STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215215	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Alice Manor	2095 Rockrose Avenue Baltimore, MD 21211

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 18819 Based on complaint, observation and staff interview, it was determined that the facility staff failed to provide maintenance and housekeeping services to maintain a safe, clean, comfortable and homelike environment for the residents. This was evident for the residents residing on the first floor of the facility during a complaint survey. The findings include: Review of complaint MD00202825 on 11/12/24 revealed an allegation that the facility was very unclean. Observations of the first floor dining and activity room on 11/12/24 at 9 AM revealed a painting and the activity calendar (July 2024) resting on the floor, orange colored buckets with fish aquarium equipment and construction tools and debris, the HVAC units (6) are observed with dust, cobwebs and debris located in the top grates were the heating and air conditioning would exit the unit, and 10 unpackaged brand new chairs stacked in the middle of the room. The large pane windows in the dining/activity room were noted with cobwebs, general dirt and leaves that block the view on the property. In an interview with the facility administrator on 11/13/24 at 7:40 AM, the administrator stated that the facility has added improvements to the first floor and had to move the fish tank closer to the nurse's station due to the construction in the activity/dinning area. The administrator also stated that the staff were getting ready to unpackaged the new chairs and place them in the activity/dining area for the residents. In an interview with EVS/staff member #7 on 11/13/24 at 7:50 AM, the surveyor observed staff member #7 wet moping the floor of the activity/dining room. The surveyor observed bolts and screws laying on the floor in the corner of the activity/dining room and brought this to the attention of staff member #7.

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 0600 Level of Harm - Minimal harm or potential for 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. 29673 Based on interview, record review, facility document review, and facility policy review, the facility failed to protect the residents' rights to be free from verbal abuse from staff and sexual abuse from another resident, which affected 3 (Residents #27, #28, and #39) of 15 residents reviewed for abuse. Specifically, Resident #37 sexually abused Resident #39, and Resident #27 and Resident #28 were verbally abused by a staff member. Findings included: A facility policy titled, Abuse, Neglect and Exploitation, reviewed 11/13/2023, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy revealed, 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. The policy revealed, 'Mental Abuse' includes but is not limited to humiliation, harassment, threats of punishment or deprivation. The policy also revealed, 'Sexual Abuse' is non-consensual sexual contact of any type with a resident. Per the policy, 'Verbal Abuse' means the use oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. 1. An Admission Record revealed the facility admitted Resident #39 on 07/25/2022. According to the Admission Record, the resident had a medical history that included unspecified dementia and delirium due to known physiological condition. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/29/2023, revealed Resident #39 had severe impairment in cognitive skills for daily decision-making and had long-term and short-term memory problems per a Staff Assessment of Mental Status (SAMS). The MDS revealed Resident #39 had fluctuating behaviors of inattention, disorganized thinking, and altered level of consciousness during the assessment period. Resident #39's Care Plan, included a focus area initiated 04/27/2022, that indicated that the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, immobility, and physical limitations. Interventions indicated that the resident needed assistance or an escort to activity functions. An Admission Record revealed the facility admitted Resident #37 on 04/29/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar type schizoaffective disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An annual MDS, with an ARD of 02/20/2023, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident did not exhibit any physical or verbal behavioral symptoms directed toward others during the assessment timeframe. The MDS indicated that the resident used a walker to aid in mobility. The MDS indicated that the resident received antipsychotic and antianxiety medication each day during the seven-day look-back period. Resident #37's Care Plan, included a focus area initiated 04/30/2022, that indicated the resident had an activity of daily living (ADL) self-care performance deficit related to confusion and impaired balance. The Care Plan included a focus area initiated 05/17/2022, that indicated that the resident had a behavior problem of rummaging through others' items and physical fighting with others, related to mental illness. Interventions directed staff to intervene as necessary to protect the rights and safety of others (initiated 07/29/2022) and to monitor the resident's behavior episodes and attempt to determine the cause (initiated 05/17/2022). Resident #37's Care Plan also included a focus area initiated 07/08/2022, that indicated the resident had the potential of being verbally inappropriate with poor impulse control with sexual verbalizations toward female residents and staff. Interventions directed staff to administer medications as ordered (initiated 07/08/2022); analyze the times of days, places, circumstances, triggers, and what de-escalated the resident's behavior (initiated 07/08/2022); provide physical and verbal cues to alleviate anxiety (initiated 07/08/2022); and allow the resident choices about care and activities (initiated 07/08/2022). Resident #37's Behavior Monitoring and Interventions Report for the timeframe from 09/04/2022 through 04/02/2023 reflected that staff did not document any behaviors. The report revealed staff did not document monitoring for each date in the timeframe and did not have any documented monitoring for 03/16/2023. Resident #37's General Nurses Note, dated 03/16/2023 at 9:00 PM, revealed that at 8:30 PM Resident #37 was noted to have an inappropriate behavior in the day room, where the resident exposed their genitals to another resident. A Comprehensive & Extended Care Facilities Self-Report Form, dated 03/16/2023, revealed that staff witnessed Resident #39 have their hands on Resident #37's genitals in the dining room. The document indicated that Resident #39 was fully dressed and in an adaptive ambulation device at the time of the incident. A Comprehensive & Extended Care Facilities Self-Report Form, dated 03/20/2023, revealed that after interviews with witnesses, Resident #37 did place Resident #39's hand on their (Resident #37's) genitals and the residents were immediately separated. A handwritten statement by Geriatric Nurse Aide (GNA) #31, dated 03/16/2023, indicated that she witnessed Resident #37 with their pants half-way down and Resident #37 using Resident #39's hand to touch their genitals. During an interview on 11/14/2024 at 10:15 AM, Director of Social Work #8 stated that she was told about the incident and then tried to talk to both residents, but neither was able to remember the situation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/2024 at 1:54 PM, the Business Office Manager stated that she remembered hearing GNA #31 yell for help from the dining room. The Business Office Manager stated that when she arrived at the dining room, she saw GNA #31 trying to keep Resident #37 and Resident #39 separated. She stated that she saw the two residents, and both were dressed. The Business Office Manager stated that GNA #31 then took Resident #39 to their room to be put to bed. During an interview on 11/19/2024 at 3:05 PM, GNA #31 stated that she did not remember everything, but she did remember Resident #37 had their pants down and was holding Resident #39's hand on their (Resident #37's) genitals and telling the resident to perform a sexual act. GNA #31 stated that the residents were immediately separated, and Resident #39 was taken to their room and put to bed. She stated that Resident #39 was sent to the hospital to be examined but was fully clothed when staff discovered them. During an interview on 11/20/2024 at 11:41 AM, the Administrator stated that he did not have the clinical background to determine the level of supervision needed for Resident #37. 36105 2. An Admission Record revealed the facility admitted Resident #28 on 10/23/2018. