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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on observation and interview it was determined the facility failed to maintain a clean, homelike environment. This was evident throughout the facility in some resident rooms and common areas during the recertification/complaint survey. The findings include: During surveyor's initial tour on 8/19/24 at 8:36AM the surveyor observed various resident belongings within three cardboard boxes and two plastic bags amongst other items including a plastic urinal, stacked up against the baseboard heating. Further observation of the room revealed splattered food like material, debris, and crumbs present across the resident's wall below their window, and across their wall air conditioning unit, and a full trash receptacle next to the resident's bed. The floor was observed to have sticky soiling and debris present in various areas and extending from the corner of the room to underneath bedside furniture. The mirror affixed to the wall was observed to have a cloudy appearance. An interview was conducted on 8/19/24 at 8:36AM with Resident #31 who expressed their concern for the unclean condition of their room. On 8/20/24 at 3:01PM the surveyor conducted a dual observation with the facility Administrator in the room of Resident #31. At this time, the Administrator acknowledged and confirmed the surveyor's concerns and reported the following to Resident #31: This will get cleaned up. On 8/21/24 at 11:01AM the surveyor conducted an interview of a complainant who reported to the surveyor they personally had provided cleaning of Resident #31's window area for them in an effort to maintain a cleaner environment for the resident. On 8/19/24 at 9:15AM the surveyor observed the station one hallway linen cart with only one fitted bed sheet available on it. On 8/19/24 at 9:16AM the surveyor observed a mattress in room [ROOM NUMBER] that did not have bed linens, room [ROOM NUMBER]B with a bare mattress and no fitted sheet present, room [ROOM NUMBER]A with a bare mattress and no fitted sheet, and room [ROOM NUMBER]B with a bare mattress and no fitted sheet present. 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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. The baseboard heat cover was observed to be bent in condition, with brown splattering present on the wall behind the bed of Resident #7, and various yellow, brown, and black debris with splattering and sticky areas present along the heating unit and on the floor. 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. On 8/21/24 at 2:41PM the surveyor conducted an observation of room [ROOM NUMBER] and observed a bed pan under the bed which was filled with dirty tissues and assorted trash. 08/21/24 at 2:43 PM the surveyor observed both bed mattresses bare, with no sheets/linens on them in room [ROOM NUMBER]. On 8/22/24 at 10:45AM the surveyor conducted a review of the facility concern/grievance logs which included the following concerns: 1.) 7/24/24 concern regarding a room being dirty, 2.) 1/14/24 need room completely cleaned, 3.) 1/18/24 wants walls and heater wiped down, 4.) 1/29/24 needing the bathroom cleaned, 5.) 6/27/24 matted food on floor, garbage can issues, needing the floor to be mopped, and cleanliness of the hospital tables, amongst other logged environmental concerns. On 8/27/24 at 7:40AM the surveyor observed two of two sitting chairs with peeling, worn off, cracked areas in the surface material located in the front entrance area to the facility. On 8/27/24 at 7:43AM the surveyor observed room [ROOM NUMBER] with broken areas of cove molding around the base of the heating unit, with exposed area which was observed to be dirty with a black, brown, and white appearance. Cove molding along the wall area was observed to be separated from the wall, and grey debris was observed present on the wall surface and floor surface. Two bathroom ceiling tiles were observed with brown staining present. On 8/27/24 at 7:46AM the surveyor observed room [ROOM NUMBER]'s bathroom lighting fixture with 2 different color lighting bulbs present, one which was warm in color, and one which was fluorescent in color. No molding strip was present between the floor tiles and entrance to the bathroom, with an exposed soiled black surface with worn areas of red tape. Grey markings were observed along the wall across from the resident beds. A wall hole was observed with orange colored spray insulation material protruding from the wall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 7:48AM the surveyor observed two ceiling tiles with brown staining present in the bathroom located across the hall from room [ROOM NUMBER]. On 8/27/24 at 7:51AM the surveyor observed room [ROOM NUMBER] with peeling paint along the wall behind the resident bed located closest to the door. The lighting fixture located behind the resident bed was observed to not be reachable for the resident to utilize. On 8/27/24 at 7:52AM the surveyor observed several areas of dark black staining present on the bathroom floor of room [ROOM NUMBER]. Horizontal grey and black marks and worn areas were observed on the bathroom door leading to room [ROOM NUMBER]. Splattered dried liquid was observed on the bathroom door leading into room [ROOM NUMBER]. Caulking material around the base of the commode was observed to be uneven and dirty in appearance, with areas of brown debris present. On 8/27/24 at 7:58AM the surveyor observed the utility room door across the hall from room [ROOM NUMBER] with dark grey markings along the bottom of the door. Upon opening of the door to the utility room, the surveyor observed black debris and a used medical glove on the floor. Further observation revealed the trash can lid which was labeled linen was resting over top of and against a hopper receptacle which was observed to have various brown staining present with light brown liquid present within it, and a layer of speckled white areas sitting on top of the liquid. At this time, the surveyor shared the concerns and conducted a dual observation with Registered Nurse (RN) #33 who observed, acknowledged, and confirmed the surveyor's concerns in the utility room. At this time, the surveyor conducted an interview with Registered Nurse #33, who reported to the surveyor that the hopper was utilized by staff to pour urine into from urinals and flush it. On 8/27/24 at 8:06AM, the surveyor conducted a dual observation of the utility room concerns with Director of Housekeeping #32 who reported to the surveyor that the hopper was very old and was not in use. At this time, Director of Housekeeping #32 observed, acknowledged, and confirmed the surveyor's concerns and stated the following information: This is supposed to be cleaned, and yes, this does not look clean. On 8/27/24 at 8:07AM the surveyor observed black areas present on two floor tiles toward the foot of the resident's bed in room [ROOM NUMBER]. Cove molding was observed to be broken in appearance surrounding the heating unit. Grey markings and a dried red substance was observed present on the wall near the window. On 8/27/24 at 8:09AM the surveyor observed peeling paint behind the resident's bed along the wall in room [ROOM NUMBER], on the window side of the room. On 8/27/24 at 8:15AM the surveyor observed the ice/nutrition room located near nursing unit 3. Upon entry to the room, the lock and door handle to the room was loose and movable. Areas of dark debris were observed on the floor, and an area of standing water was present on the floor in front of the ice machine. A broken area of drywall was observed along the cove molding approximately 4 inches wide x 1 inch tall. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 8:19AM the surveyor observed the nursing supply room. One ceiling tile hanging directly above nursing supplies was observed to have a bowed appearance with cracks and brown and white debris present on the tile's surface. Various small trash items were observed on the floor amongst grey debris, dead ants, and small cobwebs were present along the floor area. Two additional ceiling tiles were noted to have brown staining present. On 8/27/24 at 8:26AM the surveyor conducted a dual observation of the nursing supply room and shared concerns with Unit Manager #7 who observed, acknowledged, and confirmed understanding of the concerns. On 8/27/24 at 8:32AM a dual surveyor observation of environmental concerns was conducted. On 8/27/24 at 8:56AM the surveyor observed the the right lower corner of the door to room [ROOM NUMBER] which was covered by a piece of paper held up by tape, with an unpainted broken surface beneath. One bathroom ceiling tile was observed to have brown staining present, and dark areas were observed on the floor surface surrounding the commode. Chipped paint and orange speckling was observed on an air duct inside the room on the wall. Broken areas of wood were observed on the bathroom door. Grey markings were observed along the room walls and bathroom walls. On 8/27/24 at 9:01AM the surveyor observed an open area above the door handle to Resident #198's room. At this time the surveyor observed a privacy curtain separating the two resident beds which was dirty in appearance with various brown staining present. Regarding the privacy curtain, Resident #198 stated the following to the surveyor: It's dirty, I've been looking at that. Further observation of the resident room revealed grey markings on the room walls, broken cove molding around the heating unit, and gum stuck near the top of the window area. On 8/27/24 at 9:06AM the surveyor observed brown splattering on the surface of the wall and heating unit in room [ROOM NUMBER], black debris present around the perimeter of the room's flooring, broken wooden areas on the bathroom door, and a loosely affixed vent in the bathroom ceiling. On 8/27/24 at 9:09AM the surveyor observed pooling of water underneath the air conditioning unit and underneath of Resident #8's belongings in their room. At this time, Resident #8 stated that the water was first observed last night, and the way the concern was resolved, was that nursing staff wiped it with a towel. Grey debris was observed present underneath the resident's heating unit. On 8/27/24 at 9:13AM the surveyor observed various debris and visible dirt present on the floor in room [ROOM NUMBER]. On 8/27/24 at 9:17AM the surveyor observed large areas of visible grey soiling with pieces of trash, crumbs, and debris present on the flooring in room [ROOM NUMBER]. Additionally, resident bedding was observed with crumbs present in it, the overbed table was observed to have a visibly soiled and greasy appearance, and areas of dried brown liquid splattering were present on walls, furniture, and the door to the bathroom. Dark areas of marking were present on the molding and doorframe near the bathroom and on the bathroom wall across from the commode. On 8/27/24 at 9:29AM the surveyor observed room [ROOM NUMBER] with a broken area of drywall in the corner of the room with exposed insulation material present. Peeling and cracked areas of paint were observed along the baseboard heat unit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 9:31AM the surveyor observed the baseboard heat unit in bent condition in room [ROOM NUMBER]. On 8/27/24 at 9:32AM the surveyor observed the room number signage to room [ROOM NUMBER] to be in worn, scratched off condition. The wall next to the bathroom was observed to have two areas of missing paint. On 8/27/24 at 9:33AM the surveyor observed dark markings along the wall in the resident hallway between rooms #30 and #29. On 8/27/24 at 9:36AM the surveyor observed the floor in room [ROOM NUMBER] to be visibly soiled, with grey areas, and visible crumbs and debris present. Two different light bulb colors were observed in the lighting fixture in the bathroom, and the door handle to the bathroom was loose and movable. On 8/27/24 at 9:38AM the surveyor observed an electric wheelchair in the resident hallway with the name of Resident #3 present on it. Dried staining/debris was present on the seat of the chair, and a visible layer of grey matter and debris was present on the chair's foot rest, and surrounding the base of the chair's seat. On 8/27/24 at 9:39AM the surveyor observed visibly soiled cove molding in disrepair, and a cracked area of wall along the visibly soiled baseboard in room [ROOM NUMBER]. On 8/27/24 at 9:49AM the surveyor observed approximately a two inch area of broken white covering on the resident's room door. Further observation of room [ROOM NUMBER] by the surveyor revealed a trash can which was situated inside of a cardboard box on top of the resident's belongings that were stored within the box. The baseboard heat was observed to be visibly soiled and with areas of orange speckling present. Empty plastic medication cups were observed present sitting along the baseboard unit. [NAME] splattering was observed on the walls within the resident room, and the floor was visibly dirty in appearance. Peeling paint and an area of exposed metal was observed on the corner of the wall next to the bathroom. Resident #92 reported to the surveyor that they have lived at the facility for months and had been utilizing a piece of wire to open their furniture drawer. Upon observation, the surveyor observed a yellow piece of wire situated as a handle to open their furniture drawer. Mismatched light bulb colors were observed in the resident bathroom. On 8/27/24 at 9:52AM the surveyor observed cardboard boxes against the baseboard heat in room [ROOM NUMBER]. Further observation revealed the baseboard heating pipe was exposed in areas where the metal covering was hanging below, and did not cover the pipe. Dried brown dripping and splatters were observed on room walls. The wall behind the commode in the resident bathroom was observed to have a bubbled appearance with peeling paint present. On 8/27/24 at 9:55AM the surveyor observed a soiled utility room with an exposed metal wall corner, and dried brown liquid present along the ceiling pipes. On 8/27/24 at 9:57AM the surveyor observed visible dirt and debris present along the cove molding in the station one hallway. On 8/27/24 at 10:01AM the surveyor observed the metal radiator type unit in the station one hallway with grey markings present and loose, separated, doorway molding to room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 10:06AM the surveyor observed dropped belongings on top of the baseboard heat unit along the floor, and paper stuck in the baseboard heat unit of room [ROOM NUMBER]. The baseboard heating metal cover was observed to be separated and loose with exposed pipe and metal edges present. The surveyor observed Resident #40 in their bed with significantly dirty areas of amber brown matter observed to be present on the bed's rails with pieces of the the rail material missing. On 8/27/24 at 10:06AM the surveyor conducted an interview with Geriatric Nursing Assistant (GNA) #35. At this time the surveyor shared their concern with GNA #35 who observed and acknowledged understanding of the concern. GNA #35 reported the following to the surveyor regarding the condition of the bed rails: I agree, they need cleaned. On 8/27/24 at 10:08AM the surveyor observed visibly dirty areas behind resident beds, and discolored areas on the wall across from the resident beds in room [ROOM NUMBER]. On 8/27/24 at 10:12AM the surveyor observed the baseboard heating coverings with a speckled orange appearance and a cord to the air conditioning unit was observed to be plugged into an electrical socket with plastic packaging present on it, resting up against the baseboard heating in room [ROOM NUMBER]. On 8/27/24 at 10:14AM the surveyor observed the floor in room [ROOM NUMBER] to be dirty in appearance, with trash items present on the floor. Peeling