| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215326 | A. Building<br>B. Wing | 08/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Summit Park | 1502 Frederick Road<br>Catonsville, MD 21228 |

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 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>Based on record review, resident interview, and staff interview, it was determined that the facility failed to maintain an effective pest control program. This was evident in 4 out of 4 units and had the potential to affect all residents. The findings include:On 8/26/2025 at 9:18 AM, a review of Complaint #330032 was completed. The complainant alleged that Resident #52's room had a common problem with mice.On 8/26/2025 at 9:43 AM, an observation and resident interview was conducted of Resident #52 and their room. No observation made of mice, but mouse droppings observed by another surveyor during the initial pool process along with gnat and fly sightings made by all surveyors through out all units and the facility. Resident #52 stated that the last mouse sighting was about 2 weeks prior. On 8/26/2025 at 9:47 AM, the pest control logs were reviewed. The pest control logs showed evidence that a mouse was spotted on 7/27/25 in room D10 and treated by the pest management company on 8/1/25. On 8/13/25, another observation logged indicated mouse droppings were found in Resident #52's room (D18) with glue boards on 8/15/25. 08/26/2025 10:40 AM interview with maintenance director. The survey team expressed concern with gnats observed throughout the survey. Maintenance director stated that pest control company is doing better sprays of rooms for gnats, and furniture was moved to ensure old food was picked up and cleaned appropriately as of 8/18/2025 - 8/22/2025. On 8/26/2025 at 11:01 AM, a review of Pest Service Report was conducted. On the report from 8/8/2025, the pest management company treated for reported fly activity in the D wing. |

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

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on observations and staff interview, it was determined that the facility failed to treat residents with Dignity while dining. This was evident for 8 out 13 residents observed during the dining observation task in recertification survey. The findings include:On 8/12/2025 at 12:19 PM, During the dining observation for lunch in the 2nd floor dining room, this surveyor observed 13 residents receiving meals via a tray cart with the assistance of 1 staff member (Staff #1). Throughout the process, Staff #1 was observed to be handing out 1 tray to a table at a time. Each table had at least 2 residents and there were 5 tables with residents in the dining room. The first go around 5 out of 13 residents received their tray. Once 1 resident from each table got a tray, another resident from each table got their tray. The residents who received their tray the second go around, had to wait approximately 4 to 7 minutes after the 1st tray at the table was served to receive their tray. During this wait time, the residents who received their tray first go around had already begun eating the food on their tray. On 8/12/2025 at 2:12 PM, An interview was conducted with Staff #1. When asked to describe the process of handing out trays and how they decide who gets the trays first, Staff #1 stated that they try to serve the residents who need less help first and then serve those who need help after regardless of where they are sitting. This surveyor expressed concern about serving residents at the same table 4 to 7 minutes apart. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide activities to meet all resident's needs.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observations, record reviews and interviews, it was determined that the facility failed to provide activities to meet the needs and preferences of residents. This was evident to 2 (Resident #88 and Resident #103) out of 3 residents reviewed for activities during the recertification survey.The findings include: 1). On 8/13/2025 at 2:00 AM Resident #88 was observed in their room. TV was off.On 8/14/2025 at 9:10 AM A review of Resident #88's medical record was conducted. The review revealed that the resident had activities on 8/3/25 and 8/13/25. On 8/14/2025 at 9:12 AM A review of the resident's care plan indicated that they had expressed the desire to participate and be involved in more activity programs but needed guidance and transport to participate.Further review revealed a note entered on 7/2/2025 that stated facility staff would conduct one to one visit with Resident #88 