaluation dated 10/11/24 showed that Resident #48's right hand was contracted. The review also showed that IDT care plan meetings occurred on 1/16/25 and 4/10/25. However, the review failed to show that Resident #48's care plan had been updated with the new contracture. In an interview on 4/29/25 at 12:40 PM, the Director of Nursing (DON) said she or the unit manager was responsible for updating resident care plans. The DON continued to state that care plans were expected to be updated with every change in a resident's condition. However, earlier record review lacked proof that Resident #48's care plan was updated with his/her right-hand contracture.

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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. 48259 Based on record reviews, interviews and observations, it was determined that the facility failed to ensure that residents who required assistance with Activities of Daily Living (ADL) were provided with showers and incontinence care. This was evident for 3 (Resident #57, #366, #365) of 3 residents reviewed for ADL. The findings include: 1) In an observation on 4/21/25 at 12:20 PM, Resident #57 was observed sitting in a Geri-chair, in the unit dining area, and was noted with white flaky particles in facial hair and on his/her clothes. In a subsequent observation on 4/24/25 at 5:01 PM, Resident #57 was noted lying in bed and continued to have white, flaky particles in his/her facial hair. A record review later that day contained an MDS assessment (Minimum Data Set- a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs) dated 2/4/25 for Resident #57. The MDS had recorded that Resident #57 depended on staff for most of his/her self-care needs. A continued review of Resident #57's order summary report as of April 2025 contained an attending provider's order to give showers to Resident #57 twice weekly on Mondays and Thursdays in the evening. An observation made on 4/24/25 on the haven unit showed a shower schedule form for the week of 4/21/25 - 4/26/25, which indicated that Resident #57 was to receive showers on 4/21/25 and 4/24/25 on the evening shift. The form had a notation: GNA - [Geriatric nurse aid] and nurses are to initial that showers are completed. 4/21/25 was blank while 4/24/25 had an initial, meaning the resident's shower was completed before this observation. However, observation of Resident #57 on 4/24/25 from 3:00 PM to 7:00 PM showed that the resident had not been taken out of his/her room for a shower. A review of the GNA shower documentation for Resident #57 from January 1 to March 31, 2025, was completed. The review showed a record of one shower in January, three showers in February, and two in March. An interview on 4/25/25 at 6:48 AM with staff #26, a licensed practical nurse, whose role was also a GNA the previous shift and had worked with Resident #57, revealed that the resident had received a bed bath (washing a resident in bed) on 4/24/25 because s/he refused a shower. However, staff #26 was unable to provide documentation that reflected refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/25 at 9:22 AM, staff #2, unit manager for the haven unit, reported that Resident #57 was supposed to get at least eight showers in a month. Staff was asked for a record of the resident's refusal of showers and reported there was no documentation to show the resident's refusal of his/her showers. In an interview on 4/29/25 at 1:01 PM, the director of nursing confirmed concerns after checking Resident #57's GNA shower record with the surveyor. The DON continued to state that every resident was to receive eight showers a month. And if they refused, the staff was to document the refusal. 48470 2) Resident #366 was admitted to the facility in late 2024. A review of a complaint packet related to MD00212858 alleged that on multiple occasions, the resident was left in soiled diapers for prolonged periods. On 4/30/25 at 9:33 AM, a review of Resident 366's medical record was conducted. The review revealed a comprehensive assessment with a reference date of 11/20/24 that indicated the resident was dependent on staff for toileting. The Task documentation on Resident #366 for toilet use and bladder continence for November 2024 was reviewed on 4/30/25 at 10:12 AM. The review revealed multiple shifts with no documentation. The Director of Nursing (DON) was interviewed on 4/30/25 at 10:46 AM. During the interview, the DON reported that the Geriatric Nursing Assistants (GNA) were responsible in documenting under the Task and indicated that