paint was observed on the door frame molding to the bathroom, and peeling cove molding was observed near the bathroom entrance. On 8/27/24 at 10:19AM the surveyor observed shoes wedged between furniture and the baseboard heat, one wheelchair foot rest was wedged under the baseboard heating, a plastic bag of dirty laundry was observed sitting against the baseboard heating, and other items were observed situated on top of the baseboard heating in room [ROOM NUMBER]. The baseboard heating and flooring was observed to have a visibly dirty appearance. On 8/27/24 at 10:23AM the baseboard heating on room [ROOM NUMBER] was observed by the surveyor to have a visibly dirty appearance. The mirror on the resident's wall was observed to have a cloudy appearance. On 8/27/24 at 10:24AM the surveyor observed flooring in room [ROOM NUMBER] to be dirty in appearance with various debris and crumbs present. Wet paper towels were observed laying on the window sill, and the baseboard heating was observed to be brown speckled in appearance. On 8/27/24 at 10:26AM the surveyor observed the flooring in room [ROOM NUMBER] to be visibly soiled and dirty in appearance. The baseboard heating was observed to have areas of worn paint. Further observation in the room revealed visible matter/soiling on the bathroom door handle. A medical glove was utilized to open the bathroom door, however, when it was time to remove the glove, the surveyor observed that there were no trash cans within the room or bathroom present. At this time, the surveyor shared their concerns and observations with Licensed Practical Nurse #36, who observed, acknowledged, and confirmed understanding of the surveyor's concerns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 10:31AM the surveyor observed gray markings and peeling paint present on the wall across from resident beds in room [ROOM NUMBER]. Cove molding across from the resident beds was observed to have gray markings present. The surveyor observed the air conditioning unit present in the room had no covering, with the screen visibly exposed and tape holding the screen in place. Visible areas of orange speckling were observed on the baseboard heating. At this time, the surveyor conducted an interview with Resident #16 who reported to the surveyor that the cover fell off weeks ago, and staff had been made aware of the cover needing to be put back onto the unit. The surveyor observed the cover was present within the resident's room. Flooring within the resident room was observed to be visibly dirty. On 8/27/24 at 10:36AM the surveyor observed extensive amber brown areas present on the baseboard heating in room [ROOM NUMBER]. Pieces of trash were observed on the floor, and the bedside table was observed to be greasy in appearance. Gray material was observed affixed to the baseboard heating, and hanging off into the baseboard heating. Paper was observed laying up against the baseboard heating. At this time, the surveyor shared concerns with Geriatric Nursing Assistant (GNA) #37, who observed, acknowledged, and confirmed understanding of the concerns. GNA #37 additionally confirmed that they did not believe any heat had been turned on in the facility as of yet. On 8/27/24 at 10:40AM the surveyor observed the flooring in room [ROOM NUMBER] to be visibly dirty, and was felt to be sticky upon entering of the room. A resident's trash can was observed to be dirty in appearance and broken in several areas, with no trash bag present within. Discolored areas were observed on the bathroom flooring, and areas of unfinished painting were present on the bathroom wall across from the commode. The commode seat was observed to be unclean in appearance, and a bed pan was present in the shared bathroom on the floor. On 8/27/24 at 10:42AM the surveyor observed wear and discoloration present on the locked staff door across from the nurse's station (1). On 8/27/24 at 10:49AM the surveyor observed worn paint along the baseboard heating in room [ROOM NUMBER]. Thick, dark debris was observed around the base of the commode in the bathroom. Areas of missing sealant around the base of the commode was observed. The surveyor noted missing areas of molding along the perimeter of the floor in the bathroom. [NAME] splattering was observed on the door frame in the shared resident bathroom. Thick brown matter was observed on the mirror's ledge in the shared resident bathroom. One resident trash can was observed to be in broken condition. On 8/27/24 at 10:50AM the surveyor observed a damaged area of the wall in the corner of room [ROOM NUMBER] with peeling paint, and peeling cove molding. The wall and door frame next to the commode in the bathroom was observed to be bubbled and discolored in appearance. On 8/27/24 at 10:52AM the surveyor observed gray markings along the wall across from resident beds in room [ROOM NUMBER]. The surveyor observed two cracked ceiling tiles with missing metal separator present in the bathroom, and four screws were observed stuck into the wall behind the commode. Two cracked areas in the wall were observed behind the bed nearest to the window. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 10:59AM the surveyor observed gray markings on the wall across from the resident beds in room [ROOM NUMBER], and on the wall near the bathroom entrance. The baseboard heating was observed to be speckled brown in appearance. An unpainted area on the wall was observed, approximately four inches wide and two inches tall next to the air conditioning unit. Soiling and debris was visibly present on the room wall by the window. Wooden molding was observed to be separated approximately 0.5inches from the wall behind the beds. On 8/27/24 at 11:07AM the surveyor observed a wall in room [ROOM NUMBER] near to the air conditioning unit which had a brown stained appearance with used towels and a used washcloth on the floor. The bathroom wall across from the commode was observed to be dirty in appearance with brown stains present. On 8/27/24 at 11:09AM the surveyor observed discolored paint on the wall near to the bulletin board in room [ROOM NUMBER]. Thick black debris was observed around the cove molding and along the floor near the inside of the doorway. Splattered soiling was observed on various walls throughout the resident room. On 8/27/24 at 11:11AM the surveyor observed various resident belongings present on the floor next to the bed including a urinal, roll of toilet paper, metal item, an unplugged cord, a trash bag of dirty laundry, a plastic kitchen/dietary food plate cover, and personal care products. On 8/27/24 at 11:18AM the surveyor observed brown staining and unpainted spackled areas above the air conditioning unit in room [ROOM NUMBER]. The surveyor observed areas of peeling paint on the wall near the bathroom, and two areas were present on the wall with a total of six screws present and mismatched paint. One plastic cover was observed to be detached from the wall where the phone cord was plugged in. 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 Director of Maintenance reported being unaware of several repairs that residents reported they had brought to nursing staff's attention. On 8/28/24 at approximately 1:37PM the surveyor smelled a strong foul odor in the hallway near the Station 1 shower room. Upon surveyor inquiry to several nursing staff present, the concern was acknowledged and the Director of Maintenance was called by nursing staff and responded to the shower room, and acknowledged the foul odor, and was observed troubleshooting the commode located in the shower room. On 8/29/24 at 9:37AM the surveyor observed five out of five chairs in the station one community area with various staining present on the sitting material on the chairs. Two out of five chairs present were observed to be ripped, one with a four inch rip in the material along the top of the chair,and one with approximately a seven inch rip in the material along the top of the chair with the inner foam exposed. One of two station one community room tables was observed to have an approximately two by two inch damaged area. A dark, worn, stained, damaged area on the flooring was observed next to the exit door to the courtyard, approximately 5.5 feet long and approximately 1 foot wide. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 9:45AM the surveyor observed an unlocked clean supply closet, and the concern was shared at this time with the Director of Nursing (DON) who observed, confirmed, and acknowledged understanding of the concern. The surveyor observed the DON attempt to lock the supply room, however, it was unable to be locked. At this time, the surveyor observed the DON ask for maintenance to address the concern. Maintenance Tech #39 was observed responding to the DON. At this time, the surveyor conducted an interview with Maintenance Tech #39 who confirmed the door was unable to lock. 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.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on the review of medical records and staff interviews, it was determined that the facility failed to provide the resident and or their representative with a summary of the baseline care plan. This was evident for 1 (Resident # 10) of 1 resident reviewed for baseline care plans, during a recertification/complaint survey. The findings include: On 08/27/24, at 09:40 AM, medical record review revealed that the Resident #10 was admitted to the facility on [DATE]. Further review of medical records failed to reveal that a copy of the baseline care plan summary was offered to Resident #10 or the resident's representative during the care conference held on 7/30/2024 at 11:52am. In accordance with the Code of Federal Regulations 42 CFR 483.21(a)(3), the facility must provide the resident and the representative with a written summary of the baseline care plan. The summary must be in a language and conveyed in a manner the resident and/or representative can understand. This summary must include Initial goals for the resident, A list of current medications and dietary instructions, and services and treatments to be administered by the facility and personnel acting on behalf of the facility; however, the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable. On 08/26/24 at 09:39 AM, an interview with LPN staff #3 revealed that with all new admissions, the Nursing staff initiates the baseline care plan, and other disciplines (departments) are also involved in completing the baseline care plan form. However, staff #3 was not aware of the baseline care plan summary. On 08/26/24 at 09:42 AM, during an interview with the Director of Nursing (DON), it was stated that nurses and other disciplines created the baseline care plan, which was then discussed during the Care plan meeting and offered baseline care plan summary to the resident or resident's representative. The surveyor reviewed with the DON regarding the facility not offering a copy of the baseline care plan.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50502 Based on observation, interview and record review, it was determined that the facility staff failed to follow professional standards of nursing practice when administering medications to residents by 1) not verifying current order before administering, 2) not documenting controlled medications use on the count sheet and Medication Administration Records, and 3) mishandling Insulin pen. This was evident for 4 (Resident #86, #66, #21, #8) of 5 residents reviewed for medication administration during the recertification/complaint survey. The findings include: Nurses follow several professional standards when administering medications, including: verifying the right patient, right medication, right dose, right route, right time, and right documentation. [Simple nursing June 2024] A controlled medication utilization record (known as a count sheet) is a form to record controlled medication dispense. It documents the details for each use of any controlled substance amount removed from its original containers, including date, time, the dose given, the signature of the nurse administering medication, the amount remaining, wasted, and the signature of who checked. All controlled substances are documented on the narcotics record as soon as they are removed, and all controlled substances, like all other medications, are documented on the client's medication record as soon as they are administered. If a controlled substance is wasted for any reason, either in its entirety or only partially, this waste must be witnessed or documented by the wasting nurse and another nurse. Both nurses document this wasting. [Registered Nursing.org medication -administration] Transferring insulin from a pen cartridge or prefilled pen to an insulin syringe is NOT a practice that is endorsed by any of the insulin manufacturers and is an unlicensed activity. A prefilled pen (KwikPen (Trademark)) must only be used as recommended in its user manual. It is not recommended to withdraw insulin from the cartridge or the prefilled pen. [Primary Care Diabetes Society February 2015] Oxycodone and Oxycontin are narcotic medications 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. Lorazepam is a controlled medication used to treat anxiety. It can cause paranoid or suicidal ideation and impair memory, judgment, and coordination. Combining with other substances, particularly alcohol, can slow breathing and possibly lead to death. Percocet is a combination medication used to help relieve moderate to severe pain. It contains an opioid pain reliever (oxycodone) and a non-opioid pain reliever (acetaminophen). Oxycodone works in the brain to change how the body feels and responds to pain, while acetaminophen can also reduce a fever. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An insulin pen is a device that looks like a pen used to inject insulin into the body. It is a type of insulin therapy for people with diabetes. Insulin pens have a cartridge filled with insulin and a dial on the outside to set the dose. The pen has a single-use needle that injects the insulin into the subcutaneous tissue, which is the innermost layer of skin. 1) On 8/27/24 at 9:45 AM, the surveyor observed Registered Nurse (RN #9) was preparing the following medications for Resident #86 on the medication cart located in nurse station two: Oxycodone 15 mg ordered to be given every 4 hours as needed for pain. Lorazepam 0.5 mg 1 tablet every 12 hours and Oxycontin Extended Release 30 mg 1 tablet twice daily. RN #9 was observed using only a binder containing the controlled medication record and also the information written on the medication pack; there was no documentation, including a device (tablet or computer), to verify the residents' current order. The surveyor verified from RN #9 if it was a standard nursing practice in the facility of not to verify medications against the order in the Medication Administration Record (MAR), he/she stated it was not the standard of practice but because he/she was in a hurry to administer the medications of Resident #86, he/she left the facility provided laptop in station three. RN #9 added that he/she knew the resident well and was familiar with Resident #86's medications. He/she added that he/she felt verifying was unnecessary. RN #9 said that he/she would sign the MAR when he/she gets back to station 3. During an interview with the Director of Nursing (DON) and the corporate nurse (Staff # 10) on 8/27/24 at 2:20 PM, they stated that the nurses should verify the orders on the computer for medication administration. The DON and Staff #10 were notified that RN #9 was observed not verifying the orders prior to giving the medications and that the nurse did not sign the MAR. A review of the controlled medication utilization record on 8/27/24 at 11:26 AM revealed that Oxycodone 15 mg, Lorazepam 0.5 mg, and