if they did not wish to participate in group activities. On 8/14/2025 at 9:30 AM A review of activities log provided by the facility revealed that Resident #88 was offered activities 4 days out of 31 days in July. In August, the resident had activities for 2 days from August 1st to August 13th. On 8/15/2025 at 8:45 AM An interview with the Activity Assistant, Staff #11, was conducted. She reported that for dependent residents the expectation is to conduct one-to-one activities 3 times a week. Additionally, she stated for Resident #88, the facility had not provided one-one as frequently as expected. A review of July and August activities log was conducted with the surveyor and Staff #11. Staff #11 confirmed that for Resident #88 had no refusals for activities offered and that the resident had received 1-1 activity twice from august 1st to august 13th and only 4 sessions of activities were provided for the month of July. On 8/15/2025 at 9:11 AM The Director of Nursing (DON) was made aware of the activities' concerns. 2). On 8/12/2025 at 10:46 AM A resident representative interview was conducted. Resident #103 representative stated that they were concerned that the resident always stayed in bed and did not participate in any activities. On 8/15/2025 at 10:05 AM A review of Resident #103's electronic medical records was conducted. The review failed to show that the resident had participated in activities. The facility was asked to provide evidence of activities provided to the resident in July and August 2025. On 8/15/2025 at 1:06 PM The facility provided Resident #103's July and August activities log. A review of these documents revealed that the resident was not provided with any activities for the month of July. Additionally, from August 1st to August 14th, the resident was provided activities for 3 days (August 3rd, 4th, and 6th) On 8/15/2025 at 1:17 PM An interview with Staff #11 was conducted. Staff #11 confirmed that Resident #103 was not provided with any 1-1 activities in July, and it was the facility's expectation to provide dependent residents with 1-1 activities 3 times a week. Staff #11 was made aware that this was a concern. On 8/15/2025 at 1:20 PM The DON was made aware of concerns with activities provision for dependent residents. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on review of Geriatric Nursing Assistant (GNA) personnel files and staff interview, it was determined that the facility staff failed to conduct yearly performance evaluations at least every 12 months for 3 (Staff #13, Staff #14 and Staff #15) of 3 GNAs reviewed for annual performance evaluation. The findings include: On 8/19/2025 at 9:06 AM as part of sufficient and competent nurse staffing task, the facility was asked to provide employee files for Staff #13, Staff #14 and Staff #15. On 8/19/2025 at 9:46 AM review of facility provided documents indicated that Staff #13 was hired on 12/14/28, Staff #14 was hired on 6/20/2010, and Staff #15 date of hire was 5/21/24. However, the review of the employees' files failed to reveal any performance evaluations that were completed in the last 12 months. On 8/19/2025 at 1:41 PM an Interview with Human Resource Director, Staff #18, was conducted. When asked who was responsible for completing the annual nurse assistant's performance evaluations, she stated that it was the responsibility of the Director of Nursing (DON). She also confirmed that Staff #15 had no performance evaluation on file, Staff #13 last performance evaluation was done on 10/25/2023 and Staff #14 was completed on 8/14/2023. On 8/19/2025 at 2:21 PM an interview with the DON was conducted. He confirmed that he had not completed performance evaluations for Staff #13, Staff #14, and Staff #15 yet. On 8/20/2025 at 12:26 PM the Regional DON and Facility Administrator were notified of the concern. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on resident interview, observations, and staff interviews, it was determined the facility failed to maintain a homelike environment. This was evident in 2 (Room A21 and Room D18) out of 9 rooms reviewed for environment. The findings include:1.) On 8/12/2025 at 8:12 AM, During an interview with Resident #4, the resident stated that their bathroom sink had no working hot water. This surveyor observed the bathroom sink to only have the hot-water faucet handle to functioning. When opening the cold-water faucet handle there was no water coming out of the faucet. This surveyor made the Unit manager on the A-wing (Staff #2) aware of the findings. On 8/15/2025 at 2:15 PM, this surveyor asked the Director of Nursing (DON) about the progress