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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility failed to provide privacy to a resident during a dressing change. This was evident for 1 (Resident #108) of 4 residents observed for pressure ulcer care. The findings include: On 04/24/25 at 01:16 PM during an observation of Resident #108's dressing change, the resident's frontal private area was exposed. The privacy curtain was only half drawn around the bed. Present were the Licensed Practical Nurse (LPN #6), unit manager (Staff #41), and an unidentified Geriatric Nursing Assistant (GNA). During the observation, another unidentified GNA entered the resident's room to collect meal trays. The surveyor informed the second GNA that Resident #108 was having personal care provided and tried to redirect the GNA. The GNA proceeded into the room, walked past the exposed resident, and stated I know, I'm collecting the [roommate for Resident #108] tray. On 4/24/25 at 4:10 PM in an interview with the unit manager (LPN #3), she was informed that the Resident #108's private area was exposed during a dressing change and that staff failed to ensure the resident's dignity/privacy. LPN#3 acknowledged the deficiency. 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.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, pertinent document review and interviews, it was determined that the facility failed to have an effective process in place to ensure that the residents receive their choices from the alternative menu. This was evident for 1(Resident #69) in a random dining observation. The findings include: On 4/24/25 at 6:52 PM an observation in the dining room of the [NAME] Grove nursing unit was made. An observation of Resident #69's dinner tray revealed two separate meal tickets laying on the dinner tray. One of the meal tickets was titled Resident meal change. It revealed that a peanut butter & Jelly sandwich was circled and extra gravy was handwritten on the ticket. The second meal ticket indicated that the resident was to receive hot tea. Observation of Residents #69's dinner plate revealed steak and rice with no gravy and failed to reveal a peanut butter sandwich or hot tea. On 4/24/25 at 7:00 PM, interviews were conducted with the residents sitting at the table with Resident #69. Resident #88 reported that s/he does not always receive his/her alternative choices for a meal. S/he reported that s/he submitted his/her alternative meal ticket for dinner tonight but did not receive the alternatives s/he requested. Resident #88 reported that s/he had submitted a ticket in the designated area (a basket at the nurse's station) prior to 1:30 PM. After 3:30PM, s/he noticed the ticket was still in the basket and s/he handed the meal ticket to Kitchen staff #14. S/he reported that s/he did not receive his/her alternative items that were requested for the dinner 4/24/25. Resident #42 reported that s/he does not submit an alternative food request because in the past the requested alternative food is not delivered. Resident #78 reported that the facilities system for receiving alternatives for menu items does not work. S/he reported that s/he has gotten to know kitchen staff and makes a verbal request directly to the kitchen staff and does not submit his/her request through the facility process. On 4/25/25 at 11:10 AM the Certified Dietary Manager Consultant (CDM Staff 11) was interviewed. During the interview, the above observations and interviews were shared. She confirmed that having two meal tickets on the tray and the current systems in place for requesting and receiving menu alternative was not effective. On 5/01/25 The above concerns were shred with the Nursing Home Administrator. No additional information was provided prior to the end of the survey.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews, it was determined that the facility failed to ensure that Beneficiary Protection Notifications were issued to residents discharged from Medicare Part A services but had benefit days remaining and intended to remain at the nursing facility receiving non-skilled care. This was evident for 2 (Resident #5, #39) of 3 residents reviewed for Skilled Nursing Facility Beneficiary Protection Notification. The findings include: Residents with Medicare Part A have certain rights and protections related to financial liability and appeals. The financial liability, appeal rights, and protections are communicated to beneficiaries through notices given by providers to residents who are being discharged from Medicare services but have Medicare benefit days remaining. The notices include: Notice of Medicare Non-Coverage (NOMNC): This must be issued at least two calendar days before the last day of Medicare coverage. The NOMNC informs the beneficiary of his/her right to an expedited review of the services termination. The resident and/or their representative must receive a copy of the notice in enough time to appeal the decision to terminate the paid coverage. The facility must indicate that the notice was sent/and/or given within the specified time. Skilled Nursing Facility Advance Beneficiary Notice (SNFABN): This notice must be issued far enough before delivering potentially non-covered services to allow sufficient time for the beneficiary to consider all available options. 1) Record review on 4/23/25 of the Beneficiary Notification checklist completed and provided by the facility to the survey team showed that Resident #5's Medicare A services in the facility started on 11/7/24 and ended on 1/20/25. The resident continued to remain in the facility after the last day of his/her Medicare coverage. The review contained a NOMNC for Resident #5. The NOMNC was signed on 1/17/25 by business office manager (staff #19), to indicate that the notice was delivered via telephone to the resident's representative. However, the review did not show that Resident #5 or his/her representative was issued SNFABN. The SNFABN should have been provided to Resident #5's representative at the end of his/her skilled services. This would have allowed the resident to choose to continue with non-covered items or services. The notice would have also estimated the cost of services and listed why Medicare may not pay. The facility's Advance Beneficiary Notices policy given to the surveyor was reviewed on 4/23/25 at approximately 12:10 PM. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy stated, If the notice cannot be hand-delivered (for example, such as in the case of an incompetent resident and the representative is out of town), a telephone notice shall be made, followed up immediately with a mailed, emailed, faxed, or hand-delivered notice. However, the earlier review lacked evidence that a copy of Resident #5's NOMNC was mailed to his/her representative after the notification was done via phone. In an interview on 4/23/25 at 12:21 PM, the business office manager (staff #17), reported that she was unaware that she had to mail the NOMNC to the Resident's representative because it was not hand-delivered in person. She also confirmed that Resident #5 continued to stay in the facility after Medicare A services ended. However, she did not issue SNFABN to the Resident or his/her representative. 2) A review was completed on 4/23/25 at 10:48 AM of Resident #39's Beneficiary Notification checklist, which the facility completed. The review indicated that Resident #39's Medicare Part A services in the facility started on 11/27/24 and ended on 2/3/25. The continued review noted that the facility initiated Resident #39's discharge from Medicare Part A services when benefit days were not exhausted and s/he remained in the facility. However, the review failed to show that NOMNC and SNFABN were issued to the resident or his/her representative before services were ended. In an interview on 4/23/25 at 12:21 PM, staff #17 said she lacked documentation to show that a NOMNC and SNFABN were issued to Resident #39 when Medicare A services ended on 2/3/25.