Oxycontin Extended Release 30 mg were signed at 9:50 AM. However, the MAR of Resident #86 showed a discrepancy and indicated that RN #9 failed to sign the Oxycodone 15 mg that was given on 08/27/24 at 9:50 AM. 2) On 8/27/24 at 1:20 PM, an audit of the Controlled Medication Utilization Record against the MAR for the Month of August 2024 for Resident #66 revealed that out of 23 times the as-needed Oxycodone 10 mg was recorded in the controlled sheet, nine entries did not match the MAR. The following dates were entered in the Controlled Medication Utilization Record as given. However, they were not signed in MAR: 8/23 2:00 AM 8/23 6:00 AM 8/24 2:20 AM 8/24 9:00 PM 8/25 2:00 AM 8/26 2:30 AM 8/26 6:50 AM (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/26 3:00 PM 8/26 7:00 PM On 8/28/24 at 8:58 AM, an audit of the Controlled Medication Utilization Record against the MAR for the Month of August 2024 for Resident #21 revealed that out of 27 times the as-needed Percocet 7.5- 325 MG was recorded in the controlled sheet, 16 entries did not match the MAR. The following dates were entered in the Controlled Medication Utilization Record as given. However, they were not signed in MAR: 8/9 6:00 AM 8/10 1:30 PM 8/11 12:30 AM 8/12 6:00 AM 8/13 8:00 PM 8/14 7:00 AM 8/15 8:00 PM 8/19 5:00 AM 8/20 12:30 AM 8/20 3:00 PM 8/21 10:00 PM 8/21 9:00 AM 8/22 6:00 PM 8/22 6:00 AM 8/24 1:00 AM 8/24 11:00 PM On 8/28/24 at 9:10 AM, an audit of the Controlled Medication Utilization Record against the MAR for the Month of August 2024 for Resident #86 revealed that out of 53 times the as-needed Oxycodone 15 mg was recorded in the controlled sheet, 21 entries did not match the MAR. The following were entered in the Controlled Medication Utilization Record as given. However, there were not signed in MAR: 8/17 9:00 AM (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/17 1:00 PM 8/18 4:30 PM 8/19 2:00 PM 8/20 2:00 AM 8/20 10:00 AM 8/20 2:00 PM 8/20 6:00 PM 8/20 11:00 PM 8/21 3:15 AM 8/22 3:30 AM 8/23 7:00 PM 8/23 11:00 PM 8/24 9:00 AM 8/24 3:30 PM 8/24 6:00 PM 8/25 5:00 AM 8/25 2:45 PM 8/26 1:55 AM 8/26 1:20 PM 8/27 9:50 AM During an interview with the Director of Nursing (DON) and the corporate nurse (Staff # 10) on 8/27/24 at 2:20 PM, they stated that when the nurses removed controlled medication from the narcotic box, the nurses should sign and date the controlled sheet, after administering the controlled drug, the nurses should come back and sign the MAR. Also, they were notified that an audit was conducted for three residents and found that the narcotics that were administered did not match the Controlled Medication Utilization Record against the MAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 8/27/24 at 10:06 AM, RN #9 was observed drawing insulin from the insulin pen using a 1 cubic centimeter (cc) syringe and drew 25 units of insulin. When asked why he/she used a separate syringe to draw the insulin, he/she stated that he/she drew from the pen because he/she felt that the resident didn't get the exact dose if a pen was used. The insulin was administered to Resident #8 using the one cc syringe on the right arm per Resident #8's request. During an interview with the Director of Nursing (DON) and the corporate nurse (Staff # 10) on 8/27/24 at 2:20 PM, they stated that for Insulin medications such as Kwik pen, the nurses should use a specified needle and attach it to the pen, turn the dial and get the ordered dose. The DON and the corporate nurse were notified that RN #9 drew insulin from the pen with the use of a 1 cc syringe; the corporate nurse stated that we just educated the nurses about insulin administration. On 8/28/24 at 8:12 AM, the DON handed the surveyor a corrective counseling report dated 8/27/24, which revealed that RN #9 was suspended pending investigation for the following violations: passing meds from memory without using a computer, drawing insulin from a syringe pen, not signing off meds in a timely manner.

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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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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 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 50502 Based on observation, record review, and interview, it was determined that the facility failed to provide appropriate treatment and services to residents receiving tube feeding. This was evident for one (Resident #88) of three residents reviewed for tube feeding during the recertification/complaint survey. The findings include: A feeding tube is a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation. The state of being fed by a feeding tube is enteral feeding or tube feeding. Osmolite is therapeutic nutrition that provides complete, balanced nutrition for long-or short-term tube feeding for patients with caloric requirements of less than 2000 calories per day or for patients with increased protein requirements. It is used for tube feeding and as supplemental or sole-source nutrition. On 8/20/24 at 8:18 AM, the surveyor observed Resident #88's Osmolite bottle of tube feeding hanging on a pole but not running. On 8/22/24 at 10:40 AM, the surveyor observed another Osmolite bottle of tube feeding hung on a pole but not running for Resident #88. The label for the water flush was marked 8/20 2 pm. On 8/23/24 at 11:34 AM, an Osmolite 1.5 tube feeding was observed running at 50 ml/hour, the label for the Osmolite indicated 8/22/24, however the bag for water flush was still dated 8/20 2 pm. On 8/23/24 at 11:36 AM, while the surveyor was in Resident #88's room, the tube feeding machine was heard beeping and indicated feeding complete. RN #9 entered the resident's room and turned off the machine. The surveyor asked RN #9 to verify the dates written on the label of the Osmolite bottle and the date on the bag of water flush. He/she confirmed that the Osmolite 1.5 bottle had 8/22/24 written on it and 8/20/24 for the bag of water flush. On 8/23/24 at 12:39 pm, a review of the following physician orders indicated: - 8/12/24 Enteral Feed Order every shift Osmolite 1.5 at 50 ml/hr x 20 hrs via enteral tube, up at 12 pm & down at 8 am or until total amount infused: provides 1000 ml TV, 1500 kcal, 62 g protein,1200ml fluid. - 8/12/24 Diet: Regular diet, chopped texture, Thin consistency; small portions. - 8/9/24 TUBE FEEDING FLUSHES; Flush G-Tube with 5ML water after each Med Pass; Keep head of bed elevated 30-45 degrees. every shift. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/9/24 flush tube w/50 ml H2O q 6 hrs x 24 hrs or until total amount infused for hydration to provide additional 200 ml free H2O (809 ml/d total free H2O from formula + flush). every shift. On 8/23/24 at 1:17 PM, a review of the Registered Dietitian (RD #12's) note dated 8/21/2024 at 09:29 am revealed, Continues on both a PO (oral) diet and enteral nutrition via PEG. PO diet is considered for pleasure/therapeutic and energy needs are obtained via Enteral nutrition. PO diet is chopped, small portion entree, intake is poor-minimal at meals. Current tube feeding formula; 50ml Osmolite/hr x 20hrs 50ml water flush q6hrs. To provide; 1500kcal, 62g PRO, and 1200ml fluid daily. Continue current plan of care, make recommendations as needed. On 8/23/24 at 1:31 PM, a review of the tube feeding administration record revealed that it had not been signed from 8/12/24 until 8/23/24 for all shifts except one signature noted on 8/13/24 for the 7-3 shift. On 8/23/24 at 2:05 PM, the surveyor informed the Unit Manager, RN #7, of the issues with tube feeding water flush dated 8/20/24 that were observed on 8/23/24. Also, the surveyor showed RN #7 the enteral feeding administration record and noted that it was not signed from 8/12/24 to 8/23/24 for all shifts except one signature noted on 8/13/24 for the 7-3 shift. On 8/23/24 at 2:11 PM, the surveyor notified the Director of Nursing (DON) and Staff #10 that the tube feeding water flush had been kept the same since 8/20/24. Staff #10 also verified the tube feeding orders in the medical record and confirmed why the nurses were not signing. She stated that the order was written incorrectly by RD #12. She added that she would re-write the tube feeding orders, conduct an audit for all the residents with tube feeding orders, and educate all the nurses. A review of the tube feeding order on 8/26/24 at 8:04 AM revealed that Staff #1 wrote the order on 8/23/24 at 3:07 PM.