they also report to the nurses. The Task documentation for Resident #366 was reviewed with the DON. The DON confirmed the shifts that had no documentation from the GNA's and stated, I see it, it looks like for at least 2 days the resident did not go to the bathroom. The concern was discussed with the DON that there was no documentation to indicate incontinent care was provided to a dependent resident. The DON indicated that she would review the resident's medical record. On 4/30/25 at 11:15 AM, the DON reported that she found progress notes from the nurses that pertained to toileting of Resident #366. A review of the progress notes was conducted with the DON and confirmed the documentation. However, there were still several shifts that staff had failed to document on toileting. The shifts identified within the 17 days reviewed for November 2024 were: a) 11/15/24 evening shift b) 11/22/24 evening shift c) 11/24/25 night shift d) 11/27/24 evening shift e) 11/28/24 day shift f) 11/28/24 night shift (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 11:28 AM, the DON confirmed that there was no documentation to indicate that incontinence care was provided to Resident #366 for 6 shifts in the 17 days reviewed. 3) Resident #365 was admitted to the facility in early 2025. A review of a complaint packet related to MD00214039 alleged that the resident was left wet for extended periods. A review of Resident #365's medical records was conducted on 4/30/25 at 12:04 PM. The review revealed a comprehensive assessment with a reference date of 1/31/25, that indicated the resident needed substantial/maximal assistance from staff for toileting. Further review of Resident #365's medical record revealed a care plan for Activities of Daily Living (ADL) self-care performance deficit with interventions that include: Resident is to be assisted with toileting or changed after each meal and at bedtime, and as requested; Resident is to be checked and changed frequently through the night; and resident requires assistance of 1 staff for toileting. A review of the Task documentation for bladder continence and toilet use in contrast with the progress notes was conducted on 5/1/25 at 8:28 AM. The documentation reviewed was for the last 7 days in January 2025. The review identified 4 shifts with no documentation to indicate incontinence care was provided. The shifts identified were: a) 1/25/25 night shift b) 1/27/25 day shift c) 1/28/25 day shift d) 1/30/25 evening shift The concern was discussed with the DON on 5/1/25 at 9:39 AM. The DON reported that Resident #365 resided in the Catoctin unit where staff worked 12-hour shifts. The DON indicated that she would pull staffing sheets and review the resident's medical records to explain the missing documents for toileting and continence care. On 5/1/25 at 10:52 AM, the DON reported that after she reviewed Resident #365 medical records and staffing sheets, she did not find documentation to indicate incontinent care was provided to the resident on the identified shift stated above. The DON verbalized understanding and acknowledged the 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. 51900 Based on record review, and interviews, it was determined that the facility failed to ensure that medications and treatments were administered per physician orders. This was evident in 1 (Resident #363) of 53 residents reviewed during the survey. The findings include: Resident #363 has a medical history of kidney failure, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), depression, and chronic pain. On 4/30/25 at 8:10 AM, the surveyor reviewed Resident #363's Medication Administration Records (MAR) and Treatment Administration Records (TAR), which revealed multiple instances of missed medications and treatments that had been ordered by the resident's physician. The missed medications and treatments are as follows for March 2025: -3/31 - Mirtazapine 15 mg -3/19 & 3/31 - Rocklatan Ophthalmic Solution 0.02-0.05% -3/19 & 3/31 - Buspirone 7.5 mg -3/19 & 3/31 - Trospium Chloride 20 mg -3/21 - Behavior monitoring for medication side effects (related to Buspar, Hydroxyzine, Remeron, and Zoloft) -3/21 - Observation for side effects related to psychotropic medication -3/21 - Fluid restriction: 2000 mL daily for CHF monitoring -3/21 & 3/28 - Oxygen use at 2 L/min via nasal cannula continuously (monitor for hypoxia [the bodies tissues and organs are not receiving enough oxygen]) -3/19 & 3/21 - Pain management monitoring -3/19 & 3/21 - Vital signs monitoring -3/18 - Wound care: Surgical