STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215316	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Baltimore Washington	313 Hospital Drive Glen Burnie, MD 21061

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 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. 49409 Based on observation and interview with residents and staff, it was determined that the facility failed to promote care of residents in a manner and in an environment that maintains or enhances each resident's dignity and respect by failing to serve residents seated at the same table food at the same time. This was identified for two residents (Resident #356, #90) when observing dining during a recertification/complaint survey. The findings include: On 08/19/24 at 12:06 PM a dining observation in the main dining hall revealed that three alert and oriented residents were seated at table #2. Food was served for two of the residents and third resident was served food after 12 minutes. Additionally, two alert and oriented residents were seated at table #4. Food was served for one resident and the other resident was served food after 12-14 minutes. On 08/19/24 at 12:48 PM Resident #356, stated that he/she told the staff before he/she comes to the dining room every day, and the staff keeps messing up his/her food. Of the 19 residents seated in dining room, 4 residents were served food after 12 -14 minutes. The staff had to either go to kitchen or to other units to locate the resident food trays. On 08/19/24 12:50 PM Resident #90 was upset that she did not get his/her food tray timely, as she usually comes to the dining room. Interview with GNA staff #52 on 08/19/24 at 12:55 pm, revealed that Nursing staff takes turns to assist in the dining hall and gets the missing food items or trays from other areas or from the kitchen. On 08/19/24 at 1:10 PM the surveyor reviewed with Director of Nursing (DON) and with Regional clinical Director the above concerns. On 08/20/24 at 11 AM the DON submitted the new plan for the residents who go to dining room and their seating. The DON stated that the information was communicated with the kitchen.

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43096 Based on a review of complaints, medical record reviews, and interviews with complainants and staff, it was determined that the facility staff failed to protect the privacy of residents' medical information by giving a resident's medication to a different resident upon their discharge. This was evident one (Resident #161) of 78 residents reviewed during a recertification/complaint survey. The findings include: The surveyor reviewed complaints on 8/27/24 at 1:00 PM. The review revealed that on 11/22/22, a complainant reported their concerns regarding the facility's possible medication error, evidenced by the facility giving another resident's medication to Resident #161 when he/she was discharged . In a phone interview with the complainant on 8/27/24 at 2:50 PM, the complainant said, When [Resident #161] was discharged from the facility on 11/15/22, they gave me a bottle of [medication name] with another resident's name on. I felt like it was a very dangerous situation. They did not know who took what medication. I still have that bottle. The surveyor requested the complainant to send a picture of the medication through the surveyor's state phone. On 8/28/24 at 7:15 PM, the surveyor received a picture from the complainant: Metoprolol (blood pressure medication) 50mg tablet bottle with Resident #200's name on it. On 8/29/24 at 8:00 AM, the surveyor reviewed Resident #200's medical records and verified the resident was in the facility from 11/10/22 to 11/12/22 and took Metoprolol 50mg. During an interview with the Director of Nursing (DON) on 8/28/24 at 9:53 AM, the DON stated when residents were discharged from the facility, they gave residents' medication that the facility had. The surveyor asked whether it was possible to provide another resident's medication. The DON answered that it was possible. The surveyor shared concerns regarding Resident #161's family member being handed Resident #200's medication on his/her discharge date , which had Resident #200's private medical information on it. The DON validated it.

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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. 42507 Based on record review and interview it was determined the facility staff failed to 1) report an allegation of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ), 2) failed to report residents' injuries of unknown origin to OHCQ, and 3) failed to submit initial reports of the facility-reported incidents to OHCQ. This was evident for 2 (Resident #155, #158) of 13 residents reviewed for abuse and 4 (Residents #187, #162, #170, #171) of 14 residents reviewed for complaints and self-reported incidents during a recertification/complaint survey. The findings include: 1a) On 8/28/2024 at 9:50 AM, review of the investigation report of Facility Reported Incident (FRI), MD00182673, revealed Resident #155 reported on 8/18/2022 that the nurse bent their finger back while giving them meds. On 8/28/2024 at 11:00 AM, surveyor requested from the Director of Nursing (DON) the email/fax receipt of the initial and final (5-day) report of the FRI to the state agency (OHCQ). On 8/28/2024 at 12:28 PM, surveyor received the email receipt for facility final self-report dated 8/23/2022 at 5:20 PM. However, there was no email/fax receipt of the initial self-report. On 8/28/2024 at 1:10 PM, surveyor received from DON an email receipt of the initial report to the state agency. A review of the initial self-report revealed it was sent to the state agency on 8/19/2022 at 4:35 PM. Thus, failing to meet the 2 hours reporting requirements for any allegation of abuse. On 8/28/2024 at 1:11 PM in an interview with DON, Surveyor reviewed the above FRI with her. DON was informed of surveyor's concerns regarding the actual date of the above incident (8/18/2022) and the date/time the initial report was sent to OHCQ (8/19/2022 at 4:35 PM). DON confirmed that the initial report did not meet the 2 hours reporting requirements for any allegation of abuse. 1b) On 8/29/2024 at 10:50 AM, review of Facility Reported Incident (FRI), MD00182377, revealed that Resident #158's daughter stated since she reported a CNA (Certified Nursing Assistant) was rough with Resident #158, the resident has been neglected and was not being changed timely. On 8/29/2024 at 11:50 AM, further review of the report file revealed an email from the Nursing Home Administrator (NHA) on 2/15/2022 at 5:36 PM to the then Director of Nursing (DON) that instructed the DON on what to do regarding the above complaint from Resident #158's daughter: .This needs to be a priority tomorrow. Break down each issue and get statements from the people who are working each day and shift. This will need to be reported, I think. Either way if that folder is completed and all information is placed inside, we can survive this coming storm. Below the email was attached another email from the Director of Corporate Compliance sent to the NHA on 2/15/2022 at 5:17:40 PM regarding the above complaint made by Resident #158's daughter: I know that you were briefed on the below call. The caller expressed the following: The caller stated she reported CNA for being rough with her [parent] and since then, s/he has been neglected . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/2024 at 1:10 PM, additional review of the investigation report of the FRI revealed an email from the then Director of Nursing dated 2/15/2022 at 9:43 AM which stated that I made the daughter aware on Sunday when I was here, and she insisted on talking to me. Now that I know which GNA (Geriatric Nursing Assistant) it is, she's off their assignment however I have 2 staff going in to care for them, even when the family is there. A review of the compliance line facility investigation form included in the investigation packet revealed that Abuse in-servicing was initiated on 2/16/2022. The form also noted that the initial self-report of neglect was submitted to the state (OHCQ) on 2/17/2022 and local law enforcement notified on 2/17/2022, two (2) days after the facility administration (NHA and DON) were made aware of the allegation of abuse/neglect. On 8/29/2024 at 2:27 PM, in an interview with the NHA, he stated the DON at the time of the above incident no longer worked in the facility. NHA further stated that he could not recall the above incident as it happened 2 years ago. Surveyor reviewed with the NHA the investigation report of the FRI and the facility's failure to timely report to the state and local law enforcement an allegation of abuse/neglect. NHA stated that they would do better moving forward. 43096 2) On 8/28/24 at 11:09 AM, the surveyor reviewed complaints. The review revealed that a complainant reported a few concerns regarding Resident #187's care: the resident had an incident on 9/13/22 by wandering to another resident's room and had a fall while others helped Resident #187 to get out of the room. The Family was told there were no injuries, but the next day (9/14/22), the family found Resident #187 had a red mark on his/her chest with a deep cut. A review of Resident #187's medical records on 8/28/24 at 11:10 AM revealed that the facility documented a change in condition form on 9/13/22 at 11:49 AM, 'Resident wandering into another resident's room and laid down in his/her bed. When the resident returned, he/she noted that Resident #187 was in his/her bed and helped him/her off the bed, grabbed by shirt and told to get out of his/her bed. Resident #187 lost his/her balance and fell to the floor. The facility documented a pain assessment for the resident on 9/13/22. However, there was no further documentation regarding the resident's assessment. Another change in condition form documented on 9/14/22 at 8:44 PM showed, Dark discoloration noted on resident's mid-chest. No opening noted. No bleeding. The site is intact. Measuring 4.0 x 1.8. No sign of pain noted when touched. There was no additional documentation to explain how the changes were noted. During an interview with the Director of Nursing (DON) on 8/28/24 at 1:41 PM, the DON stated that the unknown origin of injuries needed to be reported to the OHCQ and immediately investigated. The surveyor shared Resident #187's change in condition reported on 9/14/22 regarding bruises on the chest. The DON said, I will search the facility's documentation for that. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 8:09 AM, the facility submitted a file with the facility's investigation regarding Resident #187's bruise on the chest. The file had a typed sheet named 'Summary for [Resident #187's name] bruise on chest' with signatures of DON and ADON (assisted Director of Nursing) with the date 9/20/22. It documented, Resident #187 was found on the floor in another resident's room on 9/13/22. The nurse assessed resident #187; no redness or open areas were noted, and no complaints of pain or discomfort. On 9/14/22, Resident #187's family member noted a bruise on his/her chest, but no complaint of pain. The Medical Director reviewed the resident's photo and fall incident; he suggested the bruise could be from Senile Purpura (typically affects older patients as their dermal tissues atrophy and blood vessels become more fragile), especially due to his/her fragile skin and aspirin use. The investigation packet included interview form with three staff and safety check records from 10/04/22 to 10/08/22. However, there was no additional documentation to support the facility reporting this incident to the OHCQ. During an interview with the DON on 8/29/24 at 1 PM, the surveyor shared concerns regarding Resident #187's unknown origin of injury which was not reported to the OHCQ. The DON validated it. 50502 Oxycodone is a narcotic used to treat moderate to severe pain. It is a high risk for addiction and dependence. It can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol or other illicit drugs such as heroin and cocaine. 3a) On 9/3/24 at 2:14 PM, a review of the facility's investigation of a self-report MD00184248 revealed that on 10/6/22 at 4:00 AM, Omnicare pharmacy delivered Oxycodone 5mg and Oxycodone 10mg for Resident #162 and Oxycodone 10mg for Resident #170 to the facility. The facility was unable to locate the medications after they had been delivered. Further review of the facility's investigation documentation revealed that the investigation result was submitted to the OHCQ on 10/11/22. However, there was no evidence to support that the facility submitted an initial report to OHCQ in a timely manner. On 9/4/24 at 1:58 PM, the Director of Nursing (DON) confirmed that the facility had no record of the initial report for missing Oxycodone for Residents #162 and #170. 3b) On 8/30/24 at 9:02 AM, a review of the facility's investigation of a self-report MD00182100 revealed that on 2/26/22, early on the 3-11 shift, Resident #171 reported that a staff member cursed at him/her. Further investigation revealed no evidence that an initial investigation report was submitted to the Office of Health Care Quality (OHCQ), but the final report indicated that it was submitted on 03/02/22 at 9:30 AM. The facility initiated an investigation and suspended the alleged Geriatric Nursing Assistant (GNA #34) pending investigation. The local enforcement was notified on 2/26/24, but Resident #171 denied the incident. Resident #171 later stated to the supervisor, Licensed Practical Nurse (LPN #25), that he/she heard GNA #34 curse under his/her breath at the doorway and not at him. Ten staff interviews, as well as ten resident interviews, were conducted for allegations of abuse on 2/28/22. On 9/03/24 at 10:13 AM, the DON confirmed that the facility had no copy of the initial report. On 9/6/24 at 1:20 PM, the DON and the corporate nurse were made aware of the concerns.