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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 interviews and observation it was determined that the facility failed to maintain a clean home-like environment. This was evident for 1 shower room out of 2 shower rooms observed during a survey. The findings include: On 4/25/25 at 8:06 AM, Resident #69, a long-term resident of the facility, reported to the surveyor that the [NAME] Grove shower room floors had a black and brown substance on/in the cracks in the shower room floor. On 4/25/25 at 8:15 AM an observation of the Sugar Loaf shower room was made with the nurse unit manager (Staff #5). The observation revealed cracks along the grout edge of the floor in the two of the three shower stalls rooms. In addition, small black and brown spots were visible in the cracks of the shower stall floor. Staff #5 reported she would notify housekeeping and maintenance. On 4/25/25 at 9:51 AM The Maintenance Director (Staff #18) was interviewed. Staff #18 reported that he was aware of the concerns with the shower stall floors. He reported that he recommended the walls and the floor be replaced several years ago. He reported that the tile on the walls had been replaced but not the floor tiles. He reported he has applied silicone and grout but, it has not corrected the issue. On 4/29/25 at 3:27 PM an observation was made with the Nursing Home Administrator (NHA) of the Sugar Loaf shower room stall. The NHA confirmed the black and brown substance on/in the cracks in the shower room floor.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interviews, it was determined that the facility failed to identify a Grievance Official in the facility's grievance policy, and failed to ensure that grievances were followed up with a written response. This was evident for 5 of 5 grievance investigations reviewed during the recertification survey. The findings include: A review of the facility's grievance policy, dated 12/22/22 revealed Name and Title instead of the grievance officer's name, and List contact information instead of the actual contact information. Further review of the policy revealed the following definition: The Grievance Official for the facility navigates the grievance process as a part of resident rights by receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. On 04/28/25 at 02:44 PM, a review of the grievance investigations for February 2025 was conducted with documents provided by the Nursing Home Administrator (NHA). All 5 grievance investigations reviewed failed to reveal who completed the grievance investigation, when they were completed, and if the decisions regarding the grievance were provided in writing to the resident. On 4/29/25 at 12:09 PM, in an interview with the NHA, she stated that she was the official grievance officer. When asked how residents were informed of results of grievance investigations, the NHA said everyone is provided a verbal follow up. The grievance policy dated 12/22/22 was reviewed with her and she confirmed that the policy did not indicate who the grievance officer was. A review of the 5 grievance investigations for February 2025 were also reviewed with the NHA and she confirmed that residents did not receive written follow up. On 05/01/25 at 10:35 AM, the deficiency was again discussed in an interview with the NHA. No further evidence was provided by the end of the survey.

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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. 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.

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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** 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. 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/25 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. 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. (continued on next page)

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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. Based on record review, interviews, and observation, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately recorded. This was evident for 2 (Resident #39, #48) of 4 residents reviewed for limited range of motion (ROM), 1 (Resident #40) of 7 residents reviewed for unnecessary medications, and 1 (Resident #110) of 3 closed record reviews. The findings include: The MDS (Minimum Data Set) is a complete assessment of the Resident that provides the facility information necessary to develop a care plan, provide the appropriate care and services to the Resident, and modify the care plan based on the Resident's status. MDS assessments must be accurate to ensure that each Resident receives the care they need. 1) A record review for Resident #39 on 4/21/25 at 1:48 PM included occupational and physical therapy evaluations dated 11/29/24 that had recorded that Resident #39 had impaired ROM to his/her left lower extremity and full ROM to both upper extremities. However, continued review of Resident #39's MDS assessments dated 12/1/24 and 1/28/25 showed documentation that Resident #39 had one-sided impairment to his/her upper extremity. In an interview on 4/21/25 at approximately 2:00 PM, staff #10, a licensed practical nurse (LPN), reported that Resident #39 had no impairment in ROM to his/her upper extremities. During an interview on 4/25/25 at 1:36 PM, staff #7, an MDS coordinator, indicated that part of documenting impaired ROM in the MDS was to review therapy evaluations and notes. Staff then said Resident #39's MDSs were coded in error in section GG after checking his/her therapy evaluations dated 11/29/24. 2) An observation of Resident #48 on 4/21/25 at 11:20 AM revealed that the Resident's right hand had contractures (fingers bent at the knuckle joints and unable to stretch them out). A record review on 4/23/25 at 6:48 AM contained an occupational therapy (OT) evaluation of 10/11/24 that documented impaired ROM to Resident #48's right shoulder, elbow, forearm, wrist, and fingers. The review showed that Resident #48's lower extremity had no impairment in ROM. Continued review of a rheumatology consultation report dated 10/14/24 indicated that Resident #48 had right-hand contracture. The review also contained an attending provider's order for Resident #48 to have a right-hand contracture management device. Further review contained MDS assessments for Resident #48 dated 1/2/25 and 4/5/25. The 1/2/25 MDS assessment had recorded that Resident #48 had no functional limitation in range of motion to his/her upper extremity. In the 4/5/25 MDS assessment, it was documented that Resident #48 had a limited ROM in his/her lower extremity. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/25/25 at 2:10 PM, staff #7 reported that Resident #48's MDS assessments dated 1/2/25 and 4/5/25 were recorded in error. 3) A record review on 4/23/25 at 1:12 PM, found a hospital OT evaluation dated 7/31/24 for Resident #40 that indicated that the Resident had full ROM to both of his/her upper extremities. The continued review showed the facility's OT evaluation and plan of treatment dated 8/3/24 and 2/21/25, which showed that Resident #40 had no impairment in ROM to either of his/her upper extremities. However, Resident #40's MDS assessments dated 8/8/24, 11/8/24, 2/8/25and 3/17/25 had all recorded that Resident #40 had functional limitation in range of motion to his/her upper extremity. During an interview on 4/25/25 at 1:51 PM, staff #7 confirmed that Resident #40's MDS assessments were documented inaccurately and said she would correct them.4) On 04/24/25 at 06:11 PM, a closed record review revealed a nurses note dated 2/07/25 that stated Patient discharged home today at 1330pm. Patient left with daughter. All physical medications in cart given to patient except for Narcotics. Discharge summary reviewed with patient. All questions answered accordingly. Scripts given to patient to take to her local pharmacy for refill. Patient left in good spirits, happy to be going home. Denies pain. Discharge vitals: BP-126/73, P-80, R-18, T-97.2, SP02-97%RA. On 4/25/25 at 10:37 AM, a review of Resident #110's MDS Assessment, dated 2/07/25 was conducted. In Section A 2105, Discharge Status, the entry indicated that the resident was discharged to a 04 Short-Term General Hospital. On 4/25/25 at 01:59 PM in an interview with the MDS Coordinator,(Staff #7), she reviewed Resident #110's MDS and verified the entry that the resident was coded as discharged to a hospital. She was asked to review the nursing note documentation and after she did so, she confirmed the MDS coding error. 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on pertinent document review and interviews, it was determined that the facility failed to perform a Pre-admission Screening and Resident Review (PASSAR) screen within 40 days of the resident admission. This was evident for 1 (Resident #69) out of 4 residents reviewed for PASSAR screening during a survey. The findings include: On 4/21/25 at 11:57 AM Resident #69, was a long-term resident of the facility. Review of medical records revealed Resident # 69 has a pre-admission screening and resident interview (PASSAR) screening completed on 12/12/23. Further review revealed that the attending physician certified, before admission to the nursing facility, that the resident is likely to require less than 30 days at the nursing facility. On 4/22/25 a review of Residents medical record failed to reveal an additional PASSAR completed within 40 days of Resident # 69 residing in the facility. 04/22/25 04:53 PM The Administrator was interviewed. She confirmed that Resident #69 was required to have new PASSAR screen after residing in the facility more than 40 days. The Administrator reported she was unable to provide the follow-up PASSAR, however she would continue to look for the document. 5/01/2025 10:15 AM during an interview the Administrator reported she was unable to provide a follow up PASSAR for Resident #69.

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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** 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** 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. 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. 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. 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. (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 4/29/25 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.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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f) 11/28/24 night shift 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. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 -3/31 - Monitor for abnormal breathing related to anticoagulant use (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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** 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 [DATE] 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 1/3/25 . 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. 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. 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 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. 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and record review, it was determined that the facility failed to have an effective process in place to ensure that recommendations from therapy are communicated to the nursing staff, failed to provide treatment to maintain a resident's range of motion (ROM), and failed to provide necessary adaptive equipment during meals. This was evident for 2 (Residents #50, #48) out of 4 reviewed for position and mobility and 1 (Resident #108) of 4 residents reviewed for pressure ulcers during a survey. The findings include: 1) On 4/21/25 at 4:33 PM Resident # 50, a long-term resident of the facility, was interviewed. During the interview s/he reported that s/he used to have a leg/ankle splint that s/he kept in their room, but now the splint is kept in the therapy room. Resident #50 stated s/he had worn the ankle when s/he walked. On 4/24/25 at 10:45 AM a review of a physical therapy discharge summary revealed that Resident #50 received Physical therapy in February 2025 through April 4th, 2025. Further review, under discharge recommendations, revealed Resident #50 to have a walking functional maintenance program (FMP). Continued review under comments listed ankle brace and Hemi walker (HW). On 4/24/25 at 10:53 AM a review of orders failed to reveal an order for an ankle splint or brace for Resident # 50 . On 4/24/25 at 10:54 AM a review of Resident #50's care plan failed to reveal that the resident used an ankle brace for safe walking. On 4/24/25 at 3:11 PM the Director of Rehabilitation (Staff #23) was interviewed. During the interview Staff # 23 reported that the recommended FMP for residents following discharge were relayed verbally to nursing staff. She failed to provide any documentation that the recommendations were provided to the nursing staff. On 4/24/25 at 11:38 AM the Unit Nurse Manger (Staff #5) was interviewed. During the interview Staff #5 reported that she is familiar with Resident #50 care, and that she has observed Resident #50 walking with a hemi walker. Staff #5 denied ever seeing her/him walk with an ankle brace. On 4/29/25 at 10:43 AM an Interview with conducted with Rehabilitation Director (Staff #23) Sugar Loaf nurse unit manager (Staff #5) and the facility Administer. The above facility staff confirmed that the use of a hemi walker and ankle was recommended by therapy for Resident #50's functional maintenance program, however, the nursing was unaware of the ankle brace. 