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder bipolar type, adjustment disorder with mixed anxiety and depressed mood, hemiplegia (paralysis) and hemiparesis (partial weakness) following cerebral infarction (stroke) affecting the right dominant side, and anxiety disorder. Resident #28's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had a mood interview score of 11, which indicated moderate depression. The MDS revealed Resident #28 had verbal behavioral symptoms directed toward others that occurred one to three days during assessment look-back period. The MDS revealed the resident rejected care one to three days during the assessment look-back period. Resident #28's care plan revealed a focus area initiated 01/24/2020 for the potential for verbally aggressive/antagonistic behavior toward peers, roommates, and staff related to impaired cognition, adjustment/schizoaffective disorder, and post-traumatic stress disorder. Interventions (initiated 01/27/2020) directed staff to explain constructive ways of expressing anger, help the resident express feelings of anger, listen attentively to the resident's expression of feelings, and provide an environment with minimum stimuli when possible. A facility Comprehensive & Extended Care Facilities Self-Report Form, dated 09/27/2022 at 11:00 AM, revealed during the evening shift on 09/26/2022, Licensed Practical Nurse (LPN) #37 told Resident #28 to Shut up and stop talking. Per the report, Resident #28 then told LPN #37 to Get the [expletive] out of my room before I [expletive] you up. The report revealed LPN #37 replied, No, you won't. I will [expletive] you up and left the room. According to the report, Resident #28 stated they felt safe and agreed to routine meetings with social services but declined to meet with psychiatric services. According to the report Geriatric Nursing Assistant (GNA) #36 witnessed the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated handwritten statement signed by GNA #36 revealed that GNA #36 overheard LPN #37 tell Resident #28 to Shut up. Stop talking. According to the statement, Resident #28 told LPN #37 to Get the [expletive] out of [their] room before [the resident] [expletive] her up. The statement revealed that LPN #37 replied, No I will [expletive] you up. An undated handwritten statement signed by Director of Social Work #8 revealed that on 09/27/2022, she met with Resident #28, who stated they felt threatened when LPN #37 said they needed to do what they were told or LPN #37 knew how to get back at [the resident]. Resident #28's social service Progress Notes dated 09/27/2022 at 1:25 PM, revealed Director of Social Work #8 met with the resident regarding the alleged situation with the staff person and provided one-to-one psychosocial wellbeing support and assistance. The notes revealed Director of Social Work #8 reassured the resident that they would be safe. According to the notes, Resident #28 stated that they felt safe and wanted to remain at the facility. During an interview on 11/14/2024 at 10:16 AM, Resident #28 (who had a BIMS of 13, which indicated intact cognition per a quarterly MDS with an ARD date of 08/26/2024) stated they remembered the incident. Resident #28 stated the nurse was very rude and thought the nurse swore at them. Resident #28 stated they never saw the nurse again. The facility's Comprehensive & Extended Care Facilities Self-Report Form, dated 09/27/2022, revealed that while staff were interviewing other residents in LPN #37's assigned group, Resident #27 (Resident #28's roommate) reported that LPN #37 had told Resident #27 to shut up and mind your own business on 09/06/2022. An Admission Record indicated the facility admitted Resident #27 on 11/23/2021. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder and low back pain. A quarterly MDS, with an ARD of 08/30/2022, revealed Resident #27 had a BIMS score of 15, which indicated the resident had intact cognition. Per the MDS, Resident #27 had no behavioral symptoms during the assessment look-back period. Resident #27's care plan included a focus area initiated 11/24/2021, that indicated the resident had a mood problem related to anxiety. Interventions (initiated 11/24/2021) directed staff to provide behavioral health consults as needed; monitor/document/report any risk for self-harm; and monitor/record/report any risk for harming others, including feeling threatened by others. A handwritten statement dated 09/26/2022 signed by GNA #36 revealed that LPN 37 was standing at a cart when Resident #27 called out to her. The statement revealed LPN #37 said what do you want I'm busy put your callight [sic] on. The statement revealed that when GNA #36 answered the call light Resident #27 stated why is she so mean I just wanted my pain medicine. An undated handwritten statement signed by Director of Social Work #8 revealed that on 09/27/2022, she interviewed Resident #27, who stated they were attempting to assist Resident #28, and LPN #37 told Resident #27 to Shut up and mind [their] own business. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27's social service Progress Notes dated 09/28/2022 at 8:56 AM, revealed Director of Social Work #8 provided one-to-one psychosocial wellbeing support and assistance due to a nurse making a negative statement. The notes revealed that after spending some time with Resident #27 and reassuring the resident that the nurse had been removed from the resident's care and treatment, Resident #27 stated they felt better knowing that LPN #37 was not coming back. Resident #27's Psychological Services Supportive Care Progress Note, dated 09/27/2022, revealed the resident reported having an issue with one of the staff. Per the note, the resident was oriented but somewhat guarded; however, the resident explained an incident regarding their roommate with one of the nursing staff. The report revealed the resident stated their roommate looked uncomfortable in their bed and Resident #27 told the staff member. The staff member replied and told Resident #27 to shut up. The note revealed the provider would follow up with the facility's social worker regarding the resident's concerns. The note revealed that in addition, supportive therapy would be provided one to five times monthly to discuss coping skills and psychoeducation. During an interview on 11/18/2024 at 9:02 AM, GNA #36 stated she was at the desk and could hear LPN #37 talking to Resident #28 and Resident #27 because their rooms were close to the desk. GNA #36 stated that she reported the allegation to Assistant Director of Nursing (ADON) #3. During a follow-up interview on 12/11/2024 at 9:03 AM, GNA #36 stated she remembered the incident but could not remember if ADON #3 arrived at the facility before she left her shift (at 10:00 PM). GNA #36 stated she could not remember if LPN #37 was still working when she left at the end of her shift. During an interview on 11/18/2024 at 3:02 PM, Former Director of Nursing (DON) #16 stated GNA #36 witnessed the incident, and the facility substantiated the allegation and subsequently determined that LPN #37 could not return to the facility. Per Former DON #16, after the incident, Resident #27 and Resident #28 were not afraid and were happy that LPN #37 was not taking care of them anymore. During an interview on 11/20/2024 at 12:38 PM, the Administrator stated the allegation was substantiated, and they contacted the board of nursing. Per the Administrator, he could not remember the details.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36105 Based on record review, interview, and facility document and policy review, the facility failed to report an allegation of abuse to the State Survey Agency immediately, but not later than two hours after an incident occurred for 4 (Residents #28, #37, #39, and #41) of 15 residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect, and Exploitation, reviewed 11/13/2023, revealed, VII. Reporting/Response. A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. [exempli gratia, for example], law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. 1. An Admission Record revealed the facility admitted Resident #28 on 10/23/2018. According to the Admission Record, the resident had a medical history that included diagnoses of schizoaffective disorder bipolar type, adjustment disorder with mixed anxiety and depressed mood, hemiplegia (paralysis) and hemiparesis (partial weakness) following cerebral infarction (stroke) affecting the right dominant side, and anxiety disorder. Resident #28's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/07/2022, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had a mood interview score of 11, which indicated moderate depression. The MDS revealed Resident #28 had verbal behavioral symptoms directed toward others that occurred one to three days during assessment look-back period. The MDS revealed the resident rejected care one to three days during the assessment look-back period. A facility Comprehensive & Extended Care Facilities Self-Report Form, dated 09/27/2022 at 11:00 AM, revealed during the evening shift on 09/26/2022, Licensed Practical Nurse (LPN) #37 told Resident #28 to Shut up and stop talking. Per the report, Resident #28 then told LPN #37 to Get the [expletive] out of my room before I [expletive] you up. The report revealed LPN #37 replied, No, you won't. I will [expletive] you up and left the room. According to the report Geriatric Nursing Assistant (GNA) #36 witnessed the incident. An email dated 09/27/2022, indicated Assistant Director of Nursing (ADON) #3 notified the State Survey Agency of the abuse allegation on 09/27/2022 at 1:23 PM, the day after the incident occurred. An undated handwritten statement signed by GNA #36 revealed that GNA #36 overheard LPN #37 tell Resident #28 to Shut up. Stop talking. According to the statement, Resident #28 told LPN #37 to Get the [expletive] out of [their] room before [the resident] [expletive] her up. The statement revealed that LPN #37 replied, No I will [expletive] you up. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/18/2024 at 9:02 AM, GNA #36 stated she was at a desk and could hear LPN #37 talking to Resident #28 because their room was close to the desk. GNA #36 stated that she reported the allegation to Assistant Director of Nursing (ADON) #3. During a follow-up interview on 12/11/2024 at 9:03 AM, GNA #36 stated she went upstairs to report the allegation to a nurse (on 09/26/2022), noting that she could not remember to which nurse she reported it to. GNA #36 stated she then went downstairs and called ADON #3. She stated it was close to the end of the shift and ADON #3 stated she would take care of it. GNA #36 stated she could not recall if ADON #3 came into the building before she left at the end of her shift (on 09/26/2022). She stated she could not remember if LPN #37 was still there when she left. GNA #36 stated the Administrator asked her to write out a statement the next day. During an interview on 12/13/2024 at 2:37 PM, ADON #3 stated she did not work at the facility any longer and could not remember the incident. She stated when an allegation was reported she began an investigation and had two hours to report the allegation to the State Survey Agency. She stated she did not have any memory of the incident or the report and stated if it was submitted late, she had no memory of why that happened. During an interview on 12/11/2024 at 10:45 AM, the Administrator stated that based on documentation, he did not think he was informed of the allegation until the following day (09/27/2022). During an interview on 12/13/2024 at 2:22 PM, the Administrator stated he expected abuse allegations to be reported to the State Survey Agency within two hours. The Administrator stated this case was late. The Administrator stated if the incident was reported to a nurse, the nurse should have immediately stopped and investigated the situation and notified management because once management was aware, they reported the allegation. 45555 2. An Admission Record indicated the facility admitted Resident #41 on 07/16/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of schizophrenia. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/25/2022, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #41's care plan included a focus area initiated 03/14/2022, that indicated the resident had a behavior problem related to schizophrenia and the resident perceived that staff mistreated them. Interventions (initiated 03/14/2022) directed staff to minimize the potential for the resident's allegations, offer tasks which diverted attention, monitor behavior episodes and attempt to determine the underlying cause, and praise any indication of the resident's progress/improvement in the behavior. A Comprehensive & Extended Care Facilities Self-Report Form dated 03/09/2022 at 5:10 PM indicated Resident #41 alleged that on 03/08/2022 at 10:00 PM, a man kicked them in the back. Further review revealed that the resident stated that they mixed up their days and the incident occurred on 03/05/2022 and not on 03/08/2022. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An undated handwritten statement signed by Certified Medicine Aide (CMA) #23 revealed that on 03/05/2022, while administering Resident #41's medications, the resident stated their Geriatric Nurse Aide (GNA) had put his knee in the resident's back. Email correspondence from the Administrator to the State Survey Agency (SSA) revealed the facility submitted an initial report of abuse regarding the incident to the SSA on 03/09/2022 at 5:43 PM, four days after Resident #41 told CMA #23 about the incident. During an interview on 12/13/2024 at 8:56 AM, CMA #23 stated she did not feel that the situation was necessarily abuse so she did not report it but stated she probably should have. During an interview on 12/13/2024 at 11:50 AM, Former Director of Nurses (DON) #16 stated the CMA should have reported Resident #41's concern and let the abuse coordinator deal with the specifics. During an interview on 12/13/2024 at 1:35 PM, the Administrator stated that once abuse was identified, either alleged or witnessed, it should be reported within two hours. The Administrator revealed that after CMA #23 received the complaint from Resident #41, the incident should have been reported to him to investigate as an allegation of abuse. 3. An Admission Record indicated the facility admitted Resident #37 on 04/29/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar type schizoaffective disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2023, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Resident #37's Care Plan, included a focus area initiated on 05/17/2022, that indicated the resident had a behavior problem related to inappropriate sexual interaction with a peer. Interventions instructed staff to provide an opportunity for positive interaction and attention; stop and talk with the resident as passing by; monitor behavior episodes and attempt to determine underlying cause, considering location, time of day, persons involved, and situation; document behavior and potential causes, and praise any indication of the resident's progress/improvement in behavior. An Admission Record revealed the facility admitted Resident #39 on 07/25/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified dementia. A significant change in status MDS, with an ARD of 03/29/2023, revealed Resident #39 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). Resident #39's Care Plan, included a focus area initiated 03/17/2023, that indicated the resident had a psychosocial well-being problem related to an alleged inappropriate sexual issue. Interventions instructed staff to initiate referrals as needed or increase social relationships, monitor and document the resident's feelings, monitor and document the resident's usual response to problems, and provide opportunities for the resident and family to participate in care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Comprehensive & Extended Care Facilities Self-Report Form, dated 3/16/2023 at 9:00 PM, revealed the nursing staff witnessed Resident #37 in the dining room with Resident #39's hands on their genital area. The report indicated the residents were separated and assessed. An undated handwritten witness statement by Geriatric Nurse Aide (GNA) #12 revealed that on 03/16/2023 at 8:30 PM she witnessed the incident between Resident #37 and Resident #39. A handwritten witness statement dated 03/16/2023 by GNA #31 revealed that at around 8:30 PM she witnessed the incident between Resident #37 and Resident #39. Email correspondence from the Administrator to the State Survey Agency (SSA) revealed the facility submitted an initial report of abuse to the SSA on 03/16/2023 at 10:58 PM, over two hours after the abuse incident was observed. During an interview on 12/13/2024 at 1:35 PM, the Administrator stated that once abuse was identified, either alleged or witnessed, it should be reported to the SSA within two hours. After reviewing the investigation between Resident #39 and Resident #37, the Administrator stated if the witness statement indicated the incident occurred at 8:30 PM, then that should be the time on the report. He stated if the incident occurred at 8:30 PM then it should have been submitted to the state by 10:30 PM, and he agreed the report was not submitted timely. 4. An Admission Record indicated the facility admitted Resident #37 on 04/29/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of bipolar type schizoaffective disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2023, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. Resident #37's Care Plan, included a focus area initiated on 05/17/2022, that indicated the resident was resistive to care including laboratory tests, tests, immunizations, showers, and medications related to mental health issues. Interventions (initiated 05/17//2022) directed staff to encourage as much participation/interaction by the resident as possible during care activities; give the resident clear explanation of all activities prior to and as they occur during each contact; if the resident resisted care, reassure the resident, leave, and return five to ten minutes later and try again; and provide the resident opportunities for choice during care provision. A Comprehensive & Extended Care Facilities Self-Report Form, dated 12/18/2022 at 8:00 PM, revealed that on 12/17/2022, a nurse reported that a Certified Medicine Aide (CMA) allegedly made a comment to Resident #37 that they were going to have another resident beat them up. Per the report, Registered Nurse (RN) #21 witnessed the incident. Email correspondence from Former Director of Nursing (DON) #16 to the State Survey Agency (SSA) revealed the facility submitted an initial report regarding the allegation to the SSA on 12/18/2022 at 8:59 PM, over 24 hours after the allegation was made. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 12/10/2024 at 2:24 PM, RN #21 stated that on the day in question, he was sitting at the desk and the CMA was trying to give Resident #37 their medications. RN #21 stated the resident did not want the medication and the CMA told the resident she was going to get another resident to beat them up. RN #21 stated that the resident then spit on the CMA. He stated he reported the CMA's comment to the DON and the supervisor on duty, Licensed Practical Nurse (LPN) #15. He stated any abuse situation/allegation should be reported immediately to the supervisor, the DON, and the Administrator. He stated he thought they had two hours to report it to the SSA. During an interview on 12/13/2024 at 11:50 AM, Former DON #16 stated once an allegation was reported it should be reported to the SSA within two hours. She stated she remembered the allegation was reported on a Sunday but could not say why it was reported to the SSA late. During an interview on 12/13/2024 at 1:35 PM, the Administrator stated that once abuse was identified, either alleged or witnessed, it should be reported to the SSA within two hours. After reviewing the investigation involving Resident #37 and the CMA, the Administrator stated the report was not submitted within the required timeframe but was unable to explain why it was not reported timely.