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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. 43096 Based on a review of the facility investigations, interviews, and record reviews, it was determined that the facility failed to thoroughly investigate 1) allegations of abuse and 2) missing belongings. This was evidence 5 (Resident #156, #254, # 158, #187 and #166) of 14 residents reviewed for Facility Reported Incidents during a recertification/complaint survey. The findings include: 1a) On 8/26/24 at 1:51 PM, the surveyor reviewed the facility's self-reported incidents. One of them, MD00195423, reported that the facility received a call from a County Police Department detective with details - Resident #156 stated at the hospital that he/she was sexually assaulted by an opposite-gender employee on 8/06/23 from 11 PM to 7:30 AM before transferred to the hospital. The facility initially reported this incident to the Office of Health Care Quality on 8/10/23 and started an investigation. Further review of the facility's investigation on 8/26/24 at 2:20 PM revealed that the facility had a typed interview for abuse investigation with Resident #156's roommate (Resident #46). The typed note documented that Resident #46 heard Resident #156's fall and the resident saying, Help, help, I'm being raped. And it also typed, he/she was not raped, just fell . Nobody else was in the room, just him/her and I. However, the typed documentation did not contain who conducted the interview and the signature of Resident #46. During an interview with the Director of Nursing (DON) on 8/26/24 at 2:37 PM, the surveyor reviewed Resident #46's interview sheet with the DON. She was asked who interviewed Resident #46 and how it was conducted. The DON said, I don't know. The surveyor shared concerns with the DON on 9/06/24 at 1:00 PM about the investigation of self-report MD00195423 not being conducted thoroughly. The DON validated the concern. 47200 1b) On 8/28/24 at approximately 8:30AM, the surveyor received the complete investigation file regarding an allegation of abuse made by Resident #254 on 8/19/24. Upon receipt of the file, the Director of Nursing (DON) verbally confirmed with the survey team, that the file being provided was the facility's complete investigation file. On 8/28/24 at 9:23AM the surveyor began review of the facility reported incident investigation file. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility reported incident file on 8/28/24 at 11:30AM revealed the following: 1.) Geriatric Nursing Assistant (GNA) #37 and GNA #40 were documented as both temporarily suspended pending the outcome of the investigation, however, only one (from GNA #40) out of two statements were found to be included in the investigation file, 2.) No other statements or any documentation of interviews with facility staff members were present in the investigation file, 3.) Documentation of the interview with Resident #254 did not have a statement collected or documented from them, no time of interview was documented, and no documentation was present of who conducted the interview, 4.) The statement written by GNA #40 had no date or time documented, 5.) The statement written by GNA #40 referred to them addressing the resident's situation with a nurse, however, there was no documented interview or statement from the nurse, 6.) The documented interview of Resident #87 failed to identify them as the resident's roommate, had no documented time of the interview, and no specific questions regarding the allegation of abuse were documented as having been asked, 7.) No times were found to be documented for resident interviews and it could not be determined what staff member conducted the interviews, 8.) Documentation was present in the investigative file that stated Resident #254 made claims of not having a shower in 2-3 weeks, however, there was no documentation in the investigative file to show that this allegation was further investigated, 9.) Documentation of an 8/19/24 interview with no time of interview documented of Resident #254 was observed to include information regarding their decision making status, and information stating that the resident's roommate was counter interviewed and stated that the allegations were false and the incident did not occur, however, there was no information documented other than this, regarding a second interview of the resident's roommate, additional questions asked of the roommate, or a statement documented to support this written information, 10.) The final follow up investigation report stated the following information: Alert and oriented resident interviewed denied abuse or mistreatment by staff member however, no documentation to support this conclusion could be found within the investigation file, 11.) The final follow up report stated the following: The nurse and supervisor denied any reports of resident reporting being kicked by staff, however, no information could be found in the investigative file to support an interview or questions asked of a supervisor and/or a nurse, and 12.) The final follow up investigation report stated the following information under a section of the form used for a summary of interview(s) with staff responsible for oversight and supervision of the alleged perpetrator, if staff or a resident : Denies any reports of mistreatment or abuse to residents on assignment, however, no supporting documentation of any staff interviews was present in the investigative file. On 8/28/24 at 12:06PM the surveyor conducted an interview with GNA #37, who reported that they were asked questions regarding the incident and had written a statement in paper form which was obtained by Unit Manager #20. On 8/28/24 at 1:17PM the surveyor shared concerns with the Director of Nursing, who acknowledged and confirmed understanding of the concerns with the survey team present. On 9/9/24 at 10:49AM the surveyor shared concerns with the facility Administrator who acknowledged and confirmed understanding of the surveyor's concerns. 42507 1c) On 8/29/2024 at 10:50 AM, review of Facility Reported Incident (FRI), MD00182377, revealed that Resident #158's daughter stated since she reported a CNA (Certified Nursing Assistant) was rough with Resident #158, the resident has been neglected and was not being changed timely. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the facility investigation report of the incident revealed staff training on abuse done in February 2022 after the incident and staff sign-in sheet on file. Staff and resident interviews were on file. However, the CNA mentioned in the FRI was not identified and there was no statement from her/him regarding the incident. On 8/29/2024 at 1:10 PM, additional review of the investigation report of the FRI revealed an email from the then Director of Nursing dated 2/15/2022 at 9:43 AM which stated that I made the daughter aware on Sunday when I was here, and she insisted on talking to me. Now that I know which GNA (Geriatric Nursing Assistant) it is, she's off their assignment however I have 2 staff going in to care for them, even when the family is there. However, the GNA was not identified and there was no investigation report of that GNA on file. On 8/29/2024 at 2:27 PM, in an interview with the Nursing Home Administrator (NHA), he stated the DON at the time of the above incident no longer worked in the facility. NHA further stated that he could not recall the above incident as it happened 2 years ago. Surveyor reviewed investigation report of the FRI with NHA. NHA confirmed that there was no identification of the CNA and/or statement from CNA in the report regarding the allegation. Surveyor informed him that the investigation was not thorough. NHA responded that another surveyor already identified a similar issue with one of the other FRIs and stated that they would do better moving forward. 1d) On 8/30/2024 at 10:10 AM, review of Facility Reported Incident (FRI), MD00180840, revealed that Resident #181 reported that at about 2 AM they cursed at the nurse about their pain meds, and the nurse cursed back at them. Further review of the facility investigation report of the incident noted a list of staff and residents interviewed, however, there was no signed interview statements from the staff/residents listed as interviewed. Additionally, there was some other staff and resident interview statements on file, but the resident interview statements did not have a date and/or time the allegations of abuse questionnaire were completed by those residents. There was no staff abuse training records on file for any education provided after the allegation of abuse was made. The investigation was not thorough. On 8/30/2024 at 2:50 PM, in an interview with the Director of Nursing (DON), she was informed that the investigation of the above allegation was not thorough: No date/time the residents' interviews were conducted, No abuse training of staff on file. DON provided no new/additional information to validate that the above allegation was thoroughly investigated. 50502 2) On 9/5/24 at 12:27 PM, a review of a complaint reported revealed that on 2/13/23, a family member brought to the attention of the facility that the following items of Resident #166 were missing: false teeth, eyeglasses, 5 clothes, 1 pair of shoes and 1 large blue bag with name written on it. On 9/5/24 at 2:39 PM, during an interview with the DON, the surveyor asked if there was any record that the resident or the family member filed a grievance about missing personal belongings. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/6/24 at 7:50 AM, the surveyor received a copy of the concern form dated 2/13/23 from the DON. Further review of the concern revealed that the facility investigated the concern and educated staff, Specify which belongings you are sending the resident out with. However, the document did not indicate when and who conducted the education On 9/6/24 at 8:39 AM, the DON was requested to provide an inventory sheet and statements from the witnesses; however, she confirmed that the facility did not have a copy of the inventory sheet. The DON also stated that she would obtain statements from the two staff members who verified that the resident wore dentures when transferred to the hospital. On 9/6/24 at 9:50 AM, the surveyor received a copy of the typewritten statement without signature dated 9/6/2024 from Environmental Services Staff #32. The statement indicated that on 02/18/2023, while Resident #166 was on the stretcher on his/ her way to the hospital, he/she had asked Staff #32 several times about his/her teeth. Staff #32 stated that he/she went into Resident #166's room and got the dentures and he/she placed the dentures into Resident #166's mouth. The statement was later on signed by Staff #32 at 11:32 AM. On 9/6/24 at 12:15 PM, the DON confirmed that the facility did not have a statement from the nurse who witnessed that the dentures were in the patient's mouth when Resident #166 left the facility. On 9/6/24 at 12:45 PM, during an interview with the Nursing Home Administrator (NHA), he stated that he remembered that a family member filed a concern form related to the missing items. He said he offered to pay for the clothes, eyeglasses, and a pair of shoes, but the family member declined and cursed at him. The surveyor expressed that upon review of the concern packet, the surveyor did not find any evidence that statements were obtained on 02/18/23 from the staff who witnessed the resident wearing the dentures when being transported to the hospital. On 9/6/24 at 1:20 PM, the DON and the corporate nurse were made aware of the concerns.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 44441 Based on medical record review and staff interviews it was determined the facility failed to notify the resident/resident representative (RP) in writing of a transfer/discharge of a resident along with the reason for the transfer. This was evident for 1 (#49) of 4 residents reviewed for hospitalization during a recertification/complaint survey. The findings include: On 8/19/24 at 2:39 PM review of resident #49's medical record revealed that resident was sent out to the hospital on 7/8/22 and again on 12/26/22 for a change in medial condition. Further review of the nurses' notes for the 7/8/22 hospital transfer and the 12/26/22 did not reveal that a notice of transfer was given. Continuing review of the medical chart failed to produce a copy of the notification for transfer that was given to the resident on the two hospital transfers. The administrator was asked to find the missing documents on 8/28/24 at 12:33 PM. He came back to report that it was not there and could not be found. 08/28/24 12:34 PM the Director of Nursing (DON) -in an interview was asked about the expectation for notification of transfer when a resident was transferred out to the hospital. She stated that the notification should be given to the resident at the time of transfer/discharge. That residents who are cognitively intact would sign it and a copy sent with them to the hospital. For Residents who are unable to sign, a copy was sent out to their family members to sign. The facility also retains a copy which was placed in the resident's medical chart. On 9/6/24 at 1:33 PM. The DON was made aware that Resident #49's notification of transfer could not be found and that this was a concern.