2) 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. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/21/25 at 11:20 AM, Resident #48 was noted sitting in a wheelchair with right hand contracture (fingers bent at the knuckle joints and unable to stretch them out) and had no device in place. In a subsequent observation on 4/22/25 at 10:04 AM, Resident #48 was observed lying in bed, with no device in place for the right-hand contracture. A record review on 4/23/25 7:48 AM showed that Resident #48 was admitted to the facility in March 2022. The review contained an MDS assessment dated [DATE], which recorded that Resident #48 required maximal assistance to complete dependence on staff for most of his/her self-care needs. A continued review of physical therapy evaluation and plan of treatment dated 5/23/22 showed that Resident #48 had no limitations in ROM to both upper extremities. Further review revealed a referral by a nurse to therapy dated 9/12/24 that indicated Resident #48 had a right-hand contracture and needed to be evaluated for splinting. The referral recorded that the Resident's evaluation was assigned to occupational therapy (OT). There was a follow-up notation by OT on the form that stated [patient] to be set-up for self-feeding using [left upper extremity]. Plate and utensils and cup should be on left side of tray. However, the review failed to show that Resident #48's right-hand contracture was addressed with a splint to prevent further contracture. A review on 4/24/25 at 9:26 AM contained a rheumatology consult report for Resident #48 dated 10/14/24. The report included a notation that the Resident had pain in 3rd and 4th finger flexors. Inability to extend 3rd and 4th fingers. The review also found an attending provider's order initiated on 3/28/25 for Resident #48 to wear a palm guard on the right hand for contracture prevention/management. However, earlier observations failed to show that Resident #48 was wearing the palm guard on his/her right-hand contracture. During an interview in Resident #48's room on 4/23/25 at 7:03 AM, Staff #2, Haven's unit manager, confirmed that Resident #48 was not wearing any device on his/her right hand. Staff checked the residents' nightstand table, took the palm guard, and stated she would take care of it. In an interview on 4/24/25 at 9:46 AM, staff #23, the therapy manager, said her staff acted on any referrals they received from the nurses. If any issues were identified, they were addressed immediately. However, the earlier record review failed to show that Resident #48's right-hand contracture was addressed when a referral was sent to therapy on 9/12/24. 3) A physician's order dated 4/15/2025 in Resident #108's medical record stated, Apply foam utensil adaptors at meal times. Nursing to apply with meals for optimum intake, independence. Review of the resident's care plan on 04/24/25 at 2:33 PM failed to reveal any intervention related for Resident #108 to use adaptive utensils during meals. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/25 at 6:16 PM, Resident #108 was observed as he/she ate dinner in bed without the use of any adaptive utensils. The resident, the resident's spouse, and the therapy director (Staff #23) were present. Staff #23, the spouse, and the resident all confirmed that the adaptive device had not been available for the past week. Staff #23 also said that the device was supposed to be stored at the resident's bedside. On 04/25/25 at 1:01 PM during an interview with unit manager (Staff #3), she acknowledged and confirmed the deficiency. 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, it was determined that the facility failed to provide proper urinary catheter care. This was evident for 1 (Resident #108) reviewed during the initial screening of the 32 residents of the Catoctin unit during the recertification survey. The findings include: A record review revealed an order dated 04/02/25 for Foley catheter 16 FR with 10cc balloon to bedside straight drainage for diagnosis of hx [history] of urine retention on Resident #108's Treatment Administration Record (TAR). A urinary catheter is a flexible tube inserted into the bladder to drain urine. When a catheter is in use, the drainage bag must be kept below the level of the bladder at all times to ensure urine flows by gravity, which helps prevent urine backflow into the bladder and reduces the risk of urinary tract infections (UTIs). This positioning is a standard infection control practice and is typically outlined in facility policy and The Centers for Disease Control (CDC) guidelines for catheter care. On 4/21/25 at 1:57 PM Resident #108 was observed in his/her room, up in Geri chair, visitor at bedside. The foley bag with urine was lying on the resident's lap above the level of the resident's bladder. On 04/22/25 at 9:06 AM, the surveyor observed Resident #108 seated in a gerichair with the foley bag with urine lying on the resident's lap above the level of the resident's bladder. 04/25/25 10:50 AM, a review of the facility catheter care policy dated 1/6/23 revealed policy explanations that included, but were not limited to: #9) Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. On 04/24/25 at 04:10 PM during an interview with the unit manager (Staff #3), the concerns regarding catheter care for the resident were discussed and the deficiency was confirmed. On 05/01/25 at 10:35 AM these findings were reviewed with the Nursing Home Administrator. No further evidence was provided by the end of the survey.