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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** 29673 10. Resident #41 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 03/09/2022, revealed Resident #41 reported that on 03/08/2022 at 10:00 PM, they were kicked in the back. It was determined Geriatric Nurse Aide (GNA) #22 fit the description given by the resident of the accused staff. The resident later changed their statement to say the incident happened on 03/05/2022, and the aide pushed his knee into the resident's back. The facility's investigative file did not contain any interviews with other residents to determine the extent of the alleged abuse by GNA #22, and no information was provided on the resident census at the time or the mental status assessments of the residents on GNA #22's hall at the time of the incident. During an interview on 11/10/2024 at 11:59 AM, the Administrator stated he did not see any resident interviews for this incident other than the resident making allegations. 11. Resident #41 and Resident #40 A Comprehensive & Extended Care Facilities Self-Report Form, dated 08/17/2022, revealed Resident #41 reported that on 08/17/2022 at 3:00 AM, their roommate, Resident #40, hit them in the back while they were lying in bed. Review of a written statement dated 08/17/2022 by Geriatric Nurse Aide (GNA) #34 revealed staff heard a noise overnight from the room shared by Resident #40 and Resident #41 and rushed to the room, finding Resident #40 and their chair on the floor. The facility's investigative file did not contain any interviews with other residents to determine the extent of the alleged abuse by Resident #40, and no information was provided on the resident census or mental status assessments of the residents who resided on the same hall at the time of the incident. During an interview on 11/10/2024 at 11:50 AM, the Administrator stated that any residents in the area who were interviewable should have been interviewed, but he was unable to find any resident interviews other than the residents involved. 12. Resident #38 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 08/30/2022, revealed that a family member of Resident #38 reported an injury of unknown origin to the facility on [DATE] that was seen on 08/25/2022. The resident had a scrape to the back of their left hand. The injury was reported to be a dime-size scrape on the back of the hand that was mostly healed. Staff were unable to determine how the injury happened. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's investigative file did not contain any interviews with other residents, and no information was provided on the resident census or mental status assessments of the residents on the same hall at the time of the incident. During an interview on 11/10/2024 at 11:50 AM, the Administrator stated during a psychological evaluation, Resident #38 reported there was no fight. The resident had reported to family that the scrape on their hand came from a fight. The Administrator stated there were no other residents interviewed for this incident. 13. Resident #37 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 12/18/2022, revealed that on 12/17/2022 Registered Nurse (RN) #21 accused a certified medication aide of threatening Resident #37 by telling them that another resident was going to beat the resident up. The facility's investigative file did not contain any interviews with other residents to determine the extent of the alleged verbal abuse by CMA #30, and no information was provided on the resident census at the time or mental status assessments of the residents who resided on the same hall at the time of the incident. During an interview on 11/10/2024 at 11:32 AM, the Administrator stated the process would be to interview all staff on that schedule and any residents who may have witnessed the incident. The goal was to see if the incident happened. There was an undated note that someone interviewed four residents but it was not known who did the interviews or when they were done. 14. Resident #39 and Resident #37 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 03/16/2023, revealed staff witnessed Resident #39 with their hands on the genitals of Resident #37 in the dining room. Resident #39 was fully dressed in a Merry [NAME] (a type of adaptive equipment that combines a walker and a wheelchair) at the time of the incident. The facility's investigative file did not contain any interviews with other residents to determine the extent of the alleged abuse by Resident #37, and no information was provided on the resident census at the time or mental status assessments of the residents on the same hall at the time of the incident. During an interview on 11/10/2024 at 11:41 AM, the Administrator stated other residents and staff should be interviewed to see if the resident had been inappropriate with any other residents. 15. Resident #36 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 09/05/2023, indicated that Resident #36 reported to a rehabilitation team member that on 09/04/2023 between 6:00 PM and 7:00 PM, a member of the nursing team came into their room, pulled the call bell away, and told the resident to stop pushing the call bell. Per the form, the resident then pushed the call light again to get assistance to the administrative offices, and the staff member told the resident they would not help them, at which point Resident #36 attempted to transfer to their wheelchair, and the staff member allegedly pulled the wheelchair out from under the resident, resulting in a fall. The staff member then allegedly picked the resident up off the floor and threw them onto the bed and took their call light away. Per the form, the resident described the staff member as being a little taller and heavier than [the resident] with short hair and no glasses. In addition, the report indicated Resident #36 requested medications but was told the staff member had no medications to give them because there was no record of the patient. The form did not list the name of an alleged perpetrator. A Comprehensive & Extended Care Facilities Self-Report Form, dated 09/09/2023, revealed the facility updated the form to reflect their investigative findings. The form indicated the facility interviewed Resident #36's roommate, who reported they saw Resident #36 fall while attempting to transfer to their wheelchair, and an unnamed staff member came in and picked the resident up and put them back into bed. Resident #36's roommate reported Resident #36 was argumentative, combative, and resistant to help from the staff member who came to assist them. The resident's roommate also indicated the staff member did not say or do anything inappropriate while in the room. The form indicated the roommate could not provide the staff member's name that assisted the resident off the floor but was able to say the staff member had finger waves. The form indicated that during the facility's investigation, the facility determined Licensed Practical Nurse (LPN) #19 had finger waves. Per the form, LPN #19 denied all the allegations made by Resident #36 but said the resident requested eye drops multiple times throughout the night, but their eye drops were not scheduled to be given until the morning. LPN #19 indicated they relayed that information to the resident each time they asked for their eye drops. A Resident Safe Survey, dated 09/05/2023, revealed the facility interviewed LPN #19 regarding Resident #36's allegations. The Resident Safe Survey indicated LPN #19 confirmed she worked with the resident on 09/04/2023 and 09/05/2023. LPN #19 indicated the resident had not reported any incidents or falls to the LPN but had requested their eye drops. The facility's investigative file did not contain documentation of the interview conducted with Resident #36's roommate, nor did it contain documentation of interviews with other residents that resided in the same area of the facility or were cared for by LPN #19. No information was provided on the resident census at the time of the allegation or the mental status assessments of the residents on LPN #19's hall at the time of the incident. There was also no documentation of assessments of residents who were unable to answer questions about the alleged incident. During an interview on 11/10/2024 at 11:46 AM, the Administrator stated that during the investigation, staff and interviewable residents should have been interviewed. He said he did not see any resident interviews in the investigation packet. 