incision -3/18, 3/21, 3/31 - Desitin external cream 13% topical application -3/18, 3/21, 3/31 - Observation for changes in condition -3/18, 3/21, 3/31 - Prevention of resident from lying flat; monitor for shortness of breath (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/31 - Monitor for abnormal breathing related to anticoagulant use -3/18, 3/21, 3/31 - Ensure pressure-reducing mattress is in place every shift -3/18, 3/21, 3/31 - Pressure redistribution cushion to chair every shift On 4/30/25 at 11:29 AM, The surveyor spoke with the facility's Director of Nursing (DON) and requested a review of the March 2025 MAR, which showed multiple instances where it appeared that Resident #363 did not receive medications or treatments as ordered. The DON indicated that she would investigate the matter further, adding that administration records would typically be signed off if the assigned tasks had been completed. On 4/30/25 at 12:44 PM, The surveyor spoke with the DON, who confirmed that the medications and treatments for Resident #363 had not been administered on the dates in question. On 5/01/25 at 10:55 AM, The surveyor spoke with the Nursing Home Administrator (NHA) to express concerns about multiple dates on which Resident #363 did not receive medications or treatments as directed. The NHA agreed that this is a troubling issue and that the facility would be looking into the system failure.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139 Based on pertinent document review and interviews, it was determined that the facility failed to provide treatment for a pressure injury. This was evident for 3 (Residents # 364, #369 and #108) out of 4 Resident reviewed for Pressure injury during a survey. The findings include: 1) On 4/29/25 at 12:50 PM a review of intake #MD00215184 revealed a concern regarding Resident #364's medical treatment during their stay at the facility. On 4/29/25, a review of medical records revealed that Resident #364 was transported to the hospital 2 days after admission to the facility. Review of the hospital discharge summary dated 1/3/25 revealed that resident #364 had a pressure injury described as moisture related skin injury. The continued review of the medical record revealed that Resident #364 returned to the facility on [DATE] . On 4/29/25 at 1:15 PM a review of Resident #364's medical record revealed that s/he received visits by the wound care team on 1/16/25, 1/23/25 and 1/30/25. Review of the wound care team's documentation revealed that the resident had a stage 2 (open wound) pressure injury to the Left buttock and Gluteal cleft. Further review revealed that the wound team recommended a treatment of [NAME]/Zinc cream to the stage 2 pressure injury every shift. On 4/29/25 at 2:40 PM a review of orders revealed an order with a start date of 1/28/25. Further review of the order revealed; Apply [NAME]/Zinc cream to Left buttock and Gluteal cleft Q shift and PRN every shift and as needed for wound healing. Continued review of orders failed to reveal orders for wound care treatment for the buttock and Gluteal cleft prior to 1/28/25. On 4/29/25 at 2:50 PM Review of the medication administration record and Treatment administration record, failed to reveal that [NAME]/Zinc cream was administered prior to 1/28/25. On 04/30/25 09:53 AM the Director of Nursing (DON) was interviewed regarding the pressure injury treatment for Resident #364. The Director of Nursing confirmed that Resident #364 had a pressure injury (moisture related skin injury). In addition, she confirmed that the wound care teams recommendations nor an alternative treatment was implemented to treat the pressure injury. 51900 2) Resident #369 was hospitalized prior to admission to facility with a history of cancer and was undergoing chemotherapy and immunotherapy treatments. Further s/he has a history of depression, anxiety, low back pain, had sustained a burn injury from a heating pad near the sacral (at the base of the spine near the tailbone) area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Minimum Data Set (MDS) is a standardized assessment tool that helps to evaluate the health status of residents in long-term care facilities. The information gathered helps facilities to develop patient centered care plans based on the resident's unique needs. The MDS assessment is a mandated requirement for all residents. On 4/29/25 at 8:50 AM, the surveyor reviewed Resident #369's medical record in response to an intake complaint (MD00204145). The resident's MDS assessment, specifically section M (Pressure