of the malfunctioning water faucet in Resident #4's bathroom. The DON stated they were not aware but would address the concern.On 8/18/2025 at 2:44 PM, This surveyor verified with observation that the sink is now functioning. Furthermore, an interview was conducted with the Maintenance Director (Staff #20) and stated that on Friday 8/15/2025 a call to a plumber was made because the resident's pipe was clogged. Staff #20 confirmed that the plumber fixed the issue by replacing pipe that same day. 2.) On 8/26/2025 at 9:43 AM, an observation and interview was conducted with Resident #52. Resident #52 stated that the curtains in the room were always dusty and that staff was not cleaning them appropriately. The resident stated that there were black dots all over the door frame of the bathroom. This surveyor confirmed the resident's concerns and obtained photographs of the areas. The curtain on the window had large pieces of dust and white particles. The black dots on the door frame started on the top of the frame and extended to the wall above the door frame.On 8/26/2025 at 10:40 AM, an interview was conducted with the Maintenance Director (Staff #20). This surveyor expressed Resident #52's concerns about the Black dots and Dusty curtains. Staff #20 stated they will address dust and particles on the curtains and the black dots on the wall and bathroom door frame. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>Based on medical record review and interview with staff, it was determined that the facility staff failed to ensure a resident's Preadmission Screening and Resident Review (PASARR) form was completed on admission to the facility. This was evident during the review of 1 (Resident #56) of 3 residents reviewed for PASARR screening. The findings include:Preadmission Screening and Resident Review is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. Everyone who applies for admission to a nursing facility must be screened for evidence of serious mental illness (MI) and/or intellectual disabilities (ID), developmental disabilities (DD), or related conditions.On 8/13/2025 at 8:25 AM Review of Resident #56's medical records was conducted. The review failed to reveal Level 1 PASARR screening documentation. On 8/14/2025 at 11:00 AM The facility was asked to provide evidence of PASARR screening documentation. On 8/14/2025 at 11:04 PM Further review of Resident #56's record indicated that they were initially admitted into the facility on 1/22/25. The resident had diagnoses of Schizoaffective disorder, Bipolar, and generalized anxiety disorder. On 8/14/2025 at 11:59 AM An Interview with the social worker was conducted. She reported that Resident #56's PASSAR Level 1 was not fully completed by the hospital. Additionally, the social worker provided a letter from Telligen dated 1/23/25 that stated the PASARR screening submitted by the hospital would not be reviewed due to lack of psychiatric notes. When asked whose responsibility it was to verify that the PASARR was completed prior to a resident's admission into the facility, the social worker stated it was her responsibility. The Social worker confirmed that she became aware that Resident #56 had no approved Level 1 PASARR screening on 8/14/25. On 8/14/2025 at 12:12 PM The Facility Administrator was made aware of the concerns. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on record review and interviews, it was determined that the facility failed to ensure that residents were provided with summaries of their baseline care plans including a list of their medications. This was evident for 1 (Resident #15) of 3 residents reviewed for baseline care plans.The findings include:On 8/14/2025 at 10:32 AM A Review of Resident #15's medical record was conducted. The review indicated that the resident was admitted on [DATE] and a baseline care plan was completed on 1/24/25. However, the electronic copy of the baseline care plan had no signatures that indicated the resident had reviewed or was provided a summary of the baseline care plan. On 8/14/2025 at 10:52 AM The Director of Nursing (DON) was asked to provide evidence that a summary of baseline care plan was provided to Resident #15. On 8/14/2025 at 11:38 AM An interview with the social worker was conducted. The social worker reported that the facility did not have evidence that the baseline care plan summary was provided to the resident. She further stated that the current facility process was to document a progress note to indicate that the baseline summary was reviewed and provided to residents. On 8/14/2025 at 11:48 AM Further review of Resident #15's progress notes failed to show any documentation that a baseline care plan summary was provided to the resident. The social worker confirmed that there was no note on the resident's file that addressed baseline care plan. On 8/14/2025 at 11:52 AM Administrator and the DON were made aware of the concerns. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on interviews, record reviews and observations, it was determined that the facility failed to ensure that dependent resident's personal hygiene needs were adequately met by offering and providing showers as scheduled. This was evident for 2 (Resident #103 and #88) out 3 residents reviewed for activities of daily living. The findings include:The MDS is a federally mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. On 8/12/2025 at 10:47 AM A resident representative interview was conducted. Resident #103's representative stated that the resident's hair is often not combed, and they were concerned that the resident did not receive adequate personal hygiene. On 8/14/2025 at 9:19 AM A review of Resident #103's medical record was conducted. The review revealed a care plan that indicated the resident was totally dependent on 1 staff to provide a bath daily and shower twice a week for personal hygiene.Further review of the records revealed that Minimum Data Set (MDS) section GG indicated that Resident #103 was coded as dependent on staff for showers.On 8/15/2025 at 10:52 AM A review of the residents' shower binder located at the nurses' station indicated that Resident #103 was scheduled to shower on Wednesdays and Saturdays every week.The records in the binder failed to indicate that Resident #103 received or refused showers. The facility was then asked to provide documentation that showers were provided for the resident for the month of July and August. On 8/15/2025 at 1:44 PM The facility provided Resident #103's shower log. The review of these documents revealed that the resident had showers 2 days (July 21st and July 24th) out of 31 days. There was a note that the resident was offered a shower on July 17th but had refused. From August 1st to 14th, Resident #103 showed only 2 days (August 4th and 11th).On 8/15/2025 at 1:48 PM The Director of Nursing (DON) confirmed that shower records for Resident #103 were accurate, and that the resident had received showers only 2 days in July, and 2 showers as of August 14th, 2025. The DON was notified that this was a concern. 2). On 8/12/2025 at 12:46 PM An interview with Resident 88's representative was conducted. The representative stated that the resident did not receive appropriate personal hygiene and that the resident's wore the same clothes for several days. On 8/13/2025 at 9:24 AM Resident #88 was observed wearing the same clothes she had worn the day before, on 8/12/25. On 8/15/2025 at 9:55 AM A review of Resident #88's medical records was conducted. MDS section GG indicated that the resident was coded as dependent on staff for showers and personal hygiene. A review of the resident's care plan failed to show that the resident had refusals to personal hygiene. On 8/15/2025 at 10:15 AM An interview with Staff #9 was conducted. Staff #9 reported that Resident #88 had dementia and therefore S/he was unable to distinguish clean from dirty clothes. Staff #9 also added that it was the nursing staff responsibility to change the residents' clothes daily, bathe and shower the residents.When asked how often Resident #88 showered, Staff #9 stated that the resident was supposed to get a shower 2 days per week, and often if needed.On 8/15/2025 at 10:26 AM A review of Shower logs located in the unit shower binder were reviewed. The review revealed that the resident was showered 1 day (July 11th) out of 31 days. There was another date entry on 8/5/25 that indicated the resident was offered a shower but refused. On 8/15/2025 at 10:34 AM An interview with the unit manager, Staff #10, was conducted. Staff #10 confirmed that Resident #88 was supposed to receive showers every week on Tuesdays and Fridays. She also reported that residents' showers or refusals are documented in the electronic health record or the unit's shower binder. The unit manager further stated that shower refusals are to be notified to the family and if there is a pattern, the resident is care planned for<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | refusal. On 8/15/2025 at 10:49 AM The surveyor and Staff #10 reviewed the shower documentation for Resident #88 and confirmed that the resident was not getting showers as required. The unit manager was made aware that this is a concern. On 8/15/2025 at 11:00 AM The DON was