36105 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, record review, and facility document and policy review, the facility failed to provide evidence they thoroughly investigated 15 of 20 facility-reported incidents reviewed by the survey team, involving 14 (Residents #9, #27, #28, #29, #30, #31, #32, #33, #34, #36, #37, #39, #40, and #41) of 15 sampled residents reviewed for abuse and 1 (Resident #38) of 1 sampled resident reviewed for an injury of unknown origin. Findings included: A facility policy titled, Abuse, Neglect, and Exploitation, dated 11/13/2023, indicated, 'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. The policy specified, V. Investigation of Alleged Abuse, Neglect and Exploitation. A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. [exempli gratia, for example], not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. 1. Resident #27 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 03/22/2022, revealed Resident #27 reported the night shift nurse called the resident a dog and wished the resident would fall from the bed and be sent to the hospital so the nurse would not have to deal with the resident. The facility's investigative file indicated the facility identified the accused night shift nurse as Registered Nurse (RN) #38. The facility's investigative file did not contain any interviews with other residents to determine the extent of the alleged abuse by RN #38, and no information was provided in the facility's investigative file on the resident census at that time of the allegation or the mental status of the residents that resided on RN #38's assigned hall. During an interview on 11/20/2024 at 11:28 AM, the Administrator stated there were roughly eight rooms, possibly 16 residents on the hall, but he did not know if any of them were cognitively intact enough to be interviewed during the investigation. 2. Resident #28 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 11/24/2022, revealed Resident #28 reported that the previous night the supervisor hit the resident's leg and caused a discoloration. The facility's investigative file indicated the facility identified the accused night shift supervisor as Nursing Supervisor (NS) #47. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's investigative file revealed there were no statements, aside from one from NS #47, who denied the allegation. The investigation contained no additional staff interviews, no resident interviews with cognitively intact residents, and no physical assessments of cognitively impaired residents. During an interview on 11/20/2024 at 11:20 AM, the Administrator stated for physical abuse allegations, his initial response looking at the abuse allegations was that there should be resident interviews and at times physical assessments of cognitively impaired residents. During a follow-up interview on 11/20/2024 at 12:34 PM, the Administrator stated there should have been more staff interviews and resident interviews related to the incident. 3. Resident #28 and Resident #27 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 09/27/2022, revealed Resident #28 reported on the previous day during evening shift on 09/26/2022 that a nurse told the resident to shut up and stop talking, and the resident felt threatened. the facility's investigative file indicated the facility identified as the accused nurse as Licensed Practical Nurse (LPN) #36. Further review of the facility's self-report form revealed that during the facility's investigation, an interview with Resident #27, the resident stated LPN #36 told them to shut up and mind your business. A witness statement included in the investigative file written by Director of Social Work (DSW) #8reflected that only one interview with an additional resident was conducted during the facility's investigation. There were no additional interviews with residents who resided on the hall assigned to LPN #36 to determine the extent of alleged abuse. During an interview on 11/20/2024 at 12:38 PM, the Administrator stated he could not remember the incident but his first inclination would be to have a few more statements from other residents about LPN #36. 4. Resident #29 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 05/23/2023, revealed Resident #29 reported a woman entered their room to get them up for dinner, hit them across the face, and told them to go back to the country they were from. The facility's investigative file revealed four staff interviews were obtained, and no resident interviews were obtained to determine the extent of the alleged abuse. No physical assessments were recorded for Resident #29 on that day, and no physical assessments were conducted on residents who were cognitively impaired. During an interview on 11/20/2024 at 12:25 PM, the Administrator stated that after a reported allegation of physical abuse, there should be a skin assessment completed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #30 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 06/16/2022, revealed Resident #30 reported that a year prior, a male staff member made a sexual gesture toward the resident. A written statement from Director of Social Work (DSW) #8, dated 06/16/2022, revealed that several residents were interviewed regarding any male staff member's ill treatment; however, the written statement did not identify which residents were interviewed. During an interview on 11/20/2024 at 11:38 AM, the Administrator stated that when there was a specific incident, the first thing he wanted was to determine what happened. He stated they would not be able to determine if a staff member may have done something until they interviewed other staff and residents. 6. Resident #31 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 02/04/2022, revealed Resident #31 reported that a geriatric nursing assistant (GNA) told the resident to shut up and banged the resident's hand on the bed railing. The facility's investigative file revealed no interviews with other cognitively intact residents were conducted and no skin assessments of cognitively impaired residents were performed to determine the extent of the GNA's alleged abuse. During an interview on 11/20/2024 at 12:22 PM, the Administrator stated the facility generally did not conduct skin assessments on other residents on a hall or unit during an investigation, unless there was something to warrant it. He stated for physical abuse allegations, there should be at least resident interviews and, at times, physical assessments of cognitively impaired residents. 7. Resident #32 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 09/20/2021, revealed Resident #32 reported Geriatric Nursing Assistant (GNA) #34 plucked the resident's lip the previous week, yelled at and threatened them, turned the resident when they had four falls, and pulled out the resident's indwelling urinary catheter, causing 12 days of bleeding. The facility's investigative file revealed no interviews with other cognitively intact residents were conducted and no skin assessments of cognitively impaired residents were performed to determine the extent of the GNA's alleged abuse. During an interview on 11/20/2024 at 12:22 PM, the Administrator stated the facility generally did not conduct skin assessments on other residents on a hall or unit during an investigation, unless there was something to warrant it. He stated for physical abuse allegations, there should be at least resident interviews and, at times, physical assessments of cognitively impaired residents. During a follow-up interview on 11/20/2024 at 12:45 PM, the Administrator stated that at least Resident #32's roommate should have been interviewed during the facility's investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Resident #33 and Resident #9 A Facility Reported Incident Initial Report Form, dated 02/21/2024, revealed Resident #33 and Resident #9 were found by staff in Resident #33's room, where Resident #33 was naked and Resident #9 was partially undressed. Review of the investigation's Summary of interview(s) with other residents who may have had contact with the alleged perpetrator revealed the facility indicated, No other resident was interviewed due to [Resident #33's] belief that [Resident #9] was [their] fiance. The facility's investigative file revealed no interviews with cognitively intact residents were conducted and no skin assessments of cognitively impaired residents were performed to determine the extent of the alleged/suspected abuse. During an interview on 11/20/2024 at 11:38 AM, the Administrator stated that when there was a specific incident, the first thing he wanted was to determine what happened. He stated they generally interviewed the staff to see if they heard or saw something. 