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, it was determined that the facility failed to have an order in place for oxygen administration and failed to follow an attending physician's order to administer oxygen to a resident. This was evident for 2 Resident (Resident #74, #315) of 3 residents reviewed for Respiratory Care during the survey. The findings include: On 4/21/25 at 1:57 PM, Resident #74, a long-term resident of the facility, was observed in his/her room with oxygen being administered through a nasal cannula at a rate of 2 liters per min (2L/min). On 4/21/25 a review of Resident #74's orders failed to reveal an order for oxygen. On 4/22/25 at 7:44 AM, surveyor alerted Licensed Practical Nurse (LPN #6) regarding concerns with oxygen order in the facility. On 4/22/25 at 3:12 PM, a review of the medication administration report (MAR) revealed that Resident #74 received oxygen on 3/1/25 through 3/26/25. The oxygen order was discontinued when Resident #74 was transferred to the hospital on 3/26/25. Resident #74 returned to the facility 4/1/2025. Further review of medical administration record for April 2025, failed to reveal documentation of oxygen administration from April 1st to April 21st. On 4/22/25 at 2:48 PM, review of Vital signs revealed that Resident #74 was receiving oxygen April 1st through April 21st. On 4/28/25 review of Resident #74 re-admission nursing assessment dated [DATE] revealed that the resident was receiving oxygen when he returned to the facility. On 4/22/25 at 2:38 PM, Review of orders revealed an order with a start date of 4/22/25 Oxygen at 2 L/min via Nasal Cannula, continuously. every shift for COPD start date 4/22/2025 15:00 On 4/28/25 at 3:24 PM, The Director of Nursing (DON) was interviewed. During the interview she confirmed that although Resident #74 was receiving oxygen there was no order or documentation on the MAR that the resident was receiving oxygen.2)During a tour of the Catoctin unit on 4/21/25 at 9:47 AM, Resident #315 was observed lying in bed and receiving oxygen through nasal cannula tubing attached to an oxygen concentrator set at 3.5L(Liters). The resident was asked at that time how many Liters of oxygen s/he was to receive and responded 2 L of oxygen. A subsequent observation on 4/22/25 at 7:42 AM showed Resident #315 continued to receive oxygen through nasal cannula tubing at 3.5L. A medical record review completed for Resident #315 found an order summary report for April 2024 that contained an attending provider's order initiated on 4/17/24 for Oxygen at 2 L/min via Nasal Cannula continuously every shift for recurrent [pneumonia]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/22/25 at 7:44 AM, a licensed practical nurse (LPN #6), was at Resident #315's bedside with the surveyor. Staff #6 was asked to confirm the rate of the resident's oxygen and reported it was set over 3L. A subsequent interview with LPN #6 showed that Resident #315's attending provider's order for oxygen was 2L/min. The staff confirmed the concern and said she would take care of it.

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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. 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant (GNA) personnel files and staff interview, it was determined that the facility staff failed to conduct yearly performance reviews and ensure twelve (12) hours of annual in-service education was provided. This was evident for 2 (GNA #15 and GNA #36) of 2 personnel files reviewed during the recertification survey. The findings include: On 4/22/25 at 11:52 AM, a review of GNA #15's and GNA #36's personnel files lacked evidence of yearly evaluations and 12 hours of in-service education. On 4/30/25 at 10:21 AM, in an interview with the Director of Nursing (DON), she acknowledged that annual performance reviews are supposed to be completed by the DON or unit manager and stated they're supposed to be in the employee file. On 4/30/25 at 12:47 PM, the Director of Human Resources (Staff #37) confirmed that the on-line training takes 9.4 hours to complete, and that the facility was deficient in maintaining employee records. No other documentation was provided to show additional GNA training hours for the remaining 2.6 hours.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record reviews and interviews, it was determined that the facility failed to ensure that a controlled substance logbook was signed by 2 licensed staff at change of shifts. This was evident for 1 of 4 controlled substance logbooks inspected during the survey. The findings include: Controlled substance logbooks are typically kept in medication carts and are used to determine that drug records are in order and that an account of all controlled drugs are maintained with sufficient detail. All controlled substances kept in the medication cart should match their record in the drug control book. On 4/22/25 at 11:55 AM, a review of the controlled substance logbook for April of 2025, on cart #2 in the Catoctin unit of the facility was conducted. The review revealed that the documentation had several columns to indicate information that include the date, time, nurse counting out, and nurse counting in. The review identified several concerns that include: a) Dates were not all in chronological order b) Dates with only 1 signature from a licensed staff c) Dates with no signature from any licensed staff The Licensed Practical Nurse (LPN #16) who was currently assigned to cart #2 was interviewed on 4/22/25 at 12:08 PM. During the interview, LPN #16 reported the process during change of shift between licensed staff. She indicated that nurses are responsible in signing in and out at all times and stated, when you take the keys for the cart, it does not matter what time, you should sign the logbook, referring to the controlled substance logbook. On 4/22/25 at 2:46 PM, a printed copy of the controlled substance logbook was reviewed with the Director of Nursing (DON). The DON confirmed the concerns identified above. The DON reported that the Catoctin unit had 3 medication carts but was usually staffed with 2 nurses. The responsibility for cart #2 was shared between the 2 nurses and indicated that it may be contributing to the concerns identified with the logbook. The DON reported that she would review the controlled substance logbook and staffing of the Catoctin unit. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 10:05 AM, the DON confirmed the missing signatures in the controlled substance logbook on cart #2 of the Catoctin unit. The DON offered no further explanation and acknowledged the concern. The DON also provided the surveyor with a copy of the communication dated 4/22/25 to all nurses working on the Catoctin unit, effective on the same date, that stated, When 2 Nurses are scheduled, the nurse assigned to Med Cart 3 will be responsible for the narcotic count on Med Cart 2. This nurse will be responsible for ensuring correct count and signing the controlled substance log.