notified of the concerns identified with personal hygiene and showers for dependent residents. |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on observations, record reviews and interviews, it was determined that the facility failed to ensure that residents received treatment and care to promote the highest practicable wellbeing as evidenced by 1) failure to follow physician orders and 2) failure to provide toileting hygiene for residents who were incontinent of bowel and bladder. This was evident for 3 (Resident #88, #126, and #137) out of 5 residents reviewed for quality of care during the recertification survey. The findings include:1) On 8/12/2025 at 11:24 AM Resident #88 was observed with redness around the left eye. When asked what happened to his/her eye, the resident answered that they fell last week. On 8/12/2025 at 11:30 AM An observation of Resident #88's room was conducted. An opened pack of regular briefs was observed in the bathroom and on top of the resident's dresser. Additionally, the resident showed the surveyor that they wore regular briefs at that time. On 8/12/2025 at 12:44 PM A review of Resident #88's medical record was conducted. The review revealed orders that stated Resident #88 should 1) wear Hipster Padded Brief q shift while awake for fall interventions and 2) float heels when the resident is in bed. Further review of the resident's record indicated that S/He was care planned to wear hip padded briefs every shift and float heels when in bed. On 8/13/2025 at 10:52 AM Resident #88 was observed without any hipster padded briefs. On 8/14/2025 at 7:00 AM Resident #88 was observed sleeping in bed, heels were not floated. On 8/14/2025 at 7:30 AM A review of resident's medical records indicated that the resident was wearing hip padded briefs on 8/12/25 and 8/13/25. Additionally, there was documentation that the resident had heels floated on 8/13/25. On 8/14/2025 at 8:10 AM Another observation was conducted with the surveyor and Staff #5. Staff #5 confirmed that the resident was not wearing hipster padded brief and heels were not floated. On 8/14/2025 at 8:13 AM An interview with the staff #5 was conducted. Staff #5 stated that she inaccurately documented that the hipster padded briefs were worn and the heels were floated. On 8/14/2025 at 11:10 AM The Director of Nursing (DON) was made aware of the concerns.2a) On 8/14/2025 at 10:45 AM A review of confidential complaints reported to the state agency revealed Complaint #330006. The complaint alleged that Resident #137 did not get their diaper changed on December 1st, 2023. On 8/14/2025 at 10:55 AM An interview with the complainant was conducted. They reported that the facility staff did not change Resident #137's diaper during various shifts. On 8/25/2025 at 9:00 AM Review of record revealed that Resident #137 was admitted into the facility on [DATE] and was discharged on 12/07/2023. Review of resident's MDS section H indicated that the resident was coded as always incontinent for bowel and bladder. Also, MDS section GG revealed that the resident was coded as dependent on staff for toileting hygiene.Further review of Resident #137's care plan indicated that the resident needed assistance with toileting and that they were dependent on staff.On 8/25/2025 at 9:20 AM The DON was asked to provide records for toileting hygiene provision for Resident # 137 for November 30th and December 1st.On 8/25/2025 at 10:10 AM Facility provided documentation for bladder and bowel incontinence for [DATE]th and [DATE]st. Review of these documents revealed no documentation on bowel and bladder incontinence for November 30th night shift 11-7. There was documentation that the resident received dressing and bladder incontinence care December 1st at 14:19.On 8/25/2025 at 10:29 AM An interview with the DON was conducted. He stated that he would expect toileting hygiene documentation if bowel and bladder incontinence care was provided to a resident. The surveyor notified the DON that this was a concern that will be taken back to the office. 2b) On 8/21/2025 at 9:45 AM A review of confidential complaints reported to the state agency revealed Complaint #330065. The complaint alleged that residents at the<br>(continued on next page) |

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|---|---|---|---|
| | 215326 | A. Building<br>B. Wing | 08/27/2025 |

