STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215082	A. Building B. Wing	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Pikesville	7 Sudbrook Lane Pikesville, MD 21208

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on record review and staff interview it was determined the facility staff 1) failed to notify the physician that a medication for an elevated potassium level was unavailable and 2) failed to have a system in place to notify the physician when residents' weight loss was identified. This was evident for 1 (Resident #251) of 1 resident reviewed for an unexpected death and 3 (Resident #73, #67, #402) of 7 residents reviewed for weight loss. The findings include: 1) On 8/4/22 at 7:30 AM a review of Resident #251's medical record revealed a 12/17/21 physician's history and physical that documented the resident was admitted to the facility on [DATE] from an acute care facility for subacute rehabilitation due to deconditioning. Resident #251 had diagnoses that included, but were not limited to hypertension, chronic obstructive pulmonary disease exacerbation complicated by pneumonia, aortic stenosis, atrial fibrillation, and heart failure. A review of a 1/4/22 physician's note documented that Resident #251 was diagnosed with COVID 3 days prior and had been monitored closely and the patient today is seen significantly worse. The physician's note documented, labs were done today, which were abnormal. The physician documented the potassium level was 5.5. According to the Lab Results Report dated 1/4/22, the reference range for potassium levels was 3.5 to 5.2 mEq/L. According to the National Institute of Health (NIH), potassium is a type of electrolyte that is an electrically charged mineral that helps control fluid levels and the balance of acids and bases (pH balance) in the body. Potassium also helps control muscle and nerve activity along with other functions. If potassium levels are too high, it could affect the rate or rhythm of the heart. The 1/4/22 physician's note continued, Lab work today is being ordered stat, showed significantly elevated BUN (blood urea nitrogen) and creatinine indicating severe dehydration. The note continued, may have progression of [his/her] underlying COVID. [He/She has a history of underlying heart failure. We will repeat [his/her] stat BMP (basic metabolic profile). Following this, [his/her] potassium is elevated, will need Lokelma, could be from severe dehydration. Lokelma is a medication to treat high levels of potassium in the blood. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the written physician's orders sheet dated 1/4/22 had the order, give Lokelma 10 gm x 1 for hyperkalemia. The order sheet did not have a time that the order was written. Review of the electronic order in the facility's electronic medical record system documented the order was put into the system at 1534 (3:34 PM). A review of Resident #251's January 2022 Medication Administration Record (MAR) documented at 2021 (8:21 PM) that the medication was not given. A note by the nurse documented medicine not available, waiting for pharmacy to deliver. Further review of Resident #251's medical record failed to reveal documentation that the physician was notified of the unavailability of the medication. On 8/4/22 at 9:49 AM physician #73 was interviewed about the elevated potassium level and was asked, if you ordered medication for an elevated potassium level and the medication was not available, would you expect the nurse to call you if the medication was not available. Physician #73 stated, yes, the expectation, even if the nurse knew the value wasn't critical, should not have taken it upon herself to not let the physician know the medication was not available. The Director of Nursing was informed of the concern on 8/9/22 at 11:20 AM. 43096 2) On 7/25/22 at 1:09 PM review of Resident #73's medical record revealed the resident weighed 228.6 lb. (pounds) on 1/5/22 and on 2/4/22 weighed 214.6 lb., which was a 14 lb. loss (6.12 %) in 4 weeks. Further medical records on 7/28/22 at 8:29 AM revealed a dietitian (staff #13) wrote a progress note on 2/17/22 as the resident was to be re-weighed by nursing to confirm weight loss. A progress note written by a previous dietitian (staff #67) on 2/18/22 stated resident has refused to be weighed. However, no documentation was found of notification to the physician for Resident #73's weight loss. During an interview with staff #13 on 7/28/22 at 10:29 AM, staff # 13 stated whenever she recognized residents' weight loss, she documented it under electronic medical records and discussed it with the facility team (including the director of nursing and physician). She also stated that physician notifications were made via phone call, text, or in-person. However, no supportive documentation was submitted to the surveyor to verify notice was made to the physician. 2) On 7/28/22 at 7:57 AM a review of Resident #67's medical record revealed the resident weighed 218.6 lb on 12/6/21 and on 1/5/22 weighed 200.4 lb., which was an 18.2 lb. loss (9.8%) in 4 weeks. Further medical records on 7/28/22 at 7:57 AM revealed staff #67 wrote a progress note on 1/14/22 RD (Registered Dietitian) to request reweight. Also, a progress note dated 1/20/22 written by staff stated resident refused weight attempted x2 and continues to refuse. However, there was no documentation to support Resident #67's weight loss was reported to the physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 8/5/22 at 8:21 AM a review of Resident #402's medical record revealed the resident weighed 116 lb. on 1/30/22 and on 2/1/22 weighed 104 lb. which was a 12 lb. loss (10.3%) in 2 days. Review of the resident's progress note dated 2/2/22 written by a dietitian showed poor PO (oral) intakes addressed; resident is receiving ensure clear TID (three times a day) to promote adequate intakes. Resident is to be re-weighed per nursing to confirm weight loss. A progress note written by the nurse dated 2/2/22 stated the resident refused to be weighed. Resident #402 was discharged to home on 2/4/22. However, there was no documentation to support Resident #402's weight loss was reported to the physician. On 8/5/22 at 1:39 PM, an interview was conducted with a Geriatric Nurse Assistant (GNA #32). She stated that residents' health status or order would check residents' body weight, and GNA checked the order, and nurses would put the number in the system (electronic medical record). During an interview with a Licensed Practical Nurse (LPN #10) on 8/5/22 at 1:45 PM, she stated, When weight change is alerted, staff, reweigh residents' bodyweight at the time and later (same day different shift or next day) to ensure it was accursate. If the resident refused to be reweighed, they document that and report to the Director of Nursing/Assistant Director of Nursing and follow their direction: notify the provider or recheck it. An interview with the Director of Nursing (DON) was conducted on 8/5/22 at 1:52 PM. The surveyor reviewed Resident #402's weight loss with the DON. The surveyor asked the DON about a process of weight loss notice. The DON stated that to verify whether residents' measured weight is accurate, the following shift staff re-measures the weight, and the dietitian reviews it and reports it to the physicians. The DON confirmed the facility staff should report to the physician timely regarding the resident's weight loss. During an interview with the maintenance director (staff #11) on 8/8/22 at 9:40 AM, staff #11 was asked the accuracy of the scales. Staff #11 stated a medical equipment company comes to the facility regularly for inspection. The latest visit was 3/17/22 to replace the 1st-floor scale. Staff #11 also explained that if the scale had been issued, the facility staff would write their concern on the 'maintenance repair request log,' located in each unit. Staff #11 stated, I did not remember any concerns reported recently. The surveyor reviewed each unit's maintenance repair request log on 8/8/22 at 10:00 AM. There was no written concern found on the record. The above concern, weight loss, was not notified to the physician and was discussed with the Director of Nursing on 8/8/22 at 4:00 PM.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on a facility-reported incident, closed clinical record review, staff interview, and reviews of the facility abuse policy, it was determined that facility staff failed to ensure a resident was free of staff abuse. This was evident for 2 (Resident #204, #412) out of 8 residents reviewed for abuse during an annual recertification survey. This deficient practice caused harm to Resident #204. The findings are: 1) A review of facility-reported incident MD00156900 on 7/25/22 revealed that the facility reported an allegation of staff to resident abuse on 08/03/2020 in which the resident was observed with a bloody nose and a bleeding area to the resident's right lower leg stump. The facility also reported that the local police were notified and conducted an onsite investigation. The resident's physician and responsible party were also made aware of the allegations. A review of the facility's Abuse, Neglect, and Exploitation policy on 07/25/22, revealed an implementation and revision date of 07/21/2021, which defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. A review of the 8/3/2020 12:30 PM, nurses note revealed, Called to resident 204's room because s/he was sliding out of the wheelchair. Went to get assigned GNA #87 to help pull Resident #204 up in the chair. As soon as assigned GNA #87 came into resident 204's room Resident #204 began to cry and said, ' get him/her out of here s/he hit me all in my face. ' Assigned GNA #87 then stated that Resident #204 hit him/her in the face. Resident #204 stated, shut up and Assigned GNA #87 stated no I don't have to shut up and became argumentative. GNA #87 was asked to leave Resident #204 ' s room and s/he stated, I'm leaving anyway. GNA #87 left the room and went downstairs. Upon assessment Resident #204 had a nosebleed and skin tear on right stump. Treatment orders were put into place and the nurse practitioner (NP) was made aware. The NP did come in and assess Resident #204 on 08/03/2020. Resident #204 was reassured by staff that GNA #87 would not return to his/her room. A review of Resident #204 ' s physician note, dated 08/03/2020, revealed Resident #204 ' s physician was called to see a patient crying with a bloody nose and a skin abrasion to his/her right lower extremity stump. Resident #204 ' s physician documented that there had been an argumentative episode between the patient and a GNA (geriatric nursing assistant). Resident #204 ' s physician documented that Resident #204 Right Stump was observed with an abrasion with bleeding. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility investigation on 07/25/2022 revealed a statement by the facility social worker on 08/03/2020 regarding the alleged staff to resident abuse. The facility social worker indicated in his/her 08/03/2020 statement that s/he was alerted by Resident #204 calling out for help from his/her room. The facility social worker indicated that Resident #204 appeared to be falling out of his/her chair. The facility social worker and another staff person went in to assist Resident #204 and this is when the facility social worker indicated Resident #204 began to cry. The facility social worker also indicated this is when s/he observed that Resident #204 ' s stump was bleeding. The other staff person brought GNA #87 into the room and s/he and Resident #204 began an argumentative discussion. GNA #87 was then asked to leave Resident #204 ' s room. Other staff members came in to assist Resident #204 and proceeded to clean him/her up. The facility social worker indicated Resident #204 continued to cry during care. The facility social worker also handed Resident #204 a tissue. When Resident #204 blew his/her nose, blood was observed coming out of Resident #204 ' s nose. In an interview on 7/25/22 at 3:47 PM, with the Assistant Director of Nurses (ADON) the ADON stated that at the conclusion of the investigation, s/he substantiated the allegation of abuse to Resident #204 on 08/03/2020 by GNA #87. The ADON stated that GNA #87 was hyper after the incident with Resident #204. The ADON stated that GNA #87 stated to her/him that if someone hits me, I am going to hit them back. The ADON stated that he/she went and spoke with Resident #204 and observed Resident #204 nose was bleeding and there was an injury on his/her right knee stump. Resident #204 went on to inform the ADON that GNA #87 was rough and punched him/her on 08/03/2020. The ADON stated that s/he believed Resident #204, and documented the allegations in the report to the State Survey Agency, that GNA #87 abused Resident #204 during care on 08/03/2020. The ADON stated that the facility implemented the following: the alleged employee, GNA #87, was immediately removed from staffing on 08/03/2020, the facility immediately started an investigation and reported the incident to the State Survey Agency, and the local police were then notified of the incident. GNA #87 was terminated and reported to the Maryland State Board of Nursing. 31145 2) Review of complaint MD00169788 on 8/6/22 at 2:00 PM revealed Resident #412 reported that [he/she] asked if someone could transport [him/her] back to [his/her] room once therapy was finished. Resident #412 reported that the staff person said, you'll be alright. Resident #412 stated, how do you know how I feel? Resident #412 stated the staff person said, I hope you get ten of your toes cut off. Resident #412 stated, I felt some kind of way about what she said. Resident #412 stated, her comment affected me emotionally because she expressed how she felt about me. Resident #412 stated, I felt she was insensitive because I am currently dealing with possible amputations. Review of Resident #412's medical record on 8/6/22 at 2:00 PM revealed Resident #412 was admitted to the facility in July 2021. Review of a CRNP (Certified Registered Nurse Practitioner) note dated 7/16/21 documented that Resident #412 presented to the hospital with fever, chills, and worsening pain around a non-healing diabetic ulcer on the sole of the left foot. After an MRI at the hospital showed evidence of acute/chronic osteomyelitis, podiatry recommended amputation of all toes versus some toes. Resident #412 decided against amputation and said, only agrees to IV antibiotics at this time and does not want to take the risk of amputation of toes. Resident #412 was discharged from the hospital to subacute rehab for IV antibiotic management and physical therapy. Osteomyelitis is inflammation/infection of the bone. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/8/22 at 11:40 AM an interview was conducted with Staff #45 (director of Rehabilitation). Staff #45 stated that Resident #412 was able to get around independently in the wheelchair and would go from his/her room to smoke and through the halls. Staff #45 stated that Resident #412 was inappropriate with one of the rehab techs previously and the resident asked that tech to take the resident back to his/her room. Staff #45 stated, the tech was uncomfortable doing that. Staff #45 stated a physical therapy assistant stepped in and said, you can take yourself. She said jokingly, why don't you cut it off. He/she (Resident #412) was subconscious about it. I explained that while it was inappropriate, she said it was a joke and didn't mean it. I'm not condoning what she said, it was wrong. I did report it to the Nursing Home Administrator (NHA), and he did an investigation. We all had to write statements about everything. On 8/8/22 at 1:49 PM a review of employee statements obtained from the Nursing Home Administrator (NHA) for the incident that happened on 7/23/21 with Resident #412 revealed a written statement from PTA #46 (physical therapy assistant) that documented, The rehab tech stated to myself and [name], [Resident name] makes me uncomfortable; I don't like [him/her], I don't want to be around [him/her]. The statement continued, attempted to grope me yesterday. Once the resident's occupational therapy session was completed, he/she looked at the rehab tech and stated, my foot hurts, I can't wheel myself. Knowing the information the tech had provided previously, I stated, I think you'll be fine since both legs were on leg rests and he/she was using his/her arms to propel his/her wheelchair and had done so throughout the entire day without incident. Resident proceeded to get increasingly irate shouting, you think I'll be ok? You think? How dare you think you know how I feel. I just finished a workout, and my shoulders could be hurting, you don't know. At this point I said, well then if you can't use your arms and legs anymore, they can just cut them off and get rid of them, sarcastically since the resident could in fact propel him/herself around the facility at will. Since I was aware of how the resident was behaving towards our rehab tech, I did not want the resident to have access to her in a situation where he/she could continue to take advantage and make her uncomfortable. On 8/22/22 at 2:07 PM an interview was conducted with the PTA #46. PTA #46 stated that they were in the rehab gym and Resident #412 made comments towards the tech that made her uncomfortable. Resident #412 was trying to get the tech to wheel Resident #412 back to his/her room and Resident #412 was able to propel the wheelchair independently at that time. I told [him/her] [he/she] could wheel [him/herself] back because [he/she] was independent. PTA #46 stated that Resident #412 became agitated, and sarcastically I said if you are not going to use your arms and legs you might as well cut them off. I meant it not literally. The surveyor asked PTA #46 if she knew what Resident #412's diagnoses were at that time. PTA #46 stated she did not know the resident's medical history, only that the resident was there for rehab and to go home. PTA #46 stated, I had sensitivity training in-service. I did not get written up. They had a discussion that it was an inappropriate comment. Discussed with the Director of Nursing on 8/9/22 at 11:20 AM.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on policy and facility documentation review and interviews it was determined that the facility failed to implement their policy regarding reporting allegations of abuse, neglect, and exploitation of residents and misappropriation of resident property. This was evident for 2 (#58, #412) of 8 residents reviewed for abuse during the annual survey. The findings include: 1) On 7/29/22 at 7:50 AM a review of the Abuse, Neglect and Exploitation policy dated 7/21/21, Section V B6. reads, providing complete and thorough documentation of the investigation. Review of facility reported incident MD00178644 on 7/29/22 at 8:00 AM revealed on 6/9/22 Resident #58 alleged that there was money missing from his/her nightstand drawer. Review of the facility investigation that was provided by the Nursing Home Administrator (NHA) included (2) employee interviews and the resident interview. It was also noted on the front page of the report that law enforcement was notified. The facility documented that police were unable to substantiate missing money. However, there were no interviews of any other staff on the second floor and no interview of any residents. On 7/29/22 at 10:50 AM an interview was conducted with the NHA about the investigation. The NHA was asked if the investigation that he gave the surveyor was complete and the NHA responded, yes. The surveyor brought up that there were only 2 staff members that were interviewed, and the NHA confirmed that he did not interview anyone else, even though there were other opportunities for staff or residents to enter the room. The NHA failed to implement the abuse policy related to investigations. 2) On 7/29/22 at 7:50 AM a review of the Abuse, Neglect and Exploitation policy dated 7/21/21, Section III D. reads, the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict or neglect; and H. assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. Section IV, A. reads, the facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse and B. Possible indicators of abuse include, but are not limited to: 5. verbal abuse of a resident overheard and 8. failure to provide care needs. Review of complaint MD00169788 on 8/6/22 at 2:00 PM revealed Resident #412 reported that [he/she] asked if someone could transport [him/her] back to [his/her] room once therapy was finished. Resident #412 reported that the staff person said, you'll be alright. Resident #412 stated, how do you know how I feel? Resident #412 stated the staff person said, I hope you get ten of your toes cut off. Resident #412 stated, I felt some kind of way about what she said. Resident #412 stated, her comment affected me emotionally because she expressed how she felt about me. Resident #412 stated, I felt she was insensitive because I am currently dealing with possible amputations. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/8/22 at 11:40 AM an interview was conducted with Staff #45 (director of Rehabilitation). Staff #45 stated that Resident #412 was inappropriate with one of the rehab techs previously and the resident asked that tech to take the resident to his/her room. Staff #45 stated, the tech was uncomfortable doing that. Staff #45 stated a physical therapy assistant (PTA) stepped in and said, you can take yourself. She said jokingly, why don't you cut if off. He/she was subconscious about it. Staff #45 stated, I explained that while it was inappropriate, she said it was a joke and didn't mean it. I'm not condoning what she said, it was wrong. I did report it to the Nursing Home Administrator (NHA), and he did an investigation. We all had to write statements about everything. On 8/8/22 at 1:49 PM a review of employee statements obtained from the Nursing Home Administrator (NHA) for the incident that happened on 7/23/21 with Resident #412 revealed a written statement from PTA #46 that documented, The rehab tech stated to myself and [name], [he/she] makes me uncomfortable; I don't like [him/her], I don't want to be around [him/her]. The statement continued, attempted to grope me yesterday. Once the resident's occupational therapy session was completed, he/she looked at the rehab tech and stated, my foot hurts, I can't wheel myself. Knowing the information, the tech had provided previously, I stated, I think you'll be fine since both legs were on leg rests and he/she was using his/her arms to propel his/her wheelchair and had done so throughout the entire day without incident. Resident proceeded to get increasingly irate shouting, you think I'll be ok? You think? How dare you think you know how I feel. I just finished a workout, and my shoulders could be hurting, you don't know. At this point I said, well then if you can't use your arms and legs anymore, they can just cut them off and get rid of them, sarcastically since the resident could in fact