Ulcers), dated 3/4/24, indicated that the resident had three unstageable pressure ulcers upon admission. It also noted that the resident was at risk for developing additional pressure ulcers and required preventive care. On 4/29/25 at 12:50 PM, the surveyor reviewed the resident's Medication and Treatment Administration Records and found that wound care treatments had been missed on the following dates: - On 2/28/24, the following wound care order was documented: Wound-buttocks and sacrum. Cleanse with normal saline, pat dry, apply calcium alginate, and cover with DCD. Perform wound care every dayshift. Monitor for signs and symptoms of infection every dayshift (order effective from 2/27/24 to 2/28/24 8:20 am). However, this treatment was not administered. An additional wound care order was entered on 2/28/24 at 8:32 AM but also was not provided to the resident. The order read: Buttocks/sacral wounds: Cleanse wound with NS, apply a nickel-thick layer of Santyl to the wound bed only (use less if the skin surrounding the wound appears mushy, moist, or white). Cover with a single layer of Vaseline gauze, avoiding contact with the peri-wound skin. Cover with gauze and secure with roll gauze tape. Perform every dayshift for wound care. Further review showed another order for Santyl external ointment 250 unit/GM (collagenase): Apply to buttock topically every dayshift for pressure ulcer. While this application was documented as completed, there was no evidence to confirm that the wound was cleaned and dressed in accordance with the additional specified wound care instructions. Further review revealed that the resident had a new wound care order dated 3/2/24, which instructed the following: Buttocks/sacral wounds: Soak with Vashe for 10 minutes, then cleanse the wound with normal saline, apply a nickel-thick layer of Santyl to the wound bed only (use less if the skin surrounding the wound is mushy, moist, or white), apply calcium alginate and DPD, daily and as needed, every day shift for wound care (order effective from 3/2/24 to 3/23/24). According to Resident 369's treatment record, this wound care was missed on 3/4, 3/12, and 3/16/25. Additionally, Resident #369 had an order stating: Customer observed daily for changes in condition. All changes are documented in nursing notes every shift (initiated on 2/26/24). However, was not completed on 3/12 and 3/16/25 during the day shifts. On 4/29/25 02:30 PM, the surveyor interviewed the Director of Nursing (DON) and expressed concerns about the missing wound care treatments and observations. The surveyor reviewed each instance of missing treatments, and the DON agreed that based on the treatment record documentation it appears the treatments were skipped. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 7:20 AM, the DON confirmed that she was unable to provide documentation showing that the wound care treatments had been completed. She acknowledged that while it appeared the Santyl medication was administered, there was no evidence to confirm that the additional wound care steps-specifically cleaning and dressing the wound-had been performed. The surveyor expressed concern that there is sufficient evidence to indicate the facility failed to support proper healing of the pressure ulcer due to missed treatments. The DON acknowledged that it is a concern and stated that it made her sad that it was missed. On 5/01/25 at 10:55 AM, the surveyor spoke with the Nursing Home Administrator (NHA) and expressed concerns that there was evidence indicating the facility failed to provide necessary treatments to prevent pressure ulcers. The NHA acknowledged that this was a valid concern. 52284 3) Review of Resident #108's care plan revealed a problem initiated on 3/31/25 for the identified problem alteration of skin integrity at the sacrum related to pressure. A pressure ulcer is skin breakdown caused by pressure, usually over a bony prominence, but can also be caused by pressure from a medical device. Pressure ulcers are categorized using numbers for stages, a stage 1 being the most superficial type, and stage 4 being the deepest. On 04/23/25 at 10:55 AM, a review of Resident #108's Treatment Administration Record (TAR) for April 2025 revealed an order dated 3/30/25 that instructed the nurse to provide wound care daily. The TAR lacked documentation of wound care on 4/08/25, 4/15/25, 4/18/25. On 4/23/25 at approximately 1 PM, in an interview with the unit manager (Staff #3), the TAR was reviewed together and she confirmed that care was not provided. She stated that no additional evidence could be provided. On 05/01/25 at 10:35 AM the deficiency was discussed in an interview with the Nursing Home Administrator. No further evidence was provided by the end of the survey.