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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 medical record review and interviews, it was determined that the facility failed to ensure that the attending physician reviewed irregularities identified by the pharmacist, acted upon them in a timely manner, and documented them in the Resident's medical record. This was evident for 1 (Resident #40) of 7 residents reviewed for unnecessary medications. The findings include: A medical record review on 4/23/25 at 1:12 PM showed a consultant pharmacist's note that indicated that Resident #40's monthly medication regimen review (MRR) was completed on 10/16/24 with irregularities identified. The note stated, see report comments/recommendation(s). However, the continued review failed to show the report filed in Resident #40's medical record and documentation that the Resident's attending provider reviewed and addressed the recommendation. In an interview on 4/24/25 at 7:57 AM, a Unit Manager Licensed Practical Nurse (LPN #2), reported that once the irregularity on the MRR was addressed, it was kept on the Resident's hard chart. However, staff stated she could not find the report in Resident #40's hard chart. In a subsequent interview on 4/24/25 at 11:11 AM, LPN #2 provided Resident #40's MRR report to the surveyor. The report lacked evidence that the Resident's attending provider reviewed and addressed it. LPN #2 stated, We missed this one. During an interview on 4/29/25 at 1:05 PM, the Director of Nursing said that Resident #40's MRR report should have been signed, indicating it was reviewed and addressed by the attending physician.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on records review and interviews, it was determined that the facility failed to ensure non-pharmacological interventions were provided or attempted prior to administering a psychotropic medication. This was evident for 1 (Resident #371) of 7 residents reviewed for unnecessary medications. The findings include: Resident #371 was admitted to the facility in early 2024. A review of the complaint related to MD00202745 alleged that the resident was over sedated due to the combination of medications that were being administered to the resident. On 4/23/25 at 2:17 PM, a review of Resident #371's medical record was conducted. The review revealed that the resident was prescribed Ativan (Lorazepam) on an as needed basis from 1/10/24 to 1/24/24. The electronic Medication Administration Record (eMAR) indicated that the Ativan was administered on 1/11/24, 1/14/24, and 1/18/24. Lorazepam (Brand name- Ativan) is used to treat anxiety disorders. It is also used for short-term relief of the symptoms of anxiety or anxiety caused by depression. Lorazepam is a benzodiazepine that works in the brain to relieve symptoms of anxiety. Benzodiazepines are central nervous system (CNS) depressants, which are medicines that slow down brain activity and can cause a range of effects, including relaxation, drowsiness, and even unconsciousness. On 4/24/25 at 9:45 AM, the Unit Manager Licensed practical Nurse (LPN #2) was interviewed. During the interview, LPN #2 explained the facility's process with the use of as needed psychotropic medications and non-pharmacological interventions (NPI). LPN #2 stated, we try not to use it (psychotropic medication) and indicated that NPI's are attempted first prior to the medication. LPN #2 reported that she remembered Resident #371 and indicated that if NPI's were not documented on the eMAR then there should be a progress note about it. A review of Resident #371's progress notes was conducted with LPN #2 on 4/24/25 at 9:54 AM. LPN #2 confirmed that the Ativan was administered on 1/11/24, 1/14/24 and 1/18/24. The review also revealed that NPI's were attempted prior to the Ativan administration on 1/11/24 and 1/18/24 but was not documented prior to the 1/14/24 administration. LPN #2 stated, I do not see anything for the 1/14/24 and indicated that she would continue to review Resident #371's medical record to see if the nurse had somewhere else. On 4/24/25 at 11:04 AM, LPN #2 reported that after reviewing Resident #371's medical records, she did not find documentation to indicate that NPI was attempted prior to administering the Ativan on 1/14/24. LPN #2 verbalized understanding of the concern.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and record reviews, it was determined that the facility failed to ensure medications were stored and labeled properly as evidenced by failing to discard expired medications and failing to date medications when they were opened. This was evident in 1 of 2 medication storage rooms and 3 of 4 medication carts inspected during the survey. The findings include: An inspection of 2 medication storage rooms and 4 medication carts was conducted during the recertification survey. Concerns identified during the inspection were: 1) On 4/22/25 at 9:48 AM, a Licensed Practical Nurse (LPN #6) was interviewed about her process in restocking her medication cart. LPN #6 reported that most medications come from the pharmacy and the rest were kept in the medical records room. On 4/22/25 at 10:04 AM, the Director of Nursing (DON) confirmed that most medications are supplied by the pharmacy that are specific to the residents. The few medications that are supplied by the facility were stored in the medical records room. The DON accompanied the surveyor to the medical records room for inspection. During the inspection, 3 bottles of aspirin 325 mg. containing 100 tablets each were observed to be expired. The DON confirmed the observation and reported that she would discard the expired bottles. The DON also reported that Staff #40, who oversaw medical records and medical supplies was currently out on sick leave. 