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Baltimore Washington		STREET ADDRESS, CITY, STATE, ZIP CODE 313 Hospital Drive Glen Burnie, MD 21061	

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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. 44441 Based on the review of medical records and staff interviews, it was determined that the facility failed to develop and implement a comprehensive resident-centered care plan, that includes measurable objectives, interventions and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. This was evident for four (Resident # 191, #7, #254, #10) out of 78 residents reviewed for during the recertification/complaint survey. The findings include: A wound vacuum, also known as a vacuum -assisted closure (VAC) device, is a treatment that uses a suction pump to help heal wounds. 1)On 9/5/24 at 2:57 PM review of a complaint incident MD00183891 stated that Resident #191 went for her doctor's appointment and ended up being admitted for septic wound infection. The complaint alleged s/he was told by the hospital physician that the infection resulted from the wound not being managed properly by the facility. Review of Resident #191's plan of care on 9/5/24 at 3:11pm failed to produce a care plan for the resident's multiple wounds. Only a risk for skin breakdown care plan was found. Staff #7(a unit manager) in an interview was asked who initiates residents' care plans. She stated that the supervisors initiate them on admission, unit managers review the chart, the diagnosis and the discharge summary and updates the care plan from there. She said that if a resident came in with multiple wounds and was placed on a wound vac, that a plan of care should have been developed to reflect that resident had them. On 9/6/24 at 10:05AM The Director of Nursing (DON) was made aware of the concern. She confirmed that there was no care plan developed to reflect the presence of multiple wounds and a wound vac. 47200 2) On 8/19/24 at 9:11AM during the surveyor's initial facility tour, Resident #7 stated the following to the surveyor: I have no pants to wear, and were observed pointing to a bag of wet clothing situated on the floor in their room. On 8/19/24 at 12:11PM the surveyor conducted an interview with Resident #7 who reported to the surveyor that they had wet their self three times since the surveyor had last spoken with them, and asked for the interview to be paused due to feeling uncomfortable from being wet with incontinence. At this time, the surveyor paused the interview and upon surveyor intervention, facility staff assisted the resident with incontinence care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 8:38AM the surveyor conducted an interview with Geriatric Nursing Assistant (GNA) #35 who reported to the surveyor that the facility expects GNA's to document on the poc task (area in the electronic health record) incontinence care provided each time they change a resident's brief or provide incontinence care to a resident. Review of the medical record for Resident #7 on 8/26/24 at 8:40AM revealed the resident was coded on the task list as dependent for toileting, requiring one person physical assist needed. On 8/26/24 at 9:14AM the surveyor requested for any and all documentation of incontinence care and toileting provided to Resident #7, from Corporate Nurse #10, who reported to the surveyor that toileting and incontinence care was to be documented in the task report and this is where they check to ensure care was given. At this time, Corporate Nurse #10 observed the documentation in the medical record present for Resident #7 and confirmed with the surveyor that the resident was documented as receiving toileting and incontinence care three times per day, once per shift. On 8/26/24 at 9:35AM the surveyor reviewed the care plan in place for Resident #7 which stated the following interventions to address a focus of bladder incontinence related to disease process: 1.) Brief use: (Resident #7) uses, large disposable briefs, Change every two hours and prn (as needed), 2.) Incontinent: Check (Resident #7) every two hours and as required for incontinence, Wash, rinse, and dry perineum, Change clothing PRN (as needed) after incontinence episodes. Further review of the care plan revealed an additional incomplete care focus which stated the following information on the care plan: (Resident #7) has incontinence episodes r/t (related to). On 8/26/24 at 9:49AM the surveyor received a copy of the task report for the month of August, 2024 which was observed to be signed off by nursing staff once per shift, three times per day. On 8/26/24 at 11:41AM the surveyor conducted an interview with Unit Manager #20, who reported to the surveyor that the current task in the electronic health record for the GNA's to provide toileting/incontinence care was at a frequency of once each shift. Unit Manager #20 further stated the following information to the surveyor regarding Resident #7: This frequency should be every 2 hours or the GNA's don't know to do that task more frequent than every shift. On 8/26/24 at 11:45AM the surveyor conducted an interview with Licensed Practical Nurse #25 who reported they sometimes have a role as a supervisor. When the surveyor inquired as to how they know that staff has changed or provided incontinence care to Resident #7, they stated: I don't know. At this time, Unit Manager #20 stated that it would be on the report and would documented twelve times (per 24 hours) under toilet use. At this time, Unit Manager #20 confirmed that the copy of the task report the surveyor had received, was the report the care was to be documented on. On 8/26/24 at approximately 11:45AM the surveyor conducted interviews with GNA #37 and GNA #40 who showed the surveyor the electronic health record and confirmed that incontinence care and brief changes were documented by GNA's under the toilet use task. At this time, both GNA's confirmed that Resident #7's frequency for incontinence care and toileting was once per shift, and confirmed that if the frequency was set for every two hours, then a task would populate for them to perform the task every two hours, and twelve sign offs would be present for the care performed. GNA #37 and GNA #40 reported they were aware to do the task every shift, however, they recalled in the past that it had been every two hours but were unsure why the task frequency was no longer like that. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, it was noted by the surveyor on 8/26/24 at 12:33PM that the Kardex report (brief overview of care needed for a resident) for Resident #7 did not include two hour incontinence checks/brief changes. 3) On 8/27/24 at 12:29PM the surveyor reviewed the current care plan in place for Resident #254 and observed there was no intervention in place for catheter hygiene care for the resident. Review of the medical record revealed an active medical order was present for the resident's foley catheter. On 8/27/24 at 12:56PM the surveyor conducted an interview with the Director of Nursing (DON) who stated to the surveyor that their expectation is for there to be a medical order for foley catheter care. Upon observation of the medical record, the DON confirmed with the surveyor that no medical order for foley catheter care was in place for Resident #254. On 8/27/24 at 12:59PM the surveyor requested from the DON, any and all documentation regarding foley catheter care for Resident #254. On 8/27/24 at 1:16PM the surveyor conducted an interview with the DON who stated the following information: We just put the order in, it wasn't in there. At this time, the surveyor shared their concern with the DON who acknowledged and confirmed understanding of the surveyor's concern. On 8/27/24 at 2:03PM the surveyor received and reviewed a copy of the resident's care plan with revisions. It was noted that a care plan focus of: urinary tract infection was initiated on 8/8/24, however, no care planning intervention was observed to be present to address foley catheter hygiene care. 49409 4)On 08/20/24 at 10 AM, medical record review revealed that Resident #10 had an active physician's order from 07/29/24, to offer Non-Pharmacological Interventions attempted prior to administering any pain medication as needed. A review of the care plan interventions for Resident #10 did not reflect the intervention of offering non pharmacological interventions. An interview with a Licensed Practical Nurse (LPN) staff #3, on 08/20/24 at 11:09 AM revealed that unit managers initiate and update the care plans. The surveyor discussed with LPN, staff #3, the issue of the care plan not being updated to reflect the physician order of offering non-pharmacological interventions. The LPN, staff #3, validated this concern. On 08/27/24 at 02:18 PM, the surveyor reviewed with the Assistant Director of Nursing (ADON) the finding that the care plan interventions for Resident #10 did not reflect the physician's order to implement non-pharmacological interventions prior to administering pain medication as needed.