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on resident interview, staff interview, and medical record review, it was determined that the facility failed to ensure that pain management is provided to residents who require such services. This was evident for two (Residents #161, #10) out of four residents reviewed for pain management during a recertification/complaint survey. The findings include: 1)During a review of complaints on 8/28/24 at 7:36 AM, it was revealed that a complainant expressed concerns regarding Resident #161's care: the resident was suffering in great pain but did not receive pain medication timely. A review of Resident #161's medical records on 8/28/24 at 7:45 AM revealed that the resident was admitted to the facility on [DATE] after a right knee replacement. Per the hospital discharge records, the resident's pain was managed by Oxycodone (Oxycodone is used to relieve pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated) 5mg- 10mg as needed. The review of the order summary revealed that the facility ordered Oxycodone 5mg every 4 hours as needed for moderate to severe pain for Resident #161 on 10/27/22 at 6:45 PM. However, the review of the Medication Administration Record (MAR) of October 2022 revealed that the resident received Oxycodone for his/her pain on 10/28/22 at 8 PM. During an interview with the Director of Nursing (DON) on 8/28/24 at 9:53 AM, the DON explained that the facility nursing staff had access to Omnicell (a medication dispensing system for emergency use) when residents needed medication that had not been delivered yet. The surveyor requested an inventory list in Omnicell, and verified that Oxycodone was available. The DON was informed of the surveyor's concern about Resident #161's pain medication not being administered in a timely manner. The DON validated the concern. 49409 2)On 08/20/24 at 11:05 AM in an interview, Resident #10 stated that he/she has chronic pain, and life can be better if I can get pain medication without asking for it. On 08/20/24 at 11:09 AM an interview with LPN staff #3 revealed that Resident #10 has chronic pain and he/she will ask for pain medication when needed. On 08/22/24 at 11 AM, medical record review revealed that Resident #10 has orders to receive three different PRN (PRN is an abbreviation for the Latin term pro re nata, and that means as the thing is needed) pain medications, without corresponding parameters. The orders include: - Acetaminophen Oral Tablet 500 MG (Acetaminophen), Give 2 tablet via PEG-Tube every 6 hours as needed, written on 07/28/2024. - Gabapentin Oral Tablet 600 MG (Gabapentin) Give 1 tablet via G-Tube every 12 hours as needed for neuropathic pain, written on 07/29/2024 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Morphine Sulfate Oral Solution 10 MG/5ML (Morphine Sulfate) Give 3.75 ml via PEG-Tube every 6 hours as needed for pain, written on 08/02/2024. Resident #10 did not have an order for routine pain medication to manage resident's pain consistently. Resident #10 also has an order dated 7/29/24, to receive non pharmacological interventions, prior to administering PRN pain medication administration. During Resident #10's initial admission pain assessment from 07/28/24, Resident #10 revealed that he/she had frequent pain. On 08/27/24 at 1:30 PM, an interview with resident # 10 revealed that he/she complained of pain to the Nurse #50 and was waiting for the pain medication. On 08/27/24 at 01:37 PM, an interview with LPN staff #50 confirmed that resident has not received any Non pharmacological interventions prior to administering PRN pain medication before resident received pain medication. On 08/27/24 at 02:18 PM the surveyor reviewed that Resident #10 was not receiving non pharmacological interventions prior to administering pain medication with the Assistant Director of Nursing (ADON).

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50502 Based on observation, interview, and record review, it was determined that the facility staff failed to ensure a registered nurse had the skills to provide necessary care for residents who needed insulin. This was evident for 1 (Registered Nurse #9) of 3 Nurses observed for medication administrations during a recertification/complaint survey. The findings include: An insulin pen is a device that looks like a pen used to inject insulin into the body. It is a type of insulin therapy for people with diabetes. Insulin pens have a cartridge filled with insulin and a dial on the outside to set the dose. The pen has a single-use needle that injects the insulin into the subcutaneous tissue, the innermost layer of skin. On 8/27/24 at 10:06 AM, RN #9 was observed drawing insulin from the insulin pen using a one cubic centimeter (cc) syringe and drawing 25 units of insulin. When asked why he/she used a separate syringe to draw the insulin, he/she stated that he/she drew from the pen because he/she felt that the resident didn't get the exact dose if a pen was used. The insulin was administered to Resident #8 using the one cc syringe on the right arm per Resident #8's request. During an interview with the Director of Nursing (DON) and the corporate nurse (Staff #10) on 8/27/24 at 2:20 PM, they stated that for Insulin medications such as Kwik pen, the nurses should use a specified needle and attach it to the pen, turn the dial and get the ordered dose. The DON and the corporate nurse were notified that RN #9 drew insulin from the pen with the use of a one cc syringe; the corporate nurse stated that the nurses were just educated about insulin administration. On 8/28/24 at 8:12 AM, the DON handed the surveyor a corrective counseling report dated 8/27/24, which revealed that RN #9 was suspended pending investigation for the following violations: passing meds from memory without using a computer, drawing insulin from a syringe pen, not signing off meds in a timely manner.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 44441 Based on a review of employee records and interviews, it was determined that the facility staff failed to conduct performance reviews of Geriatric Nursing Assistants (GNAs) at least once every 12 months. This was evident for 1 (GNA #30) of 3 randomly selected GNAs' records reviewed for annual training requirements during the recertification/complaint survey. The findings: On 8/27/24 at 8:40 AM, a review of randomly selected GNA's records revealed that GNA #30 was hired on 2/15/22. Further review of her personal file failed to produce a record of her annual performance review. On 9/9/24 at 10:15 AM In an interview the Director of Nursing (DON) was asked if the facility have a process for performance review for nurse aides. She said it's done yearly or every 90 days. She was asked who does the evaluation and she said it was done by the department heads such as herself, the Unit Managers and the Supervisors. She said that Human Resources (HR) department tracks it and would alert them on who was due for their annual evaluation review. She was made aware that GNA #30's evaluations could not be found and was asked to provide the document. On 9/9/24 at 11:30 AM, the DON came back to report that the annual evaluation record for GNA #30 could not be found. She was made aware that this was a concern.