9. Resident #34 A Comprehensive & [and] Extended Care Facilities Self-Report Form, dated 07/06/2022, revealed Resident #34's family member called the facility to report another person told them that Resident #34 was beat up and had a black eye. The facility's investigative file revealed no staff interviews, no interviews with cognitively intact residents, and no physical assessments of cognitively impaired residents to determine the extent of the alleged abuse. During an interview on 11/20/2024 at 8:15 AM, the Administrator stated they initiated an investigation in the case because a family member made the allegation, and when a family member alleged something, they would make sure it was investigated. The Administrator stated generally if there were allegations of physical abuse, they would interview other residents. In this case, the interviews were not done because the facility did a skin assessment and Resident #34 had no problems, and the family member realized the allegation did not happen.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37276 Based on medical record review and staff interview, it was determined the facility failed to notify the resident's representative(s) in writing of the reason for transfer or discharge, along with the required notification information, in a language and manner they understand and document that notification in the medical record. This was evident for 1 (#18) of 23 residents reviewed for complaints. The findings include: On 11/13/24 at 11:45 AM, a review of Complaint #MD00210696 was conducted. In the complaint, the complainant reported that s/he was not notified when Resident #18 was transferred and admitted to the hospital. On 11/14/2024 at 10:32 AM, a review of Resident #18's medical record revealed the resident was admitted to the facility in September 2022, and, in October 2024, Resident #18 was transferred to the hospital. There was no evidence in the clinical record that the facility staff had provided the resident's representative with written notification of the transfer at the time of transfer or as soon as practicable after the date of transfer out of the facility to the acute care setting. On 11/14/24 at 11:14 AM, an interview about the facility's notice of transfer process was conducted with the Nursing Home Administrator (NHA) and Director of Nurses (DON). At that time, the NHA indicated the Admissions department was responsible for sending the transfer notification, along with the bed hold policy to the Resident's Representative by mail or by email and document that it was sent in the resident's medical record. The NHA and DON were made aware of the concern that no documentation was found in Resident #18's medical record to indicate the resident's representative was notified in writing of the resident's transfer to the hospital. On 11/14/24 at 12:04 PM, , the NHA reported to the surveyor, that following a resident's transfer to the hospital, the facility's admissions department sends a copy of page of the resident's change in condition documentation which included a summary of the change in condition. At that time, the NHA was made aware of the guidance with written notification of transfer includes required information, and the and the Summary of the Change in Condition, did not include the required notification information. The NHA acknowledges the concerns, and no further comments were offered.

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Autumn Lake Healthcare at Alice Manor	2095 Rockrose Avenue Baltimore, MD 21211

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on medical record review and staff interview it was determined that the facility staff failed to code the resident's status accurately on the Minimum Data Set (MDS) assessment (Resident #8). This was true for 1 of 20 resident complaints reviewed during a complaint survey. The findings include: The facility staff failed to accurately document a residents' medication status on an admission MDS for Resident #8. The MDS is a federally mandated assessment tool that helps nursing home staff members 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. A review of Resident #8's closed medical record on 11/13/24 at 10 AM revealed that an admission MDS was completed on 05/29/23. The MDS coded the resident under Section M0210 (unhealed pressure ulcers) as yes. However, a review of the nursing and physician assessments did not reveal Resident #8 had any healing or non-healed pressure wounds upon admission to the facility on [DATE]. In an interview with the facility MDS Coordinator (staff # 42) on 11/18/24 at 12:10 PM, the MDS coordinator confirmed the admission MDS was coded incorrectly regarding Resident #8 having pressure wounds.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 18819 Based on reviews of a complaint, a closed medical record and staff interview, it was determined that the facility staff failed to initiate a care plan for a resident with a history of substance abuse disorder. This was evident for 1 (Resident #24) of 20 residents reviewed during a complaint survey. The findings include: Review of complaint MD00203494 on 11/19/2024 revealed allegation that Resident #16 was sent to the hospital on 03/09/2024 with a change in condition. While Resident #16 was being evaluated in the emergency room , Resident #16 was identified as have received Methadone. Methadone is administered to treat moderate to severe pain. Methadone can also treat narcotic drug addiction. Resident #16 was a roommate to Resident #24 in March 2024. Review of Resident #24's closed medical record on 11/19/24 at 11 AM revealed diagnoses including a cerebrovascular accident, seizures, alcohol dependence and substance abuse disorder. Resident #24 was receiving the medication Methadone for substance abuse disorder. Upon Resident #24's admission to the facility in February 2024, the nursing staff implemented care plans for seizure disorder, potential for malnutrition and dehydration, being dependent on staff for all care, having a self-care deficit, and being a fall risk. In an interview with the former director of nurses on 11/18/24 at 3:24 PM, the former director confirmed that Resident #24 was receiving the medication Methadone for addiction, not pain management. Resident #24 was being administered Methadone upon admission to the facility. This concern was reviewed with the facility Administrator and DON during exit conference on 11/20/24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on compliant, reviews of a closed clinical record and administrative records, and staff interviews, it was determined that the facility failed to ensure that a resident received services to promote healing of a surgical wound. This was found evident in 1 (Resident #14) out of 2 Residents reviewed for wound care during a complaint survey. The finding include: A wound vacuum, also known as a vacuum-assisted closure (VAC) or negative-pressure wound therapy, is a medical device that uses suction to help wounds heal. Review of complaint MD00202563 on 11/12/24 at 11 AM revealed an allegation that Resident #14 was admitted to the facility on [DATE] with an abdominal surgical wound that was to have a wound-vac applied upon admission. The wound-vac was not applied on 01/03/24. Review of Resident #14's closed medical record on 11/12/24 revealed a nursing note, dated 01/04/24 at 10:30 PM indicating Resident #14 called 911 to be transported back to the hospital because the facility had not obtained a wound-vac and the supplies necessary to apply the wound-vac to Resident #14's surgical abdominal wound. Resident #14 was readmitted to the facility on [DATE]. Reviews of Resident #14's January 2024 medication and treatment administration records revealed the nursing staff first applied the wound-vac to Resident #14's surgical abdominal wound on 01/08/24. The staff documented applying a rescue dressing to Resident #14's wound until the wound-vac and supplies had arrived to the facility. In an interview with the facility director of nurses (DON) on 11/12/24 at 1 PM, the DON confirmed the facility had not obtained the wound-vac prior to Resident #14's admission to the facility. Resident #14's wound-vac was not applied until 01/08/24.