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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. 44441 Based on observation, record review and interviews, it was determined that the facility failed to revise and update resident's comprehensive care plans. This was evident for 2 (Resident #46, #10) of 78 residents reviewed during a recertification/complaint survey. 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. 1) On 8/19/24 at 9:20 AM, during the initial observation tour of the facility, Resident #46 was observed in bed in their room. The resident was not on oxygen therapy and did not have a tracheostomy, an opening into the trachea where a tube is inserted to assist with breathing. Review of the care plan with revision date of 10/6/23 on 8/22/24 at 9:11 AM had, Resident has oxygen therapy related/to (r/t), Pneumonia (PNA), respiratory failure. The goals were that resident will have no sign/symptoms of poor oxygen absorption through the review date. Further review also revealed a second care plan with revision date of 10/12/23 that had Resident has a tracheostomy r/t Dysphagia (difficulty swallowing), respiratory failure. Interventions were also outlined for the management of the tracheostomy. A second observation was made of Resident #46 on 8/23/24 at 8:02 AM. Resident did not have a tracheostomy and was not on oxygen. Resident was in bed, getting ready to eat breakfast. Resident was asked if s/he had a tracheostomy or use oxygen. Resident stated that s/he had a tracheostomy and was on oxygen about two years ago. On 8/23/24 at 8:50 AM staff #7 a unit manager in an interview was asked who initiates residents care plan: She stated that the supervisors initiate them on admission, unit manager reviews the chat, diagnosis and discharge summary and updates the care plan from there. She was asked the process for updating the care plans. She stated that for residents on the long-term Care (LTC) units, review is done every 90 days during residents stay or when a change in condition happens. She was asked how care plans that are no longer pertinent are resolved and she said they're resolved in the care plan tab, so it does not show up as active in the care plan. On 8/23/24 at 9:05 AM The Director of Nursing (DON) and Staff #7-unit manager was shown the care plan for tracheostomy and oxygen that was still showing up as active, The DON said it was supposed to have been resolved. She was made aware that resident #46 care plan was not updated and that this was a concern. 49409 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) A record review on 08/20/24 10:04 AM revealed that Resident #10 had been in the facility for more than a month. The most recent resident assessment was completed on 08/03/24. The care plan for skin impairment reflected that the resident had stage II and III pressure ulcers. No treatment orders for pressure ulcers noted. On 08/22/24 at11:30 AM Interview with Licensed practical Nurse (LPN) staff #3 revealed that resident #10 does not have any pressure ulcers and does not receive any treatment for pressure ulcers. On 08/27/24 at 01:26 PM, an interview with resident #10 revealed that he/she does not have pressure ulcers. An interview with Director of Nursing, DON on 08/27/24 at 03:14 PM revealed that the review and updates of the care plans are done quarterly and when needed. When any change occurred, requiring to add any new problems and remove what is not current, care plans are updated by the unit managers and the wound care nurse. Surveyor reviewed with the DON that resident #10's care plans were not updated to reflect the changes on pressure ulcers.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45733 Based on observation, record review and interview, the facility failed to meet the resident's rehabilitation needs and failed to provide the necessary care which the facility had to ensure and not diminish the resident's functional abilities and skills. This was evident for 2 (Residents #41 & #65) of 3 residents reviewed for rehabilitation and restorative services during a recertification/complaint survey. The findings include: ADLs are activities related to personal care with adaptive ability. They include grooming, bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. 1) Observation, on 08/19/24 at 10:01 AM, found that Resident #41 crawled up in the bed and was semi-dozing off. During an interview, the resident shared that I used to get up and ambulate myself but I could not walk after months of hospitalization . Then I was discharged over here, had some physical therapy (PT)/occupational therapy (OT), then they stopped, but did not tell me why. I communicated that with the staff here that I needed OT/PT including wheelchair maneuvering so that I can go home. Record review, on 08/20/24 at 01:55 PM, revealed that Resident #41 was admitted on [DATE] to this facility with a history of rheumatoid arthritis, right shoulder pain and weakness and lupus. The resident's assessment indicated that he/she needed maximum assistance with most of the activities of daily living (ADLs). Further review revealed that the last OT order 6/4/24 was for a 5 weeks certified period, but the sessions only lasted for 2 weeks, from 6/4 to 6/25/24. The resident was making good progress towards to his/her discharge goal (from the maximum to moderate assistance level) however, he/she was dismissed from the OT sessions before he/she reached the highest practicable level of physical well-being. During an interview, on 08/22/24 at10:06 AM, Rehabilitation Manager Staff #19 indicated that Resident #41 was certified from 6/4/ to 9/1/24 and was discharged early on 6/25/24. Staff #19 was aware that this resident needed adaptive rehabilitation skills training i.e. wheelchair maneuvering. During interview, on 08/22/24 at 11:15 AM, Staff #19 and the Director of Nursing agreed that Resident #41 was making good progress and that OT staff needed to re-set the next level of goals and provide the services. Both were made aware that this was a concern. 2) During a floor rounding, on 08/19/24 at 11:05 AM, Resident #65 reported I was told by the physical therapist to get up 4 hours per day at least, it's not happening . I told the nurses. Record review, on 08/20/24 at 02:53 PM, found that Resident #65 was admitted on [DATE] to this facility and had a history of cervical stenosis. The resident needed maximum assistance with most of the ADLs. Interview with Physical Therapist Staff #21 revealed that the resident was discharged on [DATE], from physical therapy (PT) and referred to a functional maintenance program. Further review revealed a new order for a PT evaluation on 8/6/24. However, no PT evaluation was done at this time. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview, on 8/22/24 at 1:02PM, Rehab Director (Staff #19) stated that the facility did not have a functional maintenance program nor a restorative program. However, the Director of Nursing (DON) stated that it was the floor staff to implement a restorative program i.e. during giving a bed bath or brushing teeth. The DON was asked where a floor staff built-in program could be found in the medical record. She stated that it was built in the care plan of ADLs but could not provide the location of the functional maintenance program in the care plan. Staff #19 admitted that the 8/6/24 order for the PT evaluation was not scheduled timely which was also a concern. Record review, on 08/22/24 at 01:16 PM, found no documentation in the care plan that included a built-in nursing restorative program. The DON was made aware.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on a review of resident medical records and interviews with residents and facility staff, it was determined that the facility failed 1) to provide care timely when the resident had injuries after a fall, 2) to administer medication when the resident had a sore in the mouth 3) to follow up with resident with a new change in condition, 4) to document blood sugar as ordered and to implement an order for pressure relief, and 5) to ensure residents receive medications as ordered by the physician. This was evident for 5 (Resident #187, #175, #190, #49, and #160)) of 78 residents reviewed during the recertification/complaint survey. 1) On 8/28/24 at 11:09 AM, the surveyor reviewed complaints. The review revealed that a complainant reported a few concerns regarding Resident #187's care: when the resident's family members went to the facility to pick the resident up for his/her dental appointment on 10/28/22, they observed that Resident #187 was rocking back and forth in a wheelchair with pain. The resident had a knot under his/her eye, blood coming out of his/her ear, and other injuries. A review of Resident #187's medical records on 8/28/24 at 11:10 AM revealed that the facility documented two separate forms of change in condition on 10/28/22. The one documented on 10/28/22 at 10:38 AM reported, 'Resident #187 fell in the hallway after ambulating. Pain to left side of the face.' Another one documented at 12:30 PM showed, 'resident was observed with a tear on his/her ear, and a broken hearing aid. His/Her ear was cleaned up, and his/her hearing aid was kept safe. His/her daughter later came in and called the ambulance, which led to him/her being transferred to the hospital.' However, there was no documentation to explain how the facility staff cared for Resident #187 after the fall. During a phone interview with the complainant on 8/29/24 at 10:30 AM, the complainant stated they came to the facility around 11 AM for the dental appointment. Before entering the facility, they received no notice regarding Resident #187's fall and injuries. The complainant confirmed that Resident #187's family member called 911 on 10/28/22 for further evaluation, and the resident was diagnosed with left orbital (known as the eye socket, a bony cavity that contains the eyeball and its associated structures) and jaw fractures. On 8/29/24 at 8:20 AM, the surveyor verified Resident #187's left orbital and jaw fracture by emergency room note (for 10/28/22). In an interview with the Director of Nursing (DON) on 8/29/24 at 12:15 PM, the DON stated that the facility should assess head-to-toe, neuro, and pain and notify family members when they had a fall. She said, As needed, they will transfer to the hospital. It will be documented in the PCC (electronic medical records). The surveyor reviewed Resident #187's medical records with the DON and the DON was asked to explain the more than a 2-hour gap between the fall incident and the transfer to the hospital. The DON said, We did not know the resident had a fall. While investigating his/her broken hearing aid, we discovered the resident had a fall that morning. When the family members got here, they wanted to get involved in the situation and not allow staff to assess the resident. On 8/29/24 at 1:49 PM, the surveyor requested the facility's fall investigation and reviewed them. The review revealed that few staff observed Resident #187's fall and wrote their statement: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Assist Director of Nursing, Staff #15, stated, I last saw the resident on 10/28/22 between 10:30 AM and 11:00 AM. I saw the cut in her ear but no discoloration of her face. The daughter came in about 10 minutes. I noted the Left eye irritated and discolored. - Staff #16 wrote, This morning, Resident #187 bumped into the wall and fell to the floor; I helped him/her up and gestured to the nurse. - Staff #17 wrote that he just saw the resident before [his/her family member] walked in. I saw blood on her finger and the ear. I saw a cut in the ear and a broken hearing aid in his/her hand. - Staff #18 reported, The last time I saw the resident was about 11 AM. The resident said, My ear, as she walked past me on station 1. I told his/her nurse. During an interview with the Director of Nursing (DON) on 8/29/24 at 2:37 PM, the surveyor shared concerns about how the facility provided care for Resident #187 after his/her fall. The DON validated the concerns. 