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50502 Based on record review and interview, it was determined that the facility failed to ensure that drug records were maintained in a manner that accounted for all controlled drugs and allowed reconciliation of dispensed and administered medication. This was evident for 3 (Resident #86, #66, and #21) of 5 residents reviewed for medication administration during a recertification/complaint survey. The findings include: Oxycodone and Oxycontin are narcotic medications used to treat moderate to severe pain. It is at 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. Percocet is a combination medication used to help relieve moderate to severe pain. It contains an opioid pain reliever (oxycodone) and a non-opioid pain reliever (acetaminophen). Oxycodone works in the brain to change how the body feels and responds to pain, while acetaminophen can also reduce a fever. On 8/27/24 at 1:20 PM, a review of the facility's document entitled Controlled Medication Utilization Record against the Medication Administration Record MAR for the Month of August 2024 for Resident #66 revealed that out of 23 times the as-needed Oxycodone 10 mg were recorded in the controlled sheet, nine entries did not match the MAR as administered. The following dates were entered in the Controlled Medication Utilization Record as given. However, they were not signed in MAR: 8/23 2:00 AM 8/23 6:00 AM 8/24 2:20 AM 8/24 9:00 PM 8/25 2:00 AM 8/26 2:30 AM 8/26 6:50 AM 8/26 3:00 PM 8/26 7:00 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 8:58 AM, a review of the facility's document entitled Controlled Medication Utilization Record against the Medication Administration Record MAR for the Month of August 2024 for Resident #21 revealed that out of 27 times the as-needed Percocet 7.5- 325 MG were recorded in the controlled sheet, 16 entries did not match the MAR as administered. The following dates were entered in the Controlled Medication Utilization Record as given. However, they were not signed in MAR: 8/9 6:00 AM 8/10 1:30 PM 8/11 12:30 AM 8/12 6:00 AM 8/13 8:00 PM 8/14 7:00 AM 8/15 8:00 PM 8/19 5:00 AM 8/20 12:30 AM 8/20 3:00 PM 8/21 10:00 PM 8/21 9:00 AM 8/22 6:00 PM 8/22 6:00 AM 8/24 1:00 AM 8/24 11:00 PM On 8/28/24 at 9:10 AM, a review of the facility's document entitled Controlled Medication Utilization Record against the Medication Administration Record MAR for the Month of August 2024 for Resident #86 revealed that out of 53 times the as-needed Oxycodone 15 mg were recorded in the controlled sheet, 21 entries did not match the MAR. The following were entered in the Controlled Medication Utilization Record as given; however, they were not signed in MAR: 8/17 9:00 AM 8/17 1:00 PM (continued on next page)

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	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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/18 4:30 PM 8/19 2:00 PM 8/20 2:00 AM 8/20 10:00 AM 8/20 2:00 PM 8/20 6:00 PM 8/20 11:00 PM 8/21 3:15 AM 8/22 3:30 AM 8/23 7:00 PM 8/23 11:00 PM 8/24 9:00 AM 8/24 3:30 PM 8/24 6:00 PM 8/25 5:00 AM 8/25 2:45 PM 8/26 1:55 AM 8/26 1:20 PM 8/27 9:50 AM During an interview with the Director of Nursing (DON) and the corporate nurse (Staff # 10) on 8/27/24 at 2:20 PM, they stated that when the nurses removed controlled medication from the narcotic box, they should sign and date the controlled sheet. After administering the controlled medication, the nurses should come back and sign the MAR. Also, they were notified that an audit was conducted for three residents and found that the narcotics that were administered did not match the Controlled Medication Utilization Record against the MAR.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44441 Based on record review and staff interviews, it was determined that the facility failed to follow up on a pharmacy recommendation for a resident. This was evident for 1 (#46) of 5 residents reviewed for unnecessary medication during a recertification/complaint survey. The Findings include: On 08/23/24 at 1:15 PM a review of the Medication regimen review records from January to August 2024 was conducted for resident #46 and revealed that on 1/2/24 the pharmacist made a recommendation which stated, resident had an order Divalproex (use to treat bipolar disorder and epileptic seizures) started that was not in their electronic medical records (PCC). He recommended to have the order added to PCC if resident was receiving it. Further review did not reveal that the recommendation was addressed by the attending physician. This medication was later started on 6/4/24 for this resident. On 08/27/24 at 8:24 AM the Director of Nursing (DON) was asked in an interview who was responsible for addressing pharmacy recommended reviews. She stated that it goes to nursing, and they pass it over to the attending Physician for that resident. She explained that some of the recommendations such as duplicate orders could be addressed by the nursing staff, otherwise they call the attending physician or nurse practitioner to ask for it to be addressed. She was made aware of the concern, and she said she will have to figure it out. In a telephone interview with Resident #46's attending physician, Staff #28 on 8/30/34 at 3:02 pm, he was asked how recommendations from pharmacy reviews are communicated to him. He stated that the facility would send him the pharmacy recommendations, he reviews them and would either agree or disagree with the recommendations. He then puts down his reason for disagreeing, and approves the ones he agrees with, sign and return them to the facility for implementation. He was made aware of the concern, he stated that he would not be able to address any pharmacy recommendations unless it was presented to him by the nursing staff. On 8/30/24 at 3:14 PM the DON was made aware that the handling of the pharmacy review for resident #46 was a concern. She agreed that the recommendation was not followed up.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 42507 Based on medical record review and interview, it was determined the facility staff failed to follow physician orders by administering as needed (PRN) pain medication outside the prescribed parameters. By failing to follow the prescribed parameters for the medication administration, the resident was given an unnecessary medication. This was identified for 1 (#86) of 5 residents reviewed for unnecessary medications during a recertification/complaint survey. The findings include: On 8/21/2024 at 9:56 AM, review of Resident #86's medical record revealed the resident was admitted to the facility in January 2024 with medical diagnosis that included but not limited to low back pain, bladder cancer, Type 2 Diabetes Mellitus, fibromyalgia, osteoarthritis, rheumatoid arthritis, and chronic pain. On 8/21/2024 at 11:24 AM, review of physician orders revealed an active order with a start date of 6/27/2024 for Oxycodone tablet 15 mg, give 1 tablet by mouth every 4 hours as needed for chronic pain 6-10. Further review of the orders revealed orders for non-pharmacological interventions to be attempted prior to administering any prn pain meds such as 1. Warm beverage offered, 2. Repositioned, 3. Soft music played, 4. Lights dimmed dated 6/26/2024. On 8/22/2024 at 10:05 AM, review of the Medication Administration Record (MAR) for August 2024 was completed. PRN Oxycodone 15 mg was given outside ordered parameters of 6-10 pain level for med administration on the following dates: On 8/1/2024 - for pain score 0 at 0854 (8:54 AM) and pain score of 4 at 2132 (9:32 PM), On 8/2/2024 - pain score 0 at 0918 (9:18 AM), pain score of 4 at 1745 (5:45 PM), and pain score of 5 at 2145 (9:45 PM), On 8/12/2024- pain score 0 at 1338 (1:38 PM), On 8/14/2024- pain score 2 at 0403 (4:03 AM), and On 8/16/2024- pain score 0 at 0400 (4:00 AM) and pain score of 5 at 1400 (2:00 PM). Further review of the MAR and TAR for August 2024 did not reveal any staff documentation of non-pharmacological interventions attempted prior to the prn pain medication administration as ordered by the physician. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/2024 at 9:13 AM, Surveyor reviewed Resident #86's August MAR with the resident's Unit Manager (UM #7) in the presence of the Director of Nursing (DON). They both verified and confirmed that the 15 mg Oxycodone was given inappropriately on the days/times when the resident's pain score was below 6 (ordered parameters not followed). UM#7 stated that the nurses were expected to follow physician orders/parameters when giving prn pain meds and should have offered something else like Tylenol for a lower pain score. She added that if there was no order for Tylenol, the nurses were expected to call the doctor and get an order for a breakthrough pain medication. The DON further stated that staff could do non-pharmacological interventions to help relief pain and document what was done. Surveyor immediately reviewed the MAR and TAR with them regarding no staff documentation of any non-pharmacological interventions that was performed/attempted prior to administering the prn pain med. UM #7 and DON verified and confirmed that staff did not document on non-pharmacological interventions. UM #7 stated that sometimes staff would document in their progress notes, however, they did not provide any documentation to validate this. DON indicated that she would follow up with staff.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47200 Based on interview and record review it was determined the facility failed to ensure monitoring for side effects of psychotropic medication use. This was evident for one (Resident #254) out of twenty-two residents reviewed for abuse during the facility's recertification/complaint survey. The findings include: Review of the medical record for Resident #254 on 8/30/24 at 10:39AM revealed no medication side effect monitoring was in place for use of the following antipsychotic medication: Quetiapine Fumarate. An active medical order was observed for the medication to be administered twice daily. On 8/30/24 at 10:42AM the surveyor conducted an interview with Licensed Practical Nurse #44 who observed the medical record and confirmed with the surveyor that no monitoring was ordered for antipsychotic medication side effects. On 8/30/24 at 10:48AM the surveyor shared the concern with the Director of Nursing who acknowledged and confirmed understanding of the concern. On 8/30/24 at 10:50AM the surveyor reviewed the August 2024 treatment administration record (TAR) for Resident #254 which revealed the following order was discontinued on 8/4/24: Observation: Antipsychotic Medication -Observe for behavior: (aggressive behaviors) Observe for side effects: dry mouth, constipation, blurry vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, N&V, lethargy, drooling, EPS Sx (tremors, gait issues, agitation, restlessness, involuntary movement of mouth/tongue.) Document:Y if resident is free of side effects. N if the resident is not free of side effects. If N document SE in the PNs every shift. On 9/3/24 at 10:02AM the surveyor observed and reviewed a psychiatric note dated 8/15/24 within Resident #254's medical record which included a recommendation for monitoring of the efficacy of psychiatric medication. On 9/3/24 at 10:06AM the surveyor reviewed the medical record of Resident #254 which revealed that after surveyor intervention, an active medical order for behavior monitoring of the resident began on 8/30/24, however, there continued to be no additional medication side effect monitoring in place. On 9/3/24 at 12:39 PM the surveyor shared continued concern for no medication side effect monitoring in place for the antipsychotic medication with the Director of Nursing who acknowledged the surveyor's concern.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on the surveyor's observation and interview with staff, it was determined that the facility failed to ensure that it had qualified staff with the appropriate competencies and skill sets to carry out food and nutrition services. This has the potential to affect all residents. The findings include: Full-time means working 35 or more hours a week. Part-time employees typically work fewer hours in a day or during a work week than full-time employees. The U.S. Department of Labor, Bureau of Statistics uses a definition of 34 or fewer hours a week as part-time work. On [DATE] at 08:29 AM, interview with food service manager, staff # 51, revealed that he/she has a serve safe certificate, but does not have an active certified dietary manager (CDM) certificate. He/She was certified with CDM before, but it expired due to not maintaining the required CEUs. He/she sent transcripts to the program to start taking classes. Staff # 51 also revealed that the Registered Dietician (RD), staff #12, works part time 16 hrs, and Consultant Registered Dietician, staff # 53, works 8 hrs. The surveyor reviewed with both (RD) staff # 12, and the food service manager, staff #51, that the lack of active certificate of certified dietary manager (CDM) does not meet the facility's requirement of having qualified staff to carry out food and nutrition services.

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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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	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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50502 Based on observation and interview, it was determined the facility failed to ensure staff performed hand hygiene prior to administering medications and used appropriate handling to prevent infection. This was evident for one (a Licensed Practical Nurse #13) out of three nurses observed administering medications during the recertification/complaint survey. On 8/27/24 at 9:11 AM, during medication administration, the Licensed Practical Nurse (LPN #13) was observed not performing hand hygiene when he/she prepared the medications of Resident #21. LPN #13 was also observed poking the blister pack of medication with a pen to get the tablet. The surveyor asked LPN #13 if it was standard practice in the facility to use a pen to get the medications out of a blister pack; he/she stated that he had a hard time opening the pack, so he/she had to find a way. She added he/she did not do it all the time, only when it was hard to open. During an interview with the Director of Nursing (DON) and a corporate nurse (Staff #10) on 8/27/24 at 2:20 PM, they stated that nurses were expected to do hand hygiene before, during and after medication administration. They were notified that LPN #13 did not perform hand hygiene during medication administration observation and poked the blister pack using a pen to get the medication.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. 47200 Based on observation and interview it was determined the facility failed to ensure two handrails were firmly secured. This was evident during the surveyor's environmental tour during the facility's recertification/complaint survey. The findings include: On 8/27/24 at 11:11AM the surveyor observed two handrails located against the wall next to the facility's kitchen that were off centered in appearance. Upon closer observation, the surveyor noted that two metal screws were observed to be loose which protruded through the handrail and into a block of wood, and then into the wall. At this time, the handrails were utilized and found to be movable and not firmly secured. On 8/27/24 at 11:31AM the surveyor conducted an environmental tour and shared the concerns with the facility's Director of Maintenance #38 who observed, acknowledged and confirmed understanding of the surveyor's concern. The Director of Maintenance reported being unaware of the loose condition of the handrails. 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.

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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.