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 51489 Based on review of employee files and staff interviews, it was determined that the facility failed to conduct annual nursing staff performance reviews ensuring competencies in their skills. This was evident for 5 out of 5 employee files (#3, #15, #26, #36 and #39) reviewed for skill competencies during the recertification survey. The findings include: On 4/22/25 at 7:38 AM, in an interview with the Director of Human Resource (Staff # 37), she communicated that staff must, as a condition of employment, complete annual online in-service training and maintain competencies. On 4/30/25 at 10:21 AM, in an interview with the Director of Nursing (DON), she could not provide documentation of staff competencies, and stated, The process for tracking staff training and competencies is broken. On 4/30/25 at 12:47 PM, Staff #37 acknowledged that the facility did not maintain employee records. On 4/30/25 at 1:09 PM, a review of employee files (#3, #15, #26, #36 and #39) revealed that all staff were missing documentation for annual skill competencies.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 51489 Based on record reviews of employee files and staff interviews, it was determined that the facility failed to develop a system that provides and tracks the required training for dementia management, abuse, neglect, exploitation, and misappropriation of resident property. This was evident for 5 of 5 random employee files (Staff #3, #15, #26, #36 and #39) and 1 employee reviewed for an allegation of abuse during the survey. The findings include: 1) On 4/22/25 at 7:38 AM, in an interview with the Director of Human Resource (HR) (Staff #37), she communicated that staff must, as a condition of employment, complete the required annual in-service training. On 4/30/25 at 8:33 AM, in an interview with the Director of Nursing (DON), she explained that annual training is through Carefeed. All employees receive an email and/or text to complete the required training. Human Resources tracks staff participation. If an employee doesn't stay current, they are removed from the schedule- that's my practice, I can't speak for other departments. On 4/30/25 at 08:46 AM, in a subsequent interview with Staff #37, she explained that HR is responsible for tracking staff's compliance through Carefeed. An email and text message are sent to every employee in March and staff have a full year to complete. The surveyor clarified, it's the facility's process to get all employees on the same calendar schedule. Staff #37 replied, yes. Do you have a process in place for Agency staff? I don't work with Agency staff, that's nursing leadership. Staff #37 was asked, What happens when staff are non-compliant in completing the on-line training? I send an email to the Nursing Home Administrator (NHA) and DON making them aware. And then what happens? Staff #37 replied, I'm not sure. I don't have confidence in the system. On 4/30/25 at 10:07 AM, the DON acknowledged that agency staff did not have dementia management training because the agency didn't know that it was a requirement. The DON stated, as of today, I don't know the status of agency training because it's not being tracked. On 4/30/25 at 12:47 PM, a record review of 5 random employee files (#3, #15, #26, #36 and #39) revealed that all employees were missing most of the required training. 45139 2) On 4/24/25 at 2:43 PM, the review of Intake # MD00211246 revealed an allegation of employee to resident abuse. 4/24/25 04:33 PM The Director of Human Resources (Staff #37) provided the employee file for the alleged perpetrator geriatric nursing assistant (GNA #38.) A Review of GNA #38 file, failed to reveal any abuse or dementia education for the year 2024. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/24/25 05:32 PM, Interview with Staff #37 confirmed that there is no documentation that GNA #38 received said education. In addition, Staff #37 confirmed that the GNAs are required to receive dementia and abuse training every year. 5/01/25 10:50 AM, Interview with DON concern discussed. The DON confirmed that the staff have from January 1st to December 31st of any given year to complete their annual education. The DON confirmed that Staff #38 did not complete their required dementia or abuse training between 1/1/24 and 12/31/24.