2) During a review of complaints on 9/04/24 at 9:20 AM, it was noted that a complainant reported their concerns regarding Resident #175's care. On 8/10/22, the complainant reported that Resident #175 had soreness and discomfort in his/her mouth; the facility said they would order medication. Resident #175 did not receive the medication for 3 weeks. On 9/04/24 at 9:30 AM, the surveyor reviewed Resident #175's medical records. The review revealed that a progress note written by nursing staff on 7/31/22 at 10:55 PM showed, Nurse Practitioners (NP) came in, assessed resident's mouth, new order given for Dental consult to follow up. An additional progress note dated 8/16/22 at 1:04 PM showed, [Resident #175's name] noted with areas in mouth Nystatin (the medication treats fungal or yeast infections of the skin. It belongs to a group of medications called antifungals. It will not treat infections caused by bacteria or viruses) ordered for dental care. However, a review of Resident #175's order summary and Medication Administration Record (MAR) on 9/04/24 at 1:35 PM revealed that Nystatin suspension 1000000 unit/ml was ordered as needed use on 8/01/22 and discontinued on 9/16/22. It was never administrated to the resident. The surveyor shared the above concerns during an interview with the Director of Nursing (DON) on 9/04/24 at 2:07 PM. Resident #175 did not receive treatment for mouth sores, and the DON validated the concern. 44441 3) A Minimum Data Set (MDS) assessment is a standardized evaluation of a resident's health and functional ability in a nursing home. It helps nursing home staff identify problems and provides a comprehensive evaluation of a resident's functional capabilities. On 8/30/23 at 9:00 AM, review of a complaint incident M00205821 alleged that the facility failed to take proper action to address a resident with a new onset of change in mental status until the family arrived and called 911 to take the resident to the hospital where s/he was diagnosed with Urinary Tract Infection (UTI). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #190's admission MDS with Assessment Reference Date (ARD) of 8/6/23 on 8/30/23 at 9:50 AM documented under section C (Cognitive Assessment) that resident had a Brief Interview for Mental Status (BIMS) score of 12 which signifies moderate cognitive impairment. Resident was alert and oriented and can make their needs known. Further review of the nurses note dated 8/12/24 at 1600 had that resident has been screaming all day and hallucinating. Patient states, I have a bad dream that I was kidnapped. and the writer of this note reassured resident of her safety in the building. Resident was calm for a while but started yelling again. Review of the August 2024 Medication Administration Record (MAR) did not show that resident was given an antianxiety medication ordered to be given as needed for anxiety. A change in condition form was not completed about this incident and no further actions or interventions documented until the next day 8/13/24 when an anti-anxiety medication was documented as given at 5:00PM. The resident's family member came in to visit, saw residents change in condition and called 911, resident was sent out to the hospital same day at 7:20 PM. In an interview with Staff #26 a registered nurse on 8/30/24 at 2:47 PM, he was asked about the expectation for when a change in condition happens. He stated that the expectation was that the staff would contact the nurse practitioner or attending Physician to let them know and document the incident including any assessment and interventions provided to alleviate the change in condition. He explained that a change in condition maybe triggered by something else such as UTI or dehydration. The Assistant Director of nursing was with the staff at the time of interview and was made aware that this was a concern. 4) Review of resident #49's medical records revealed that resident was a diabetic placed on insulin with sliding scale coverage (use to indicate how much insulin a resident should be given based on their blood sugar level). Further review revealed a physician order written on 1/26/24 as: Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart), Inject subcutaneously before meals for Diabetes Meletus (DM) a blood sugar disorder. if 0 - 200 = 0 units; 201 - 249 = 2 units; 250 - 300 = 4 units; 301 - 349 = 6 units; 350 - 400 = 8 units IF BG (Blood Glucose) <70 or >400 call MD.'' On 8/28/24 at 12:18 PM review of the residents Medication Administration Records (MAR) from January - August 2024 revealed different days where the resident's blood sugar was not taken with no documentation as to why. These days include, February 16, 17, 25, 29 at 0630, March: 4, 6, 8, 19, 24 at 0630, April: 7, 9, 17, 27, at 0630 May: 13, 19, 22, 31, and August 4. 7, 13. Staff #25 a License Practical Nurse (LPN) in an interview on 8/28/24 at 1:25 PM was asked about their expectation for a resident on insulin with orders for blood sugar checks. She stated that blood sugars should be checked 30 minutes before meals. She was asked the importance of checking blood sugars as ordered. She said could be the blood sugar was low and the resident can become more hypoglycemic an abnormal low blood sugar level that can be fatal if not immediately treated. This can occur if that resident was given insulin without checking their blood sugar level as ordered. On 8/28/24 at 1:45 PM The Director of Nursing (DON) was made aware of the findings regarding the blood sugar concerns. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Baltimore Washington	313 Hospital Drive Glen Burnie, MD 21061

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/28 at 1:00PM, review of resident #49's chart had an order written on 2/16/24 that read: Float heels at all times with pillows, cushion, boot while in bed to prevent pressure ulcer every shift for pressure relief." Observation of resident by multiple surveyors on 8/19/24 at 2:21 PM, 8/28/28 at 12:57 PM, 1:51PM, 8/29/24 at 9:08AM, 2:28PM and 8/30/24 at 8:50 AM revealed that the resident's heel was not floated with pillows, cushions or boots. The Order however were signed off by staff on various shifts to reflect that it was implemented in the treatment Administration Record (TAR). On 8/30/24 at 3:15 PM in an Interview with staff #26 a Registered Nurse, he was asked why the resident did not have his heels elevated as ordered. He stated that the nurse aides were supposed to carry out the order when they bath and perform care for the resident. That his part was to ensures compliance and signing it off as done. He was told that the task was signed off even though it was not done. He said he signed it off without verifying that it was done. The Assistant Director of Nursing (ADON) and the regional nurse was there and verified that the resident did not have their heels elevated on a pressure relieving device. On 8/30/24 at 3:18 pm the ADON and regional nurse was made aware that this was a concern. 42507 5) On 9/5/2024 at 8:50 AM, review of a complaint #MD00170440 revealed that on 8/5/2021 Resident #160 reported to a family member (the complainant) that 3 nurses called out, so they didn't get their morning IV (intravenous) antibiotics. Per the complainant, Resident #160 was in the facility recovering from an infection to their knee replacement and had a left arm PICC line (peripherally inserted central catheter, a form of intravenous access that can be used for a long period of time to give medications or liquid nutrition.) On 9/6/2024 at 11:20 AM, review of Resident #160's face sheet revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included but not limited to other mechanical complication of internal left knee prosthesis, arthritis due to other bacteria, left knee, cellulitis of left lower limb, infection and inflammatory reaction due to internal left knee prosthesis, and methicillin resistant staphylococcus aureus infection (MRSA). On 9/6/2024 at 11:22 AM, a review of Resident #160's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for July 2021 revealed the resident was ordered rifampin capsule 300 mg 2 capsule by mouth one time a day for left knee infection for 30 days, order date 7/27/2021 at 2232 (10:32 PM). The first dose of the medication was scheduled to be given on 7/28/2021 at 0900 (9:00 AM). However, the first dose of the med was not given; staff initials had #8 on top of it in the sign off slot for med administration. Review of chart codes revealed #8 meant other/see progress notes. Further review of the MAR revealed Resident #160 was given the first dose of the medication on 7/29/2021 at 0900 (9:00 AM), one day later than the initial scheduled dose. Additional review of the MAR revealed IV antibiotic, Ceftaroline Fosamil solution 600mg IV every 12 hours for knee infection was ordered on 7/27/2021 at 2040 (8:40 PM). However, Resident #160 did not get the scheduled 0800 (8:00 AM) dose on 7/28/2021. The first dose of the medication was given at 2000 (8:00 PM) on 7/28/2021, almost 24 hours after the med was ordered to be given. Of note Resident #160 had a PICC line in place on admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/2024 at 12: 20 PM, an interview was conducted with the Infection Preventionist (IP), Registered Nurse (RN #6). He stated that he has been IP since February 2024. Regarding administration of antibiotics to newly admitted residents, RN #6 stated that new admissions were expected to get their first dose base on the doctor's ordered time frame. RN #6 stated he was not aware of new admissions not getting their antibiotics on time. On 9/6/2024 at 1:20 PM, in an interview with the DON and Corporate Nurse (Staff #10), surveyor reviewed Resident #160's MAR for July 2021 with them. They both verified and confirmed that there was a delay in med administration for the resident's ordered antibiotics. Staff #10 stated that the nurse should have at least called the doctor and change the time of the first IV antibiotic administration as soon as the medication was delivered by pharmacy. She confirmed that Resident #160 did not get the ordered antibiotics on 7/28/2021 at 0800 (8:00 AM) and 0900 (9:00 AM) respectively and that the # 8 on the staff initials on the MAR for both times meant see progress notes. However, Staff #10 added that she could not find any progress notes relating to the missed doses of antibiotics in the resident's records.