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 18819 Based on compliant, reviews of a closed clinical record and administrative records, and staff interviews, it was determined that the facility failed to ensure that a resident received services to promote healing of a pressure ulcer. This was found evident in 1 (Resident #6) out of 2 Residents reviewed for pressure ulcers during a complaint survey. The finding include: A pressure ulcer (also known as pressure sore or decubitus ulcer) is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according to their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister, or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), and Stage IV (full thickness skin loss with extensive damage to muscle, bone, or tendon). Review of complaint MD00188407 on 11/12/24 at 11 AM revealed an allegation that Resident #6 developed bed sores on his/her buttock area. A review of Resident #6's closed clinical record on 11/12/24 revealed that on 01/24/23 at 6:46 PM, Licensed Practical Nurse (LPN) #15 documented a weekly skin evaluation that indicated Resident #6 was observed with a skin issue on the sacral area. There were no description or measurements of the sacrum wound. LPN #15 did not indicate Resident #6 refused or declined the skin assessment. A review of Resident #6 physicians orders revealed that on 01/27/23 at 2:50 PM, Resident #6's attending physician gave orders instructing the nursing staff to cleanse Resident #6's sacral wound with normal saline, apply medihoney to the wound and cover with a dry dressing. The dressing was to be changed daily. A review of Resident #6's January 2023 treatment administration record indicated the nursing staff first applied the medihoney treatment and dressing to Resident #6's sacral wound on 01/28/23. A review of the facility policy Completing an Accurate Assessment Regarding Pressure Injuries on 11/15 24 revealed the purpose of the policy is to assure that all residents receive an accurate assessment of pressure injuries, including risk, presence, appearance, and change of the pressure injuries. Guidelines for compliance indicated: A qualified health professional will document the presence, number stage, and pertinent characteristics of any pressure injury on the wound documentation form in the medical record. In a telephone interview with Resident #6's attending physician on 11/15/24 at 12:54 PM, Resident #6's attending physician stated that the facility has a wound team that includes a physician that specialized in caring for wounds. Resident #6's attending physician stated that S/he did not recall being notified on 01/25/23 regarding Resident #6's sacral wound. Resident #6's physician stated that S/he has been following Resident #6 in the community before being admitted to the facility. Resident #6 has a history of schizoaffective disorder and would state that I was not his/her physician. Resident #6 would not allow him/her to perform examinations. Resident #6's physician stated that S/he spoke to the family regarding the problems. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview with Resident #6's wound care physician on 11/15/24 at 1:15 PM, the wound physician stated that S/he is only able to visit/assess residents identified with wounds on Wednesdays. The wound physician stated that when S/he arrives at the facility, the staff inform him/her of the residents in the facility that need to be seen by him/her. The wound physician stated that he is unavailable to visit/assess any resident in the facility for an acute visit. Resident #6's wound physician stated that Resident #6 was identified with 3 wounds which I documented when I saw Resident #6 on 02/01/2023. The 2 ischium wounds were pressure, and the third wound was from lymphedema. A review of Resident #6's 02/01/23 wound assessment that was completed by the wound physician indicated Resident #6 had a wound on the right ischium that was Unstageable due to pressure. The wound physician documented the following measurements of the right ischial wound: 11 x 6.6 x 0.3 cm, moderate serous exudate, and had necrosis. The second wound, a left ischial pressure wound measured: 14.5 x 13.0 x 0.1 cm, with moderate serous exudate. The third wound, a lymphademic wound of the left, posterior leg measured: 4.6 x 3.0 x 0.1 cm, with moderate serous exudate.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45555 Based on record review, interview, and facility policy review, the facility failed to investigate a fall, determine root cause, and implement interventions to prevent further falls for 1 (Resident #40) of 1 resident reviewed for accidents. Findings included: A facility policy titled, Falls and Fall Risk, Managing, revised 02/2018, indicated, After a fall: - If a resident has just fallen or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities. - An incident report must be completed for resident falls. The incident report form should be completed by the nursing supervisor/charge nurse on duty at the time and submitted to the Director of Nursing Services. The policy revealed, The nursing staff will begin to try to identify possible or likely causes of the incident. They will refer to resident-specific evidence including medical history, known functional impairment, etc. [et cetera; and so forth]. An Admission Record indicated the facility admitted Resident #40 on 09/08/2014. According to the Admission Record, the resident had a medical history that included diagnoses of degenerative disease of the nervous system, generalized muscle weakness, abnormalities of gait and mobility, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/13/2022, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS revealed the resident used a wheelchair. The MDS revealed the activity of walking in the room only occurred once or twice during the assessment period and the resident required one-person physical assistance. Resident #40's care plan included a focus area revised 04/13/2022 that indicated the resident was at risk for injury related to actual falls due to being unaware of safety needs, non-compliance with plan of care, and gait and balance problems. Interventions directed staff to encourage the resident to ask for help when transferring between surfaces and in and out of chair, make sure chair brakes are locked and call bell within reach (initiated 11/29/2021); resident requires prompt response to all requests for assistance (initiated 01/16/2014); encourage the resident to call for assistance with activities of daily living to prevent injury or falls (initiated 12/07/2017); and instruct the resident to ask staff to take them to the bathroom whenever they went to the bathroom (initiated 09/16/2017). A Comprehensive & Extended Care Facilities Self-Report Form, dated 08/17/2022, revealed that Resident #40's roommate alleged that on 08/17/2022 at 3:00 AM, Resident #40 hit them in the back while they were sleeping. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Resident Safe Survey, dated 08/19/2022, completed by Geriatric Nursing Assistant (GNA) #67 revealed that she had worked with the resident on 08/16/2022 on the 11:00 PM to 7:00 AM shift. The survey revealed that GNA #67 stated she and another aid heard a noise and rushed to the resident's room and saw Resident #40 on the floor. A handwritten statement dated 08/17/2022 and signed by GNA #67 revealed she worked on 08/16/2022 and heard a noise from Resident #40's room. The statement revealed GNA #67 rushed to Resident #40's room and saw Resident #40 on the floor with their chair on the floor. The statement revealed GNA #67 helped the resident get back into their chair. The statement revealed that GNA #67 stated that they did not notify the nurse about the fall. A handwritten statement dated 08/17/2022 and signed by GNA #68 revealed Resident #40 was found sitting on the floor on the 11:00 PM to 7:00 AM shift. The statement revealed GNA #68 helped the resident into a wheelchair. An incident report dated 08/17/2022 revealed that Resident #40's roommate stated that they were hit in the back while they were sleeping so they pushed Resident #40 back. The incident report revealed no documentation whether the facility had determined if the push had led to the residents fall. During an interview on 12/12/2024 at 2:19 PM, the Director of Nursing (DON) stated she was not able to find a fall investigation for Resident #40 for the timeframe from 08/16/2022 through 08/19/2022. During an interview on 12/10/2024 at 2:51 PM, Registered Nurse (RN) #26 stated if she had been notified that Resident #40 had fallen, then she would have done an incident report as required and the resident would have been put on alert charting. During an interview on 12/12/2024 at 6:27 PM, GNA #67 stated that on 08/17/2022, GNA #68 rushed into the room and called her to help get Resident #40 up to their wheelchair. She stated she did not remember what time it occurred. She stated she did not report it because Resident #40 was not her resident, and she thought GNA #68 would. She stated she did not know why the resident fell and was on the floor. Attempts were made to contact GNA #68 on 12/12/2024 at 6:26 PM, 12/13/2023 at 9:42 AM, and 12/13/2024 at 4:28 PM. Messages were left for GNA #68 with no response by the end of the survey. During an interview on 12/13/2024 at 11:50 AM, Former (DON) #16 stated that once the fall for Resident #40 was identified, then an investigation should have been completed. She was not able to say why one was not done. During an interview on 12/13/2024 at 1:35 PM, the Administrator stated a fall investigation should have been completed for Resident #40 once it was revealed that staff assisted them off the floor.