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| Autumn Lake Healthcare at Summit Park | 1502 Frederick Road<br>Catonsville, MD 21228 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | facility had poor hygiene. The complainant reported that Resident #126 did not get their diaper changed in a timely manner. On 8/21/2025 at 10:12 AM Review of Resident #126's medical record was conducted. The review revealed that the resident was admitted into the facility on 5/10/24 and was discharged to the hospital on 2/16/25. Further review of the records revealed MDS completed and accepted on 11/16/24 that indicated the resident was dependent on staff for toileting hygiene, oral hygiene, shower/bathe and personal hygiene. Also, MDS Section H for Bowel and Bladder indicated that the resident was always incontinent.On 8/21/2025 at 10:33 AM Facility was asked to provide documentation for bowel and bladder incontinence care provided to the resident for the months of January and February 2025. On 8/21/2025 at 11:05 AM The surveyor received documentation for bowel and bladder incontinence care from the facility for the month of January only. The review of these documents revealed several days in January (1, 3, 6, 8, 25, 26, and 28) that indicated the resident was not available to receive toileting hygiene care. Additionally, there was no documentation on 1/13, 1/20, 1/27, 1/29 and 1/30). However, review of Resident #126 medication administration record and progress notes, revealed that the resident never left the facility.On 8/21/2025 at 11:25 AM The DON was asked to provide documentation that indicated the resident was not available to receive care in the facility.On 8/21/2025 at 12:00 PM An interview with the DON was conducted. DON stated it was the expectation of facility staff to complete personal hygiene, bowel and bladder incontinence for the residents every shift. He further stated that it would be very unlikely for a resident to be away the entire shift for the staff to lack an opportunity to provide or assess for bladder and bowel incontinence. On 8/25/2025 at 12:30 PM The DON reported to the surveyor that the resident was in the facility for the days marked as resident not available. He also stated that there was no additional information that the resident was provided with toilet hygiene care. The surveyor notified the DON that this was a concern. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on record review and staff interview, it was determined that the facility failed provide the necessary treatment and services to promote healing. This was evident for 1 (Resident #131) out of 5 residents reviewed for pressure injuries. The findings include: On 8/18/2025 at 10:20 AM, Complaint #330046 was reviewed. The Complainant alleged the facility failed to clean and turn Resident #131 when appropriate. On 8/18/2025 at 11:02 AM, weekly wound assessments for Resident #131 were reviewed. A Stage 4 sacral wound with an onset date of 7/16/24 was documented to have worsened in the 8/14/24, 8/22/24, and 8/30/24 wound assessments. On 8/18/2025 at 12:25 PM, a review of Resident #131's Documentation Survey report for the month of August in 2024 was conducted. On the following shifts the GNAs documented that the resident was not turned or repositioned every two hours: 8/1/24 Day, 8/8/24 Night, 8/10/24 Day, 8/14/24 Day, 8/19/24 Day, 8/21/24 Evening, 8/23/24 Day, 8/29/24 Night, and 8/30/24 Day/Evening. On the following shifts the GNAs did not document anything for the Turn and reposition task: 8/7/24 Day, 8/15/24 Day, 8/21/24 Day, 8/24/24 Day, 8/25/24 Day, 8/26/25 Day, 8/31/25 Night. On 8/18/2025 at 1:52 PM, the Director of Nursing (DON) was made aware of concerns with Pressure injury treatment. DON stated that they were not here in August of 2024 but acknowledged concern of GNAs not turning or repositioning every two hours for Resident #131. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on record review and staff interview, it was determined that the facility failed to provide the necessary treatment and services to promote healing. This was evident for 1 (Resident #131) out of 5 residents reviewed for pressure injuries. The findings include:On 8/26/2025 at 1:30 PM, a review of Resident #12's orders was conducted. An order for Oxygen to be given at 2 liters per minute via Nasal Cannula every 24 hours as needed at bedtime. On 8/26/2025 at 1:43 PM, an observation was made of Resident #12's room. The resident was not in the room, but oxygen was set to 10 liters per minute. Staff #21 confirmed this observation and confirmed Resident #12's current order in the resident's chart as 2 liters per minute as needed at bedtime. On 8/26/2025 at 1:46 PM, an interview was conducted with Resident #12. When asked when they use Oxygen, they stated that they use oxygen to sleep and when they are sick. When asked how much oxygen they are using at