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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** 50502 Based on a review of the complaint, record review, and interview, it was determined that the facility failed to provide appropriate care and treatment to a resident with a pressure ulcer. This was evident for 1 (Resident #182) of 9 residents reviewed for pressure ulcers during a recertification/complaint survey. The findings include: A pressure ulcer, a bedsore or pressure sore, is an open wound that occurs when skin is damaged by prolonged pressure. Pressure ulcers can range in severity from discoloration to open sores that expose bone or muscle. They can be painful and take a long time to heal. Pressure ulcers often develop on bony areas of the body, such as the heels, ankles, buttocks, hips, tailbone, and back. They can occur in people who are bedridden or use a wheelchair and are more likely to develop in areas where the body rests against the chair or bed On 9/3/24 at 1:17 PM, a review of a complaint dated 12/7/2022 revealed that Resident #182 was admitted to the facility on [DATE]. The family member expressed in the complaint that on 12/3/22, Resident #182 noticed that his/her wound dressing to the left ankle was still marked 11/28/22. The family member verified that they asked a nurse about the frequency of the dressing change, and the nurse said there was no order for it. On 9/3/24 at 1:20 PM, a review of the nurse's progress notes dated 12/3/24 at 1:09 PM stated, residents complained of dressing not been done on the wound on the left lateral malleolus, no order in place, wound clean with normal saline and dressed in dry gauze, the physician called for order. On 9/4/24 at 8:02 AM, a review of the Treatment Administration Record (TAR) for wound care revealed that there were no orders of wound treatment upon Resident #182's admission, 11/28/22. The following wound treatment was ordered on 12/3/24 and 12/4/24 after the family member's statement. - Clean wound on left lateral malleolus with normal saline and dress with medi honey daily. one time a day for wound dressing -Order Date 12/03/2022 1316 -D/C Date12/04/2022. - Clean wound on left lateral malleolus with normal saline and pat dry, Apply MediHoney to wound bed and cover with Border Dressing daily and PRN (as needed) if dressing becomes soiled or dislodged one time a day for wound dressing -Order Date 12/04/2022. On 9/4/24 at 9:19 AM, a review of the weekly skin assessment dated [DATE] revealed that it was documented the resident had a wound to the left lateral ankle. The hospital discharge summary dated 11/28/24 indicated Left malleolus Stage II pressure ulcer: Cleanse with normal saline. Apply Medi honey as primary and bordered foam as secondary. Change dressing every other day. However, there was no order in the chart for pressure ulcer care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN #23) on 9/04/24 at 9:42 AM, RN #23 explained the process of how they planned new admission residents. She said the nurses read through the discharge summary and reviewed medications, treatments, lab orders, and appointments. She added that they call the doctor to reconcile before the orders are entered into the electronic medical record. Also, the managers conduct a second chart review. On 9/4/24 at 10:39 AM, the Director of Nursing (DON) was made aware that the wound treatment order for Resident #182 was missed on admission.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on observation and interview it was determined the facility failed to ensure a resident room was maintained free from accident hazards. This was evident for one(Resident #7) out of one resident reviewed for resident to resident interaction duing a recertification/complaint survey. The findings include: On 8/20/24 at 10:46AM the surveyor was approached by Resident #7 who reported their concerns for the environmental conditions that existed behind their bed located in room [ROOM NUMBER]. At this time, Resident #7 requested for the surveyor to observe the concerns. On 8/20/24 at 10:48AM the surveyor observed three sharp metal screws, each approximately 1 inch in length with sharp edges exposed protruding upward from a broken, separated area of the baseboard heat cover which additionally had sharp edges exposed among other environmental concerns. On 8/20/24 at 10:48AM the surveyor conducted an observation in room [ROOM NUMBER] with Unit Manager #20, and Director of Social Work #5, who acknowledged and confirmed understanding of the observed concerns. At this time, Unit Manager #20 stated the following to the surveyor in response to the surveyor's concern: We will take care of it. On 8/20/24 at 2:25PM the surveyor conducted a dual surveyor observation in room [ROOM NUMBER] which revealed a second observation of the three sharp metal screws, each approximately 1 inch in length with sharp edges exposed continuing to protrude upward from a broken, separated area of the baseboard heat cover which additionally had sharp edges exposed. On 8/20/24 at 3:01PM the surveyor shared the concern with the facility Administrator and conducted a dual observation with them, at which time they acknowledged and confirmed the surveyor's concern.

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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. 43096 Based on medical record review and interview it was determined that the facility failed to 1) ensure a resident admitted to the facility with a suprapubic catheter received care and develop a care plan which included the use of the catheter and associated interventions, 2) evaluate a foley catheter when a resident had repeated clogged foley catheter issues, and 3) ensure a resident with a foley catheter had a medical order for care of the catheter. This was evident for 3 (Resident #156, #254 and #154) of 4 residents reviewed for bowel and bladder incontinence during the recertification/complaint survey. The findings include: A suprapubic catheter is a tube that drains urine from the bladder through a small incision in the lower abdomen. It's used when other methods of draining urine aren't possible, desirable, or clinically feasible. A Foley catheter is a type of urinary catheter that drains urine from the bladder into a collection bag outside the body. It's also known as an indwelling urinary catheter (IDC). 1)During an review of complaints on 8/27/24 at 10:50 AM it was noted that a complainant reported that they had concerns about Resident #156's suprapubic catheter care in August 2023. On 8/27/24 at 11:00 AM, review of Resident #156's electronic medical records revealed that the resident had suprapubic catheter upon his/her initial admission in February 2023. The review of order summary revealed that Resident #156 had order of 'change catheter bag every month and prn for infection control. Order date 7/12/23. Cleanse supra pubic with normal saline pack with calcium alginate rope one time a day. Order date 6/07/23. Empty supra pubic catheter bag every shift. order date 2/18/23.' However, there was no order for catheter care including cleaning, monitoring, preventing infection control from February 2023 to June 2023. Also, a review of Resident #156's care plan on 8/27/24 at 11:10 AM, revealed that the care plan for suprapubic catheter was initiated on 8/17/23. There was no care plan for Resident #156's catheter care for few months upon his/her admission. During an interview with the Director of Nursing (DON) on 8/27/24 at 11:55 AM, she stated that residents' care plan initiated upon their admission based on their condition. Also, she confirmed that the facility nursing staff expected to monitor residents who had catheter by cleaning every shift, emptying the bag, and checking settlement. And they needed to be documented. The surveyor shared concerns with the DON regarding Resident #156's catheter care. 2) During a review of complaints on 9/05/24 at 1:36 PM, it was revealed that a complainant reported that Resident #154's Foley catheter was not being taken care of. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #154's medical record on 9/05/24 at 1:40 PM revealed that the resident had a Foley catheter upon his/her admission in August 2022. Further review of Resident #154's records showed that the resident had a progress note written by a nurse on 10/07/22, 'Resident reported that his catheter was not draining. Upon assessment a full bladder was noted. Catheter removed and a new 16Fr catheter inserted with no trauma observed and tolerated. catheter patent and draining yellow colored Urine.' On 10/12/22, an additional progress note was written with the exact same details as 10/07/22: no draining from the catheter, and a new catheter was inserted. Per a progress note dated 10/16/22, Resident #154 was diagnosed with Urinary Tract Infection, and a new order was placed for antibiotics. The surveyor reviewed Resident #154's Treatment Administration Record (TAR) on 9/05/24 at 2:00 PM. The review revealed that the TAR did not document the new catheter insertion even though an order to change Foley every month on Thursdays, every night shift every four weeks, started on 8/31/22. Also, there was no documentation of how the facility evaluated Resident #154's catheter after the repeated clogging issues. During an interview with the Director of Nursing (DON) on 9/06/24 at 12:10 PM, the DON stated that Foley catheter care needed to be documented in the Electronic Medical Records system. The DON added that if the catheter was not draining repeatedly, she expected nurses to discuss this with the Physician and consult with a Urologist. The surveyor informed the DON that Resident #154's Foley catheter was reinserted twice within 5 days, and no documentation was presented. The DON validated the above concerns. 47200 3) On 8/19/24 at 8:59AM the surveyor observed the foley catheter bag of Resident #254 laying directly on the floor. On 8/19/24 at 9:06AM the surveyor observed GNA #37 remove the catheter bag from off of the floor and hang it onto the resident's bed. On 8/27/24 at 12:29PM the surveyor reviewed the care plan for Resident #254 and observed there was no intervention for catheter hygiene care for the resident. On 8/27/24 at 12:56PM the surveyor conducted an interview with the Director of Nursing (DON) who stated to the surveyor that their expectation is for there to be a medical order for foley catheter care. Upon observation of the medical record, the DON confirmed with the surveyor that no medical order for foley catheter care was in place for Resident #254. On 8/27/24 at 12:59PM the surveyor requested from the DON, any and all documentation regarding foley catheter care for Resident #254. On 8/27/24 at 1:16PM the surveyor conducted an interview with the DON who stated the following information: We just put the order in, it wasn't in there. At this time, the surveyor shared their concern with the DON who acknowledged and confirmed understanding of the surveyor's concern.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45733 Based on observation, medical record review, and interview it was determined that the facility staff failed 1) to maintain the resident's meal proportions to assure a desirable body weight. The inadequate meal proportions resulted in severe weight loss of more than 12% in 6 months, and 2) to notify the Physician regarding the resident's significant weight loss and revised their care plan. This was evident for 2 (Resident #60 and #175) of 5 residents reviewed for nutrition during a recertification/complaint survey. The findings include: 1) During a floor rounding, on 8/20/24 at 10:20 AM, Resident #60 was observed running in the hallway attempting to take apple sauce from the medication cart. The resident kept saying I'm hungry. GNA Staff #22 carried some food in her hands and the resident followed her back to his/her room. Further observation, on 8/28/24 at 09:00AM, found that Resident #60's tray had 3 scoops of pureed diet and no other foods were on the tray. Again, resident was seeking for food after eating. Record Review, on 8/28/24 at 1:55PM, revealed that Resident #60 had a history of a stroke with dysphagia, alcohol abuse and depression. From the resident's facility eating assessment, it was determined that he/she was independent with supervision. During an interview, on 8/28/24 at 2:10 PM, GNA #22 stated that Resident #60 ate well and did not refuse food. Floor staff had provided additional snacks to prevent this resident from going around the unit or going to other residents' rooms to find food. Further record review, on 8/28/24 at 02:20 PM, revealed a physician's order for pureed texture thin consistency meals, including 120 ml MedPass supplement and ice cream. The weight log listed that Resident #60's weight on 2/7/24 was 116 pounds and on 8/22/24 was 102 pounds which was more than a 12% weight loss over 6 months. Dietitian Staff #12 documented on 7/17/24 the dietitian's notes that the resident's weight of 103.4 lbs. was considered stable. Observation, on 8/30/24 at 8:45 AM, found that the Resident's breakfast tray presented only 3 scoops of pureed food (2 out of 3 were eggs as a double portion). On 08/30/24 at 08:58 AM, the DON observed that the same tray and agreed that it was not enough food and the facility had failed to provide adequate food. The DON was made aware that this was a concern. Record review, on 08/30/24 at 09:19 AM, after the surveyor's intervention, found that a diet request form was sent to the kitchen, on 8/30/24, requesting: a large and small portions meal, please send 2 trays for each meal. 43096 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2)During a review of complaints on 9/04/24 at 9:20 AM, a complainant reported concerns regarding Resident #175's weight loss. On 9/04/24 at 9:25 AM, a review of Resident #175's medical record revealed that the resident's body weight documented that he/she had a 9.4 pounds difference (11%) within a month from 6/09/22 (84.6 pounds) to 7/06/22 (75.2 pounds). An additional review of Resident #175's progress note revealed that a dietician (Staff #41, who was not currently working) wrote a nutrition note on 7/08/22 as aware of inaccurate weight, likely issues with scale. Resident doesn't appear to have weight change. Reweight being taken. On 7/14/22, Staff #41 wrote a note again as, Resident doesn't appear to have weight change. Reweight pending. On 7/15/22, the Resident's weight was documented as 76.4 pounds. Also, Staff #41 wrote progress notes with interventions and ordered supplements. However, there was no documentation Resident #175's weight loss was notified to the Physician. In a review of Resident #175's care plan on 9/04/24 at 10 AM, it was revealed that the resident had a care plan regarding high risk for malnutrition related to underweight status initiated on 6/17/20. However, the care plan was not revised and/or added interventions after his/her significant weight loss was noted on 7/08/22. The surveyor conducted an interview with a Dietician (Staff #12) and the Director of Nursing (DON) on 9/04/24 at 2:07 PM. Staff #12 stated if a resident had significant weight loss, the dietician filled out an evaluation, and a meeting would be held with IDT (Interdisciplinary Team: A group of healthcare professionals who work together to provide care to patients. IDTs can include doctors, nurses, social workers, occupational therapists, and more), and nursing department should notify to physicians and family members. The surveyor shared Resident #175 weight loss documentation with the DON. The DON verified that they did not have documentation to support the resident's weight loss, which was discussed with the physician, and the care plan was updated.