2) A) An inspection of a medication cart in the sugarloaf unit was conducted on 4/22/25 at 11:22 AM. The medication cart inspected was currently assigned to LPN #42. During the inspection, an inhaler (Albuterol Sulfate 90 mcg.) with an expiration date of 1/2/25 was observed. The inhaler had Resident # 80's name on it. On 4/22/25 at 11:37 AM, LPN #42 confirmed the expired inhaler and reported that Resident #80 was not taking the inhaler anymore. B) An inspection of a medication cart in the Catoctin unit was conducted on 4/22/25 at 11:41 AM. The medication cart inspected was currently assigned to LPN #6. During the inspection, an inhaler (Wixela-Fluticasone/Sameterol 250-50 mcg.) was observed with 58 out of 60 doses left. The inhaler had Resident #315's name on it. The inhaler was also observed with an area to indicate the date from when it was opened. However, this area was not marked and there was no other documentation or marking on the box to indicate when the inhaler was opened. A label on the medication and box indicated that the medication should be discarded 1 month after removal from the foil pouch or when the counter reads 0, whichever comes first. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 11:53 AM, LPN #6 confirmed that there was no documentation to indicate when the inhaler was opened and indicated that she would review the resident's medical records to find out when it was opened. C) An inspection of a medication cart in the Haven unit was conducted on 4/22/25 at 2:20 PM. The medication cart inspected was currently assigned to LPN #10. The Unit Manager (LPN #2) was also present during the inspection of the medication cart. During the inspection, 3 inhalers (Wixela-Fluticasone/Sameterol 250-50 mcg.) for Resident #22 were observed in the medication cart. All 3 inhalers were opened. The first one had an open date of 2/21/25 with 33 doses left as indicated on the counter; the second one had an open date of 3/9/25 with 22 doses left; and the third one had 59 doses left but was not dated when it was opened. Both LPN #10 and LPN #2 confirmed the observation and could not answer definitively when asked which of the 3 inhalers was being administered to the resident. Both staff were also unaware when the third inhaler was opened. A review of the label on the inhaler and the box was conducted with LPN #10 and #2. Both staff acknowledged that the first 2 inhalers should have been discarded prior to opening the third inhaler. Also, the third inhaler should have dated as soon as it was opened. The Director of nursing was interviewed on 4/22/25 at 2:46 PM. During the interview, the concerns were discussed with finding expired medications, inhalers that were not labeled when they were opened, and inhalers kept in the medication cart beyond the discard dates. The DON verbalized understanding and acknowledged the concern.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and pertinent document review, it was determined that the facility failed to have a process in place to ensure that Residents receive their meal in a timely manner and at a palatable temperature. This was evident for 1 of 1 food test tray reviewed during a survey. The findings include: On 4/21/2025 at 1:54 PM, Resident #74, a long-term resident of the facility, was interviewed. During the interview s/he reported that food is often late and does not have a palatable taste or temperature. On 4/24/25 at 7:20 AM, the Surveyor observed breakfast Catoctin cart 1 delivered to the unit by dietary Staff #33. On 4/24/25 at 7:21 AM, review of Document titled Glade Valley Center: Meal Deliver log revealed that the breakfast tray line starts at 7:00 AM and contains a nurse initial that the tray was received on the unit at 7:20 AM On 4/24/25 7:40 AM continued observation of Catoctin cart 1, failed to reveal that any trays were removed from the cart. Continous observation revealed the last breakfast tray was delivered at 7:56 AM On 4/25/25 7:50 AM, an observation was made of the tray line in the kitchen. During the observation the surveyor requested a duplicate tray of room [ROOM NUMBER] be made and labeled as a test tray. On 4/25/25 at 8:06 AM, continued observation revealed that Sugar Loaf cart #2 (which contained the test tray), was delivered to the unit. On 4/25/25 at 8:19 AM, the surveyor observed the staff as they began delivering the trays. Continuous observations of the breakfast tray distributions were made with the consultant Certified Dietary manager (CDM Staff # 11). On 4/25/25 at 8:35 During a brief interview with Staff #11 and Food service manager Staff #12, they reported that their goal for palatability food temperature was around 120 degrees Fahrenheit for the minimum temperature. On 4/25/25 at 9:01 AM the Test tray was removed from the Sugarloaf cart #2, 71minutes after the test tray was put in the cart. The CDM reported that the temperature of eggs was 107.4 and the oatmeal was 109.1 On 4/25/25 at 9:02, a review of the daily meal times revealed that Sugar Loaf breakfast was served at 8:00 AM. On 4/25/25 at 9:02 AM, the test tray was eaten by the survey team. The eggs and oatmeal failed to be at a palatability temperature.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, observation, and staff interview, it was determined that the facility failed to ensure care documentation was accurate. This was evident for 1 (Resident #108) of 4 residents reviewed for pressure ulcer care. The findings include: A record review revealed a physician's order dated 4/15/25 stating, Apply foam adaptors at meal times. Nursing to apply with meals for optimum intake and independence. A review of the Medication Administration Record for April 2025 revealed that the nursing staff had been documenting that Resident #108 used adaptive device for each shift from 4/16/25 through 4/24/25. On 4/24/25 at 6:16 PM, Resident #108 was observed as he/she ate dinner in bed without the use of any adaptive utensils. The resident, the resident's spouse, and the therapy director (Staff #23) were present. Staff #23, the spouse, and the resident all confirmed that the adaptive device had not been available for the past week. Staff #23 also said that the device was supposed to be stored at the resident's bedside. On 04/25/25 at 1:01 PM during an interview with unit manager (Staff #3), she acknowledged and confirmed the deficiency. 