night, they stated that they use 7 liters per minute at night to sleep comfortably. On 8/26/2025 at 1:57 PM, an interview with the Assistant Director of Nursing (ADON) was conducted. Resident #12's oxygen usage was shared with the ADON, the ADON stated that they would consult with the provider, nursing team, and resident. When asked for residents who have oxygen ordered should nursing be monitoring the rate of oxygen delivery, the ADON stated that the liters per minute should be monitored by nursing when the resident is using oxygen. While interviewing the ADON, this surveyor reviewed Resident #12's Medication and Treatment Administration Record with the ADON. This surveyor confirmed with ADON that the nursing staff had not been documenting that the resident was receiving Oxygen therapy as needed. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on interviews, observations and record reviews, it was determined that the facility failed to provide residents with individualized care based on assessments and physician orders. This was evident for 1 (Resident #88) out of 4 residents reviewed for nursing skills and competency during the recertification survey.The findings include:On 8/12/2025 at 11:24 AM an interview with Resident #88 was conducted. The resident reported that they had a fall last week. Resident was observed with redness around the left eye. On 8/12/2025 at 11:30 AM an observation of Resident #88's room was conducted. An opened pack of regular briefs was observed in the bathroom and on top of the resident's dresser. Additionally, the resident showed the surveyor that they wore regular briefs at that time.On 8/12/2025 at 12:44 PM a review of Resident #88's medical record was conducted. The review revealed orders that stated Resident #88 should 1) wear Hipster Padded Brief q shift while awake for fall interventions and 2) float heels when the resident is in bed and 3) place sling on Right arm. Further review of the resident's record indicated that the resident had a fracture of the right clavicle from a fall. S/He was care planned to wear hip padded briefs every shift for fall prevention and float heels when in bed. The care plan also indicated that the resident refused to wear the ordered sling. On 8/13/2025 at 10:52 AM Resident #88 was observed without any hipster padded briefs or a sling on the right arm. On 8/14/2025 at 7:00 AM Resident #88 was observed sleeping in bed, heels were not floated. On 8/14/2025 at 7:30 AM A review of resident's medical records indicated that the resident was wearing a sling and hip padded briefs on 8/12/25 and 8/13/25. Additionally, there was documentation that the resident had heels floated on 8/13/25. On 8/14/2025 at 8:10 AM Another observation was conducted with the surveyor and Staff #5. Staff #5 confirmed that the resident was not wearing a sling, a hipster padded brief, and heels were not floated while sleeping. On 8/14/2025 at 8:13 AM An interview with the staff #5 was conducted. Staff #5 stated that she inaccurately documented that the resident was wearing a sling and hipster padded briefs. She also acknowledged that the resident's heels were not floated. Additionally, Staff #5 stated that the resident is not compliant with floating heels, but there was no care plan for refusals to this order. On 8/14/2025 at 11:10 AM The Director of Nursing (DON) was made aware of the concerns with documentation of interventions that were not implemented. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on resident interview, record review, and staff interview, it was determined that the facility failed to prevent a significant medication error. This was evident for 2 (Resident #105 and #52) out of 6 resident's review for unnecessary medications. The findings include:1.) On 8/12/2025 at 11:45 AM, a review of Complaint #330061 was completed. The complaint alleged Resident #105 received the incorrect dose of medication.On 8/12/2025 at 12:02 PM, an interview with Resident #105's representative was conducted. The Resident's representative stated in November of 2024, there was a med error.On 8/15/2025 at 10:04 AM, a review of Resident #105's progress notes was conducted. The change of condition note on 11/10/2024 stated that the resident received 2 mg of Clonazepam instead of the ordered 1 mg of Clonazepam. Order was placed to hold the next dose of Clonazepam, vital signs every shift, and to complete neuro checks every 24 hours. On 11/10/2024 at 00:15, the note stated, during med count writer found out that the clonazepam came in 1mg, so one tablet should've been given. Nurse Practitioner notified.On 8/15/2025 at 10:18 AM, a review of