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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. 47200 Based on observation and interview it was determined the facility failed 1) to ensure the secure storage of medications, 2) to ensure that medications were properly labeled and stored, and 3) to provide safe and secure storage to minimize loss or diversion of narcotic medications. This was evident for three residents (Resident #31, #56, #79) observed to have medications in their room, 2 (station 2 and station 3) of 3 medication rooms, 3 (station 3 cart 1, station 1 cart 3 and station 2 cart 1) of 6 medication carts, and 2 residents (Resident #170 and #162) reviewed for safe medication storage and labeling during the facility's recertification/complaint survey. The findings include: 1) During the surveyor's initial tour on 8/19/24 at 8:32AM an open uncapped bottle of Dakins topical antiseptic wound solution and tube of Santyl ointment was observed to be present on the windowsill next to Resident #31, and no staff were present in the room. Further observation of the room revealed the resident's wound care supplies was present on their furniture next to their television. The following additional items were observed within the resident room: two bottles of wound packing strips, an open package of previously cut Hydrofera Blue wound dressing, other wound dressing supplies, medical tape and alcohol prep pads. Resident #31 stated to the surveyor that it bothered them that the medical supplies were stored in their room. On 8/19/24 at 8:38AM the surveyor shared the specific concerns with Unit Manager #20 who observed, acknowledged, and confirmed understanding of the surveyor's concerns, however, they removed only a few items from the room, and left the open bottle of Dakin's solution on the windowsill. On 8/19/24 at 8:41AM the surveyor shared the concern again with Unit Manager #20, for the open bottle of Dakins solution on the resident's windowsill. Unit Manager #20 stated to the surveyor that they would remove it. The surveyor observed Unit Manager #20 walk past the resident's room and down the hallway before coming back to remove the solution from the room. On 8/19/24 at 8:46AM the surveyor observed Nystatin topical medication present on the over bed table of Resident #56, who was not in their room, and no staff were present in the room. On 8/19/24 at 8:48AM the surveyor shared their concern for medication left at the bedside of Resident #56 with Unit Manager #20. Unit Manager #20 stated to the surveyor: Oh, okay, alright. At this time, the surveyor observed Unit Manager #20 continue down the hallway before coming back to remove the medication at the bedside. On 8/27/24 at 8:09AM the surveyor observed medication consisting of two oval pills laying beneath the heating unit near Resident #79. On 8/27/24 at 8:11AM the surveyor shared their concern and conducted an observation of the medication in the room of Resident #79 with Registered Nurse #33 who observed, acknowledged, and confirmed understanding of the surveyor's concern. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Baltimore Washington	313 Hospital Drive Glen Burnie, MD 21061

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 10:49AM the surveyor shared concerns with the facility Administrator who acknowledged and confirmed understanding of the surveyor's concerns. 50502 2) Oxycodone is a narcotic used to treat moderate to severe pain. High risk for addiction and dependence. Can cause respiratory distress and death when taken in high doses or when combined with other substances, especially alcohol or other illicit drugs such as heroin and cocaine. Aspirin is used to treat pain and reduce fever or inflammation. It is sometimes used to treat or prevent heart attacks, strokes, and chest pain. Polyethylene Glycol is a medication used in the management and treatment of constipation. Assure Prism Control glucometer solution is a liquid used to check the accuracy of blood glucose test results and ensure that the Assure Prism multi-Blood Glucose Meter and test strips are working properly. Brimonidine tartrate ophthalmic solution is a medication used to treat high pressure in the eyes, also known as glaucoma or ocular hypertension. It's also used to treat minor eye irritations that cause redness. Trelegy is a once-daily inhaler that combines three medicines to prevent and control asthma symptoms for up to 24 hours. Incruise Ellipta is an inhaler used for the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adults. Guaifenesin is a cough and cold medication that can thin mucus. This may make it easier to clear from the head, throat, and lungs. COVID 19 reagent is a chemical used in a reaction to detect or measure a substance of interest. On 8/29/24 at 9:05 AM, the surveyors audited the two medication rooms, accompanied by a Registered Nurse (RN #7). In the medication room of station 3, the surveyors found two medications of 2 discharged residents (Resident #98 and #201). Resident #201 was discharged in July 2024, and Resident #98 was discharged the 2nd week of August. RN #7 stated that the facility usually returns the medications to the pharmacy when the resident was discharged , but the nurses overlooked the 2 medications. RN # 7 removed the medications of the discharged residents from the medication room. On 8/29/24 at 9:11 AM, in the medication room of station 2, the surveyors found non conductive connecting tubing that expired on 9/5/2021. RN #7 also removed the expired tubing. On 8/29/24 at 9:22 AM, the surveyors checked medication cart 1 in station 3 and found Aspirin 81mg with an expiration date of 7/2024. Polyethylene Glycol 3350 was opened without a date marked. RN #7 removed the medications from the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 9:36 AM, the surveyors checked medication cart 3 in station 1 with the help of the Assistant Director of Nursing (ADON). The surveyors found Assure Prism Control glucometer solution, which expired on 8/1/2024. Furthermore, the surveyors located the following medications that were opened but not dated: Brimonidine tartrate ophthalmic solution, Trelegy, Incruise ellipta 62.5 mg, Guaifenesin syrup 8 oz, Guaifenesin oral sol 16 oz, Guaifenesin oral sol 16 oz, Polyethylene glycol 3350. ADON took all the undated and expired medications from the cart. On 8/29/24 at 9:53 AM, in station 2, medication cart 1 had an expired COVID-19 reagent from 12/8/23. The Licensed Practical Nurse (LPN # 24) stated that the nurses are expected to put a date on the medications that they open so everybody knows. On 9/03/24 at 9:02 AM, the DON was notified of the issues observed during the audit of medication rooms and medication carts. 3) On 9/3/24 at 8:05 AM, based on the report filed on 10/7/22 to the Office of Health Care Quality (OHCQ), the facility was unable to locate narcotics delivered by Omnicare Pharmacy on 10/6/22 at 4:00 AM. On 9/3/24 at 9:34 AM, in an interview with LPN #3, he/she stated the pharmacy delivered narcotics at various times. He/she added that one nurse received the narcotic, and two other nurses reconciled and put the information in the narcotic book. On 9/3/24 at 9:40 AM, in an interview with RN #4, he/she stated that delivery of narcotics varied, if the nurses ordered it STAT, it would be delivered immediately. He/she added that the nurse signed the receipt of narcotics co-signed by another nurse and gave the receipt to the Unit Manager, the ADON, or the Director of Nursing (DON) during the weekdays and to the supervisor during weekends or at night. On 9/3/24 at 10:13 AM, during an interview with the DON, she stated that the pharmacy delivered the narcotics, the supervisor received them, and two nurses reconciled them. On 9/3/24 at 2:14 PM, a review of the facility's investigation of MD00184248 revealed that on 10/6/22 at 4:00 AM, Omnicare pharmacy delivered Oxycodone 5mg and Oxycodone 10mg for Resident #162 and Oxycodone 10mg for Resident #170 to the facility. The facility was unable to locate the medications after they had been delivered. Law enforcement was notified on 10/6/22. The nurses who were involved in the incident were LPN #46 and LPN #47. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/24 at 11:23 AM, further review of the self-report revealed that the incident was reported to the board of nursing on 10/10/22. The Drug Enforcement Administration (DEA) report indicated an email inquiry was sent on 10/11/22 at 6:02 PM. Based on the report of the former DON (Staff #48) dated 10/10/22, the pharmacy delivered the narcotics on 10/6/22 at 4 AM to the facility, the nurse in station 1 LPN #47 received the medications and handed them over to the nurse in station 2 LPN #46, where the two residents resided. LPN #46 denied receiving the narcotics from LPN #47. The narcotics were not found in the facility, and the facility paid to replace the medications. Based on Staff #47's statement dated 10/6/22, he/she received and signed the pink slips for the pharmacy's 3 small bags of narcotics. He/she said that he/she took the bags of narcotics and handed them to the nurse in station 2, LPN #46, and reminded the nurse to log the medications in. LPN #46 was interviewed by DON #48 via telephone on 10/6/22 at 4:30 PM, he/she denied receiving the 2 Oxycodone for the two new admissions and denied speaking to LPN #47 on 10/6/22 11-7 shift. An education entitled Counting Narcotic cards on shift to shift count off sheet was conducted on 10/6/22 and 10/7/22 by RN #49, the training was attended by 42 nursing staff and managers. On 9/6/24 at 1:20 PM, the DON and Staff #10 were made aware of the concerns the facility failed to provide safe and secure storage to minimize loss or diversion of narcotic medications.