propel him/herself around the facility at will. Since I was aware of how the resident was behaving towards our rehab tech, I did not want the resident to have access to her in a situation where he/she could continue to take advantage and make her uncomfortable. On 8/22/22 at 2:07 PM an interview was conducted with the PTA #46. PTA #46 stated that they were in the rehab gym and Resident #412 made comments towards the tech that made her uncomfortable. Resident #412 was trying to get the tech to wheel Resident #412 back to his/her room and Resident #412 was able to propel the wheelchair independently at that time. I told [him/her] [he/she] could wheel [him/herself] back because [he/she] was independent. PTA #46 stated that Resident #412 became agitated, and sarcastically I said if you are not going to use your arms and legs you might as well cut them off. I meant it not literally. Discussed with the Director of Nursing on 8/9/22 at 11:20 AM that the facility failed to implement their abuse policy.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on record review and staff interview, it was determined the facility failed to report allegations of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 2 (#412, #402) of 8 residents reviewed for abuse during the annual survey. The findings include: Review of complaint MD00169788 on 8/6/22 at 2:00 PM revealed Resident #412 reported that [he/she] asked if someone could transport [him/her] back to [his/her] room once therapy was finished. Resident #412 reported that the staff person said, you'll be alright. Resident #412 stated, how do you know how I feel? Resident #412 stated the staff person said, I hope you get ten of your toes cut off. Resident #412 stated, I felt some kind of way about what she said. Resident #412 stated, her comment affected me emotionally because she expressed how she felt about me. Resident #412 stated, I felt she was insensitive because I am currently dealing with possible amputations. On 8/8/22 at 11:40 AM an interview was conducted with Staff #45 (director of Rehabilitation). Staff #412 stated that Resident #412 was inappropriate with one of the rehab techs previously and the resident asked that tech to take the resident to his/her room. Staff #45 stated, the tech was uncomfortable doing that. Staff #45 stated a physical therapy assistant stepped in and said, you can take yourself. She said jokingly, why don't you cut if off. He/she was subconscious about it. Staff #45 stated, I explained that while it was inappropriate, she said it was a joke and didn't mean it. I'm not condoning what she said, it was wrong. I did report it to the Nursing Home Administrator (NHA), and he did an investigation. We all had to write statements about everything. On 8/8/22 at 12:38 PM an interview was conducted with the NHA. When asked if he reported the incident to OHCQ he said he did not think it was reportable even though he did an investigation. Discussed the issue with the NHA on 8/8/22 at 3:30 PM and with the Director of Nursing on 8/9/22 at 11:20 AM. Cross Reference F 600 43096 2) On 8/3/22 at 7:25 AM, a review of the facility reported incident MD00174779 revealed the resident's family reported to a nurse on 11/23/21 around 2:50 PM that Resident #402 looked in fear after a staff member came in the room to shave the resident on 11/23/21. Also, the resident stated someone popped his/her hurting knee. On 8/3/22 at 2:20 PM, the Director of Nursing (DON) submitted the facility self-report packet, including a confirmation email that was initially reported to the state agency dated 11/24/21, 11:19 AM. The review of the confirmation email revealed that the facility failed to report an allegation of abuse to the state agency within 2 hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 8/3/22 at 2:40 PM, she stated since Resident #402's family reported this incident, she didn't report this allegation of abuse to the state agency within timeframes.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096 Based on review of medical records, investigative documentation, and interviews, it was determined that the facility failed to have an effective system in place to ensure abuse allegations were thoroughly investigated to determine if abuse occurred and take appropriate action. This was evident for 2 (Resident #402, #58) out of 8 residents reviewed for abuse during the survey. The findings include: 1) On 8/3/22 at 7:25 AM, a review of facility self-report, MD00174779, revealed that Resident #402's family reported a staff member popped the resident's hurting knee on 11/23/21. Further review of Resident #402's medical record revealed that the resident was admitted to the facility on [DATE] with a past medical history that included but was not limited to dementia. Per a progress note, a nurse on 11/23/21 at 3:18 PM stated, Resident #402 was alert and oriented 1-2 (healthcare providers might only ask about person, place, and time. Alert and oriented X 3 is the highest level of orientation tested). Head-to-toe assessment attempted. Refused by the resident stating nothing is wrong. On 8/3/22 at 7:50 AM review of the facility's investigation packet revealed the facility obtained four witness statements from the staff (all day shift: 2 assigned Resident #402's care and two not assigned Resident #402's care). All four staff denied the abuse incident on Resident #402. However, the facility failed to obtain statements from other shift staff who provided care or services to the resident. On 8/3/22 at 8:30 AM review of the abuse training sheet, which was filed in the facility's investigation folder, revealed that a total of 119 staff were listed on the sheet, and 25 out of 119 staff were not signed or dated in the training sheet. The surveyor requested a copy of the staffing list for 11/23/21 on 8/3/22 at 1:40 PM. A review of the staffing list for 11/23/21 revealed that 25 staff who had not received abuse training on 11/23/21 including 12 who worked on 11/23/21. During an interview with the Director of Nursing (DON) on 8/3/22 at 2:10 PM, she was made aware of the concerns that the facility failed to do a thorough investigation. 