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 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, interview and record review, it was determined that the facility failed to ensure infection prevention and control practices were followed when 1) an unlabeled, uncovered bedpan was left on the handrail in a resident's bathroom, and 2) hand hygiene was not performed during a dressing change of a pressure ulcer. This was evident for 1) 1 (Resident #109) of 6 residents in the initial screening pool, and 2) 1 (Resident #108) of 4 residents reviewed for pressure ulcer care. The findings include: 1) On 4/21/25 at 11:44 AM, an observation was conducted of Resident #109's bathroom. An unlabeled and uncovered bedpan was against the wall on top of a hand rail, and an unlabeled and uncovered bath basin was upside down with bath linens on the floor. On 4/21/25 at 2:55 PM, during an interview with Geriatric Nursing Assistant (GNA #1) she said that she did not know to whom the bedpan and bath basin belonged since they were not labeled. The GNA acknowledged that the bedpan and bath basin should not have been there and that the usual process was to clean them and then place the bedpan in a plastic bag separate from the bath basin and place them in the drawer of the bedside table next to the resident's bed. On 5/1/25 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. 2) 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. A record review revealed that the facility's policy for clean dressing changes required the nurse to perform hand hygiene after soiled gloves were removed and prior to the application of clean gloves and the clean dressing. A review of the dressing change skills competency for Licensed Practical Nurse (LPN #6) showed that the nurse had been deemed competent to perform clean dressing changes on 11/14/23. Step #13 of the policy instructed the nurse to wash hands after the soiled dressing and soiled gloves were removed and disposed of. On 4/24/25 at 1:16 PM, an observation was conducted Resident #108's pressure ulcer dressing change. LPN #6 changed the resident's dressing while the unit manager (Staff #41), and an unidentified Geriatric Nursing Assistant (GNA) stood on the opposite side of the bed and assisted to turn the resident. During the dressing change LPN #6 removed the soiled dressing, cleansed the wound and then removed her soiled gloves. She then donned clean gloves and placed the clean dressing on the resident's ulcer. She did not perform hand hygiene after she removed her soiled gloves. On 4/24/25 at 4:10 PM, an interview was conducted with unit manager (Staff #3) to review the observation that LPN #6 failed to perform hand hygiene during Resident #108's dressing change. Staff #3 acknowledged the deficiency. On 5/01/25 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on interview and observation it was determined that the facility failed to maintain a Residents shower rooms in good repair. This was evident for 1 out of 2 resident shower rooms observed during a survey. The findings include: On 4/29/25 at 3:15 PM, Resident #69, a long-term resident of the facility, was interviewed. During the interview s/he reported that he/she had received a skin tear in the shower room when his/her arm rubbed against a jagged edge on a shelf in the shower room. On 4/29/25 at 3:17 PM, an observation of the Sugar Loaf shower room revealed a shelf at the back of the room. The shelf had a lament cover. Approximately 1 foot of the laminated edge was peeling off. Further observation revealed clear tape was placed over the edges of the lament, creating a smooth edge. On 4/29/25 at 3:31 PM, the Sugar Loaf nurse unit manager (Staff #5) was interviewed. Staff #5 confirmed that on 4/10/25, Resident #69 received a skin tear, when his/her arm rubbed against a sharp edge on the shelf in the resident shower room. Staff #5 reported that she logged the concern with the sharp edge of the shower shelf, in the maintenance book. She stated the Maintenance Director applied the clear tape over the sharp edge. On 4/30/25 at 7:45 AM, a review of Resident #69's medical records revealed a change in condition dated 4/10/2025. Further review revealed that Resident #69 scraped his/her left forearm on the counter in the shower and sustained a skin tear. On 4/13/2025 a review of Resident #69's medication administration note revealed instructions to monitor left forearm dressing every shift and change or replace if soiled, loose or missing, every shift for dressing integrity. On 4/25/25 at 9:51 AM the Maintenance Director (Staff #18), reported that he does not perform routine audits for maintenance issues. Staff #18 reported that maintenance concerns are brought to his attention through the maintenance log. He reported he checks the maintenance logbook several times a day. On 4/30/25 at 8:47 AM, an observation of the Sugar Loaf shower room revealed a new counter. On 5/01/2025 the above concerns were reviewed with the administrator. No additional information was provided prior to the end of the survey.

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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. 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. 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. 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. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on a record review of a facility reported incident, employees' file and staff interviews, it was determined that the facility failed to ensure Geriatric Nurse Assistants (GNA's) received training that included dementia management, abuse, neglect, exploitation, and misappropriation of resident property. This was evident for 4 of 4 GNA's employee files (#15, #21, #29 and #36) reviewed during the recertification survey. The findings include: 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 4/22/25 at 11:52 AM, a review of employee records for facility GNA's #15 and #36 and agency GNA's #29 and #36's revealed the lack of required training. On 4/30/25 at 08:46 AM, in an interview with Staff #37, she explained that HR is responsible for tracking facility staff's compliance through Carefeed and that nursing leadership tracks agency compliance. On 4/30/25 at 10:07 AM, in an interview with the DON, she 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.