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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. 43096 Based on the surveyor's observation, interview with facility staff, and medical record review, the facility failed to maintain medical records on each resident in accordance with professional standards and practices that are: i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. This was evident for three residents (Resident #187, #31, # 10) out of 78 residents reviewed during the recertification/complaint survey. The findings include: 1)On 8/28/24 at 11:09 AM, the surveyor reviewed complaints about residents' care at this facility. One complainant reported that Resident #187 did not receive appropriate care regarding his/her health condition. A review of Resident #187's medical records on 8/28/24 at 11:15 AM revealed that the resident was transferred to the hospital on 10/28/22 around 1-2 PM for further evaluation after the fall and was not readmitted to the facility. However, blood pressure was documented on Resident #187's electronic medical record vital sign section on 10/29/22 at 11:09 PM. During an interview with the Director of Nursing (DON) on 8/29/24 at 12:15 PM, the DON verified that Resident #187 was transferred to the hospital on 10/28/22 and was not in the facility on 10/29/22. The surveyor shared documented blood pressure dated 10/29/22 for the resident. The DON said, There were some data entry errors. The DON validated the surveyor's concern. 47200 2)Review of the medical record on 9/9/24 at 11:16AM revealed no active medical order was in place for an air mattress for Resident #31. Review of the care plan for Resident #31 revealed the following intervention dated as beginning on 8/4/24: Provide Clintron bed for wound healing. On 9/9/24 at 11:42AM the surveyor conducted a dual surveyor observation of a specialty air mattress in place for Resident #31. On 9/9/24 at 11:42AM surveyors conducted an interview with Geriatric Nursing Assistant #43, who observed and confirmed that the mattress in place was a specialty air mattress for Resident #31. Review of the wound care provider's (staff #42) follow up progress note dated 6/25/24 revealed the air mattress was recommended to address factors affecting wound healing for Resident #31. On 9/9/24 at 11:45AM the surveyor shared their concern with the Director of Nursing who acknowledged and confirmed understanding of the concern. 49409 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3)On 09/04/24 at 01:35 PM, a medical record review revealed that resident #10 has been at the facility for more than one month, receiving enteral tube feeding, 80ml Osmolite 1.2/hr x 18hrs, from 07/28/24. A review of the Tube feeding administration record revealed that the enteral feeding order of glucerna for August 2024 was not signed for 22 days. On 9/4/24 at 2:28PM an interview with the DON and Registered Dietician (RD) revealed that the enteral feeding orders are entered into the electronic medical record by the RD and then require the nurse to confirm the order. Incompletion of this process resulted in a failure to sign the orders.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on observation, interview, and record review it was determined the facility failed to: ensure an effective process was in place to report pest issues, ensure pest issues were effectively and timely managed, and ensure the environment was free from pests. This was evident during the surveyor's review of complaints and during the facility's recertification/complaint survey and has the potential to affect all residents. The findings include: On 8/19/24 at 10:33AM Resident #92 reported to the surveyor that there were lots of flies/gnats in their room and especially in their bathroom. On 8/19/24 at 10:50AM Resident #32 reported to the surveyor their observations of pests within the room which included gnats. On 8/19/24 at 10:55AM Resident #354 reported to the surveyor the presence of flies within their bathroom. On 8/20/24 at 10:46AM Resident #7 reported to the surveyor in the hallway of station one, that their skin had become very itchy including their scalp. The resident was observed to be actively itching their body. Upon surveyor intervention, nursing staff responded to the resident. On 8/21/24 at 2:41PM the surveyor observed many gnats flying around within room [ROOM NUMBER]. On 8/22/24 at 9:13AM the surveyor conducted an interview with Unit Manager #20 who reported that they unaware of the purpose of the station one pest log book and further stated : I don't use it. On 8/22/24 at 9:19AM the surveyor interviewed the Director of Maintenance who reported that in response to the surveyor's request the day prior, they gave 8 documented incidents to the facility Administrator regarding facility pest issues found that were reported to the maintenance department by staff via the electronic system. The surveyor noted documentation was requested the day prior, however, the documentation had not been provided to the surveyor. The Director of Maintenance reported to the surveyor that the facility's process in place for the reporting of pest and maintenance issues was via the electronic system. When asked by the surveyor if staff utilized paper logs to communicate maintenance and pest concerns, the Director of Maintenance responded to the surveyor that there were no paper logs on the units. The Director of Maintenance further confirmed with the surveyor that the maintenance department did not utilize or check any paper logs on the nursing units. The Director of Maintenance further reported they were aware of the gnat/fly issue within the facility and had attempted drain treatments approximately one week ago, and reported being unsure if the pest control company was aware of the issue. On 8/22/24 at 10:17AM the surveyor conducted an interview with the facility Administrator who reported to the surveyor that the pest log books on the nursing units were used by staff to communicate pest concerns/citings in addition to verbally informing staff members, and that the maintenance department should be checking the logs. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/22/24 at 10:45AM the surveyor conducted an interview with the facility Administrator who, in response to the surveyor's prior request for pest documentation, stated they did not find any documentation of bed bugs in their concern/grievance logs. At this time, the surveyor requested and conducted review of the 2023 and 2024 facility concern/grievance logs. Upon observation and review of these logs the following concerns were found reported to the facility by both residents and resident family members which included: 1.) a concern form dated 6/27/24 which included a concern for gnats present in the room of Resident #87, 2.) a concern form dated 7/21/24 stating bed bugs were noted in the room of Resident #58 and Resident #34, 3.) a concern form dated 12/21/23 reporting observation of a rodent, 4.) a logged concern dated 1/2/24 for a pest control issue/concern for a resident of unit 2, 5.) a logged concern dated 1/5/24 stating the following information regarding bed bugs: Resident wants to wait for treatment to room, has not seen anymore, and documented as resolved on 1/17/24, 6.) a concern form dated 1/15/24 reporting the following information by facility staff: I talked to Resident #31 about the process of the bed bug treatment, Resident #31 stated s/he has not seen anything since Saturday so s/he wants to wait until he sees the bed bug to begin the process. Surveyor review of the pest log books on 3 of 3 nursing units revealed no staff reporting of pest issues via the log books was present for the pest control company. The surveyor conducted review of the current pest control company's contract with the facility dated 3/12/24 which revealed the following information: Additionally, we provide your facility with the following organizational tools: .2.) Pest monitoring logs/notebooks for specific areas which are checked each visit . Upon surveyor review of the previous pest control company's contract utilized by the facility revealed the following information: We will check in at all nurse stations and treat any complaints listed in the logbooks. The surveyor requested to the facility Administrator to observe documentation relating to room tracking of the bed bug issues, to which the Administrator responded that there was no tracking of this aside from the pest control invoices. On 8/22/24 at 11:14AM the surveyor observed gnats flying in the station one hallway. On 8/22/24 at 2:30PM the surveyor conducted an interview with Unit Manager #20 who stated the following to the surveyor: I would not have thought if someone was itching to look at it as a potential for bed bugs. Review of pest documentation and records on 8/22/24 at 2:37PM revealed the following work orders submitted via the electronic system: 1.) 5/2/23 regarding bugs/gnats in room [ROOM NUMBER] marked as completed on 5/3, 2.) 8/25/23 regarding mice in room/area 21A which was marked as set to cancelled, 3.) 12/21/23 regarding mice in room [ROOM NUMBER] which was marked as set to cancelled, 4.) 12/28/23 with a created time of 6:39AM regarding bug found in bed in room [ROOM NUMBER]a which was marked as set to cancelled at 8:06AM, 5.) 1/30/24 with created time of 7:23AM regarding bugs in room [ROOM NUMBER] which was marked as set to completed at 8:26AM, 6.) 2/7/24 regarding bed bug noted in the room (#43), 7.) 3/5/24 regarding a mouse in room [ROOM NUMBER], 8.) 3/7/24 regarding mice in bathroom between rooms #46 & #47, 9.) 4/24/24 regarding mouse seen in the room, 10.) 7/1/24 regarding gnats/fruit flies/small flying bugs in room/area 103A. Review of the pest service record dated 1/19/24 revealed the first bed bug treatment for room [ROOM NUMBER] did not occur until 1/19/24, approximately 14 days after a concern for bed bugs in the room had been brought to the facility's attention. Review of the pest control records revealed mice issues continued to be reported for several months. On 8/23/24 at approximately 11:15AM the surveyor conducted an interview with Certified Medication Assistant #45 who reported that the way they report pest concerns was by putting it in the book and letting the department head know. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/23/24 at 11:18AM the surveyor conducted an interview with Licensed Practical Nurse #25 who reported that the way they report pest concerns was by logging it in the pest control book at the nurse's station, and then they let maintenance know. During the interview, gnats were observed flying in the station one hallway. On 8/27/24 at 8:19AM the surveyor observed dead ants present along the floor area in the nursing supply room. On 8/27/24 at 9:40AM the surveyor observed gnats present flying around in room [ROOM NUMBER]. On 8/27/24 at 10:12AM the surveyor observed a sticky strip hanging on the bathroom door in room of Resident #41, and flies were observed in the bathroom. At this time the surveyor conducted an interview with Resident #41 who stated that the flies were present in their room for approximately five months. On 8/27/24 at 10:14AM the surveyor observed room [ROOM NUMBER] and noted flies present around the room and on a dirty laundry bag that was hanging partially out of a furniture drawer. On 8/27/24 at 10:31AM the surveyor observed flies and gnats present in room [ROOM NUMBER]. On 8/27/24 at 10:52AM the surveyor observed flies at the doorway upon entering room [ROOM NUMBER]. On 8/27/24 at 11:07AM the surveyor observed flies and gnats throughout the room and within the bathroom in room [ROOM NUMBER]. The surveyor noted there were multiple flies and gnats present on the toilet paper stored within the bathroom which was uncovered. On 8/27/24 at 11:18AM the surveyor observed a sticky strip with flies present on it in room [ROOM NUMBER]. On 8/27/24 at 11:31AM the surveyor conducted an environmental tour and shared concerns with the facility's Director of Maintenance #38 who acknowledged and confirmed understanding of the surveyor's concerns. The surveyor conducted several observations of the gnats and flies which included room [ROOM NUMBER], with the Director of Maintenance who observed and confirmed the surveyor's concerns. At this time, the surveyor conducted an interview with the Director of Maintenance who reported they were aware of the problem within the facility of the flies/gnats. On 9/9/24 at 10:49AM the surveyor shared concerns with the facility Administrator who acknowledged and confirmed understanding of the surveyor's concerns.