31145 2) Review of facility reported incident MD00178644 on 7/29/22 at 8:00 AM revealed on 6/9/22 Resident #58 alleged that there was $30 in his/her nightstand drawer in the morning of 6/9/22 and when Resident #58 came back from an afternoon appointment there was only $2 in the nightstand drawer. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation that was provided by the Nursing Home Administrator (NHA) included (2) employee interviews and the resident interview. It was also noted on the front page of the report that law enforcement was notified. The facility documented that police were unable to substantiate missing money. However, there were no interviews of any other staff on the second floor and no interview of any residents. On 7/29/22 at 10:50 AM an interview was conducted with the NHA about the investigation. The NHA was asked if the investigation that he gave the surveyor was complete and the NHA responded, yes. The surveyor brought up that there were only 2 staff members that were interviewed, and the NHA confirmed that he did not interview anyone else, even though there were other opportunities for staff or residents to enter the resident's room. The NHA was informed that this was not a complete investigation.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 31145 Based on medical record review and staff interview it was determined the facility staff failed to conduct an accurate, comprehensive assessment by failing to assess a resident's mood and cognitive status on comprehensive and quarterly MDS (Minimum Data Set) assessments. This was evident for 3 (#27, #46, #28) of 38 residents reviewed during the annual survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on these individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 7/21/22 at 10:04 AM a review of Resident #31's medical record revealed a comprehensive MDS assessment with an assessment reference date (ARD) of 1/3/22 was not complete. Section C, Cognitive Patterns and Section D, Mood was not assessed. 2) On 7/27/22 at 8:04 AM a review of Resident #46's medical record revealed a comprehensive MDS assessment with an ARD of 3/22/22 was not complete. Section C, Cognitive Patterns and Section D, Mood was not assessed. 3) On 7/29/22 at 1:16 PM a review of Resident #28's medical record revealed a comprehensive MDS assessment with an ARD of 12/1/21 was not complete. Section C, Cognitive Patterns and Section D, Mood was not assessed. On 7/27/22 at 12:56 PM an interview was conducted with the MDS Coordinator who confirmed those sections of the MDS were not done. The MDS Coordinator stated, we have had issues with the Social Worker getting to do them timely. I send an email out to remind her. The Director of Nursing was informed of the concern on 8/9/22 at 11:20 AM.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 10 (#53, #87, #57, #58, #80, #208, #251, #28, #67, #311,) of 38 residents reviewed during the annual survey. The findings include: The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. 1) On 7/27/22 at 10:30 AM a record review of Resident #53's quarterly MDS with an assessment reference date (ARD) of 6/6/22, Section N, Medications, documented that the resident received an anti-coagulant for 7 days during the lookback period. Review of Resident #53's July 2022 Medication Administration Record (MAR) documented that Resident #53 received the medication Plavix (Clopidogrel Bisulfate) every day for DVT (deep vein thrombosis) prophylaxis. According to the FDA (Food and Drug Administration) Clopidogrel is an antiplatelet medicine used to prevent blood clots in patients who have had a heart attack, stroke, or problems with the circulation in the arms and legs. It works by helping to keep the platelets in the blood from sticking together and forming clots that can occur with certain medical conditions. According to CMS (Centers for Medicare and Medicaid) RAI (Resident Assessment Interview) Manual, under medications received, it was documented, Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. 2) On 7/27/22 at 11:00 AM a record review of Resident #87's quarterly MDS with an ARD of 6/28/22, Section N, Medications, documented the resident received an anti-coagulant for 1 day during the 7-day lookback period. Review of Resident #87's June 2022 MAR documented that Resident #87 received the medication Plavix (Clopidogrel Bisulfate) every day related to acute embolism and thrombosis of unspecified deep veins of the right lower extremity. The MDS should not have been coded for an anticoagulant. On 7/27/22 at 12:56 PM an interview was conducted with the MDS Coordinator regarding coding of an anticoagulant on the MDS. The MDS Coordinator stated, I was not aware that you didn't code Plavix as an anticoagulant. She confirmed both errors. On 7/28/22 at 8:24 AM the MDS coding errors were discussed with the Director of Nursing (DON). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 8/3/22 at 12:55 PM a review of Resident #57's July 2022 and April 2022 revealed Resident #57 received the medication Bumex, a diuretic, every day for hypertension. According to NIH (National Institute of Health), diuretics are a medication used in the management and treatment of edematous and other non-edematous disease conditions. Review of Resident #57's quarterly MDS with an ARD of 7/12/22 and 4/11/22, Section N, Medications, failed to capture the use of the diuretic. This concern was discussed with the Director of Nursing (DON) on 8/3/22 at 2:22 PM 4) On 7/28/22 at 7:47 AM a review of Resident #58's medical record revealed Resident #58 was previously admitted to the facility following a motor vehicle accident and was discharged home on 5/12/22, however had a fall and was readmitted to the facility from an acute care facility on 5/20/22. Review of the 5/20/22 Fall's risk assessment documented 1 to 2 falls within last 6 months. Review of the admit/readmit screener dated 5/20/22 documented, reason for admission as per client or family/caregiver was fall. Review of the admission MDS with an ARD of 6/1/22, Section 1700, Fall history on admission/entry or reentry, A. did the resident have a fall any time in the last month prior to admission/entry or reentry? was coded 0 which failed to capture the fall between the time the resident was discharged on [DATE] and readmitted to the facility on [DATE]. 5) On 7/29/22 at 7:43 AM a review of Resident #80's June 2022 MAR documented Resident #80 received the medication Tramadol every day for pain. According to the FDA Tramadol is a specific type of narcotic medicine called an opioid that is approved to treat moderate to moderately severe pain in adults. Review of Resident #80's quarterly MDS assessment with an ARD of 6/17/22, Section N, failed to capture the use of opioid medication for the 7-day lookback period. 6) On 8/1/22 at 9:00 AM a review of Resident #208's medical record revealed a wandering/elopement assessment dated [DATE] that Resident #208 had a history of wandering and was observed to wander aimlessly within the home or off the grounds. A 3/3/21 at 12:31 PM nurse's note documented, resident is alert and confused. Continues to wander through unit. A 3/1/21 at 6:14 AM nurse's note documented, resident awake and confused, needed closer monitoring. Resident wander all night and continue to need redirection and orientation. A 2/28/21 at 23:42 (11:42 PM) nurse's note documented, resident is alert and confused. Continues to wander around unit looking for [his/her] sister. Staff continues to reorient resident back to [his/her] unit. Review of Resident #208's MDS with an ARD of ARD 3/4/21, Section E0900 and impact in Section E1000 failed to capture wandering. On 4/21/21 at 6:45 a nurse's note documented, new admit, alert and oriented x 1 with confusion. no noted distress, resident wandered during the night from room to room redirected several time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #208's MDS with an ARD of ARD 4/21/21, Section E0900 and impact in Section E1000 failed to capture wandering. Continued review of Resident #208's medical record revealed March 2022 and April 2022 MARs which documented Resident #208 received the medication Clopidogrel every day. Review of Resident #208's MDS with an ARD of 3/4/21 and 4/21/21 coded that Resident received an anticoagulant. Review of Resident #208's March 2021 and April 2021 MAR documented the resident received Clopidogrel. Per the CMS RAI Manual, Clopidogrel is an antiplatelet drug and should not be coded as an anticoagulant. 7) On 8/4/22 at 7:30 AM a review of Resident #251's December 2021 MAR documented the resident received the medication Clopidogrel Bisulfate Tablet every day. Review of Resident #251's admission MDS with an ARD of 12/21/21, Section N, Medications, documented Resident #251 received an anticoagulant. This was incorrect as Clopidogrel is not to be coded as an anticoagulant per the RAI Manual. 8) On 8/4/22 at 12:15 PM a review of Resident #28's medical record revealed a 5/9/22 at 11:51AM progress note that documented that Resident #28 complained that when he/she ate that the upper teeth that broke was sharp and hurt his/her gum. The Nurse Practitioner ordered a dental consult. Review of Resident #28's quarterly MDS with an ARD of 5/12/22, Section L 0200F, Mouth or facial pain, discomfort, or difficulty with chewing, failed to capture the resident's mouth pain. All MDS concerns were discussed with the DON on 8/9/22 at 11:20 AM. 43096 9) On 7/29/22 at 8:38 AM, a review of Resident #67's medical record revealed that the resident has resided at the facility for several years. Resident #67's psychiatry notes dated 7/17/19 indicated the resident had paranoid delusion (a symptom of Psychosis: it involves irrational thoughts and fears that one is being persecuted). However, Resident #67's MDS assessment section E. Behavior E100. B. Delusion has been coded no since 9/18/2019. 8/1/22 2:52 PM during an interview with the Director of Nursing (DON) reviewed Resident #67's medical record together and informed MDS coding was inaccurate. 42507 10) On 8/9/22 at 9:00 AM, review of Resident #311's MDS with an ARD of 4/6/21 was completed: Section J1800, any falls since admission, was coded, no. Under Section J1900, number of falls since admission or prior assessment: Nothing was checked under this section. This was inaccurate as the resident fell on [DATE] and 4/6/2021 while in the facility. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Under section M1040, other ulcers, wounds and skin problems, Z was checked for None of the above were present. This was inaccurate as the resident had a right hip skin tear noted on the admission skin sheet dated 4/1/2021. On 8/9/22 at 9:25 AM, review of progress notes revealed nurses change in condition notes dated 4/5/21 at 10:45 Resident was found on the floor lying beside her/his bed. On 4/6/21 at 21:34, change in condition notes documented altered mental status, concurrent falls without injury. On 8/9/22 at 11:29 AM, in an interview with the Director of Nursing (DON), s/he stated that the resident fell on [DATE] and was sent to the hospital. Review on 8/9/22 at 2:10 PM of Resident #311's hospital discharge summary under wound consult dated 3/31/21 revealed Pt has IAD (Incontinence- Associated Dermatitis) of the bilateral groin and right buttocks Pt also has a right hip skin tear that was covered . Blanchable redness identified bilateral elbows and heels. On 8/10/22 at 2:38 PM, in an interview with the MDS Coordinator #40, s/he confirmed that s/he did not capture the fall and/or skin tear on Resident #311's MDS. However, MDS Coordinator #40 stated that s/he has corrected the falls section on the MDS but not the skin section. On 8/11/22 at 4:15 PM, all concerns were addressed with the Administrator and the Director of Nursing prior and during the survey exit conference.