Resident #105's Medication Administration Record indicated that Staff #23 was the Licensed Practical Nurse who gave Clonazepam prior to the change of condition note and the order of Clonazepam being held. On 8/15/2025 at 10:49 AM, a review of Resident #105's orders was completed. The clonazepam Oral Tablet 0.5 mg Controlled Drug was ordered to give via G-Tube every 8 hours for seizures on 10/19/24 and discontinued on 11/9/24. The order was revised and stated, PLEASE GIVE ONLY ONE TABLET, on 11/9/24. On 8/15/2025 at 11:05 AM, a review of Facilities investigation was conducted. A statement from Staff #23 states the staff found out the medication was given incorrectly at narcotic count on change of shift on 11/9/2024 at 11:00 PM.On 8/15/2025 at 1:53 PM, an interview was conducted with the Director of Nursing. When asked about the medication error, they stated medication error was confirmed and staff were educated. 2.) 8/26/2025 8:48 AM, a review of Complaint #330032 was conducted. The complaint stated that a nurse gave Resident #52 the wrong medication. The complaint extended from 2/20/2024 to 8/15/2025.On 8/26/2025 at 9:34 AM, a review of Resident #52's progress notes was conducted. In a change of condition note from 3/4/2025 at 5:39 PM, it stated, Med error, administer 4-unit lispro due to wrong identification of resident picture by name. MD and Supervisor was notified. Md recommend q6 b/s monitoring. Vital signs was stable; b/s 107 @ 5.39pm, 113 @ 11.54pm. pt alert x4, No sign of hypoglycemia or hyperglycemia. Non-adverse reactions noted. call light within reach. Family notified.On 8/26/2025 at 11:15 AM, a review of the facilities incident report regarding the medication error was conducted. In the incident report, there was education provided to the Licensed Practical Nurse (Staff #22) who administered the medication to the incorrect resident (Resident #52) on 3/4/2025.On 8/26/2025 at 11:20 AM, an interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) was conducted. It was confirmed that Staff #22 made a medication error by not identifying the correct resident and giving a dose of 4 units of Lispro to the incorrect resident. Per the ADON, the nurse was placed back on 3-day orientation after the error and another competency was completed on 3/11/25. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Number of residents sampled:<br><br>Number of residents cited:<br><br>Based on record review, observation and interview, it was determined that the facility failed to use appropriate infection control practice of hand hygiene when performing wound care. This was evident during a wound care and dressing change observation conducted for 1 (Resident #7) of 2 residents who had pressure ulcers. The findings include:A pressure ulcer, also known as a bed sore or decubitus ulcer, is a skin injury that develops when prolonged pressure is applied to the same area of the bodyA stage 4 pressure ulcer is a severe skin injury that involves complete loss of the skin, underlying tissue (subcutaneous tissue), muscle, and sometimes bone.On 8/18/2025 at 9:00 AM, review of Resident #7's record indicated that they had multiple pressure ulcers. The resident had a facility acquired stage 4 pressure ulcer of the sacrum and unstageable ulcer of the right foot.On 8/19/2025 at 9:28 AM, an observation of wound dressing change on Resident #7 was conducted. The wound care and dressing change was performed by Staff #12. On 8/19/2025 at 9:39 AM, Staff #12 performed hand hygiene, wore clean gloves and removed the old dressing on the sacrum. The old dressing was observed to have yellow substance. Staff #12 failed to perform hand hygiene and wore clean gloves then cleaned the resident's wound with wound cleanser and Dankin solutions. Flagyl powder was applied and lastly a labeled calcium alginate dressing was applied to the resident's sacrum. Hand hygiene was then performed when staff #12 was leaving the room. Throughout the wound care and dressing change, Staff #12 only performed hand hygiene at the beginning and upon completion of the task.On 8/19/2025 at 10:22 AM An interview with the Staff #12 was conducted. She was asked to outline when hand hygiene is supposed to be performed. Staff #12 answered that after removal of dirty dressing, staff is expected to perform hand hygiene. Staff #12 stated she forgot to perform this step.The surveyor pointed out that this was an infection control concern due to failure to perform hand hygiene between the removal of contaminated dressing and the application of clean dressing. On 8/19/2025 at 10:29 AM The Director of Nursing was notified of the concerns. |