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31145 Based on medical record review and interview with staff, it was determined the facility failed to timely provide medication to meet the needs of residents. This was evident for 1 (#251) of 1 resident reviewed for an unexpected death during the annual survey. The findings include: 1) Review of the medical record for Resident #251 on 8/4/22 at 7:30 AM revealed the resident was admitted to the facility on [DATE]. Review of Resident #251's December 2022 Medication Administration Record (MAR) documented the medications Daliresp Tablet 500 MCG (Roflumilast) for asthma, Colchicine Tablet for Gout, and Mucinex Tablet Extended Release 12 Hour 600 MG for cough were not available. The 3 medications were ordered on 12/15/21. The MAR documented that the Daliresp was not available on 12/16 and 12/17, the Colchicine was not available on 12/17, 12/18, and 12/19 and the Mucinex was not available on 12/16, 12/17, 12/18 and 12/19/21. On 8/4/22 at 3:32 PM the Director of Nursing (DON) was asked if the facility had issues getting medications from the pharmacy. She stated they switched the pharmacy vendor in January 2021. The DON stated, sometimes we have issues with pharmacy delivering the meds and if we do we call and they get the medication out.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43096 Based on observation, staff interviews, complaints from anonymous staff, and facility documentation review, it was determined that facility staff failed to maintain an effective pest control program, so the facility was free of pests. This practice had the potential to affect all residents, staff, and visitors. The findings include: During multiple observations in the facility building from 7/25/22 to 7/29/22, the surveyor observed dead bugs, crawling bugs, and flying bugs. -On 7/25/22 at 10:44 AM, a black, pinky nail-sized, smashed dead bug was found in front of room [ROOM NUMBER]. -On 7/25/22 at 7:49 AM, a dark brown, about 1.5 inches long, a smashed bug was found between room [ROOM NUMBER] and the medication room. -On 7/26/22 at 7:28 AM, a brown, pinky nail size dead bug was found on the 1st floor in front of the women's locker room. -On 7/26/22 at 8:39 AM, a dark brown, ring fingernail size, dead bug was found on the right side of the nursing office's director. -On 7/27/22 at 6:47 AM, a pinky finger size, brown dead bug was found in front of room [ROOM NUMBER] left side door. -On 7/27/22 at 8:36 AM, the surveyor observed a live bug, brown, about 2 inches long, moving toward room [ROOM NUMBER]. -On 7/28/22 at 1:46 AM, the surveyor observed a pinky nail size, brown live bug crawling between rooms [ROOM NUMBERS]. -On 7/29/22 at 7:23 AM, the surveyor observed a smashed dead bug, brown and about 3 inches long, in front of DON's office. -From 7/25/22 to 7/29/22, three dead flies were found behind the window blinds in the conference room. (continued on next page)

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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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/29/22 at 9:46 AM, an interview was conducted with the maintenance director (staff #11). Staff #11 stated that the facility had contracted a pest control company that visited the building twice a month. Staff #11 also explained that the pest control company did their regular interventions to prevent pest issues and follow up on the facility's concerns based on the pest control logbook. Any staff could write their concerns regarding pests, or Staff #11 could call the company for an extra visit. Staff #11 was asked whether the pest control company's visit or activities were tracked or not. The staff confirmed that there were no official documentation related to pest control company's interventions, recommendations, or report to the facility. On 7/29/22 at 9:10 AM, the surveyor investigated two complaints (MD00179186 and MD00166690). The complainants reported over ten cockroaches in and on patients on the first floor and brought this to the administrator's attention. The alleged event date was 2/21/22, and more than eight cockroaches scatter across the floor with the alleged date of May 2021. However, a review of the pest control log on 7/29/22 at 11:54 AM revealed that the contracted pest control company did not visit this facility around 2/21/22. The closest visit near the complaint submitted was on 3/2/22. During an interview with the Director of Nursing (DON) on 07/29/22 at 1: 50 PM, the surveyor informed the pest control program was ineffective. 31145 Several observations were made during the survey of insects in the facility. On 7/21/22 at 8:07 AM observed a live drain fly in the medication room on the first floor nursing unit. On 7/21/22 and 7/22/22 at 8:23 AM observed a gnat flying around the conference room. On 7/22/22 at 8:14 AM a fruit fly was observed flying outside of room [ROOM NUMBER]. On 7/27/22 at 10:15 AM observed a fly in the conference room. On 8/10/22 at 11:50 AM there were flies and gnats in the conference room, crawling on surveyor's drinks, papers, and computers.