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 37276 Based on medical record review, observation and interview with resident and facility staff, it was determined that the facility failed to provide appropriate interventions for a resident with identified history of trauma. This was evident for 1 (#19) of 23 residents reviewed for complaints. The findings include: On 11/13/24 at 10:58 AM, a review of complaint # MD00211446 revealed the complainant reported that in October 2024, during a visit with Resident #19, in response to interactions with Resident #19, the complainant alleges s/he encountered unprofessional and inappropriate conduct from facility staff related to his/her interactions with Resident #19. On 11/14/24 at 2:07 PM, a review of Resident #19's electronic medical record (EMR) was conducted. The medical record documented that Resident #19 had medically complex conditions with multiple diagnosis which included Parkinson's, Schizophrenia, and depression and resided in the facility for long term care following admission to the facility in May 2023 until the beginning of September 2024, when the resident was admitted to the hospital for a change in condition. Resident #19 readmitted to the facility in mid-October 2024, following his/her acute hospitalization . Resident #19's admission assessment with an assessment reference date of 10/25/24 documented a brief interview for mental status could not be conducted because Resident #19 was rarely or never understood. The MDS Staff Assessment for Mental Status coded Resident #19 had memory problems, and severely impaired cognitive skills for daily decision making. Review of Resident #19's Social Service Notes in the medical record revealed on 7/28/23 at 1:40 PM, Staff #8, Director of Social Worker (DSW) wrote that when Resident #19 was admitted to the facility, the SW received a call from Adult Protective Services (APS) reporting that APS had open case involving Resident #19 due to the resident's significant other's alleged aggressive behavior in the community. On 3/20/24 at 1:29 PM, in a Social Service Quarterly note, Staff #8 wrote that Resident #19's significant other was an unwanted guest [in the facility] at that time. On 4/29/24 at 5:58 PM, in a Social Service Quarterly note, Staff #8 wrote that staff continued to support and assist Resident #19 due to the resident's history of aggression with his/her significant other. On 11/1/24 at 4:09 PM, in a Social Service Note, Staff #8's indicated that when the resident's public guardian social worker initially visited Resident #19, Staff #8 informed him/her of Resident #19's history of abuse from the resident's significant other. On 11/14/24 at 2:15 PM, during an interview, Staff #8, Director of Social Work (DSW), indicated Resident #19 had a history of trauma related to alleged abuse by Resident #19's significant other, and that the resident's significant other was not allowed in the facility. On 11/15/24 at 1:50 PM, during an interview, the Director of Nurses (DON) stated that prior to Resident #19's admission and readmission to the facility, the resident had been abused and hurt by his/her significant other. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24, a continued review of Resident #19's medical record failed to reveal evidence that a care plan had been developed and implemented with person-centered, non-pharmacological approaches to care for the resident with a history of trauma resulting from abuse by his/her significant other. On 11/19/24 at 3:15 PM, during an interview, Staff #8, DSW stated that when Resident #19 was admitted to the facility, Staff #8 became aware APS had an open case of alleged abuse towards the resident by Resident #19's significant other and it was clear that Resident #19 did not want the significant other to come see him/her in the facility. Following the interview, the concerns with the facility failing to develop and implement a care plan that addressed Resident #19's potential trauma resulting from the resident's history of being abused, with person-centered interventions such as the resident's significant other was not allowed to visit, were discussed with Staff #8. At that time, Staff #8 indicated she understood the concerns, and stated she would look for further documentation. On 11/19/24 at 3:33 PM, Staff #8 reported to the surveyor that a trauma care plan for Resident #19 was not found in the resident's medical record, and that something should have been in place for the resident. The Nursing Home Administrator (NHA), the Director of Nurses, and Staff #6, [NAME] President of Operations, were made aware of the above concerns on 11/20/24 at 1:45 PM. The NHA acknowledged the concerns and offered not further comments at that time.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37276 Based on medical record review and staff interview It was determined that the facility failed to ensure that a resident's medication regimen was free from an unnecessary psychotropic medication failing to ensure that a psychotropic medication prescribed as needed was limited to 14 days. This was evident for 1 (#17) of 23 residents reviewed for complaints. The findings include: As needed (PRN) orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. On 11/12/24 at 10:33 AM, a review of complaint #MD00210287 was conducted. In the complaint, the complainant expressed concerns with how Resident #17's medication prescribed. On 11/12/24 at 12:36 PM, a review of Resident #17's November 2024 Medication Administration Record (MAR) revealed a 6/10/24 order for Ativan (Lorazepam) Injection Solution, inject 2 milligrams (MG) intramuscularly (IM) every 5 minutes as needed for uncontrolled seizures related to epilepsy, with a maximum of 3 doses. May administer a shot every 5 minutes x 3, if seizure is unresolved. The as needed order for Lorazepam was not limited to 14 days and the order did not have a duration and a discontinuation date. Review of the medical record failed to reveal physician documented rationale for continuing the order beyond 14 days. On 11/15/24 at 11:15 AM, the Director of Nurses (DON) was made aware of the concern with Resident #17's Lorazepam order, prescribed as needed, was not limited to 14 days and the order had no duration with physician documented rationale for continuing the order beyond 14 days, At that time, the DON acknowledged the concern and express understanding that psychotropic medications prescribed as needed, required a stop date.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 37276 Based on medical record review, review of pertinent facility documentation, hospital record review and staff interview, it was determined the facility failed to ensure that residents were free from significant med errors as evidenced by a resident being administered medication that was not prescribed resulting in the resident ' s hospitalization . This was evident for 1 (#16) of 3 residents reviewed for medication administration during a complaint survey. This failure resulted in actual harm to Resident #16. The facility implemented effective and thorough corrective measures following this incident and prior to the start of this survey. The facilities plan and action were verified during this survey, therefore this deficiency was found to be past noncompliance with a compliance date of 3/15/24. The findings include: Methadone (a synthetic opioid used medically to treat chronic pain and opioid use disorders). Naloxone (Narcan) is a medication that quickly reverses an overdose of opioids. On 11/15/24 at 9:00 AM, a review of complaint MD00203494 was conducted. In the complaint, the complainant reported Resident #16 was admitted to the hospital on 3/9/24 with acute encephalopathy (change in brain function due to injury or disease), bradycardia (slow heart rate), acute hypercapnic respiratory failure (condition with too much carbon dioxide (CO2) in the blood) and the resident tested positive for methadone. Resident #16, who had not been receiving methadone treatment at that time, was managed for opioid intoxication. The complainant reported that the facility was called, and the Director of Nurses (DON) confirmed Resident #16 was not on methadone treatment and the DON did not know anything about the methadone overdose. On 11/15/24 at 9:28 AM, during a phone interview, the complainant indicated s/he was a hospital case manager and that following Resident #16 ' s arrival to the hospital emergency room , a toxicology screen revealed the resident, who had not been on a methadone treatment program, The emergency department (ED) records for Resident #16 ' s 3/9/24 ED visit, and the hospital records for his/her 3/10/24 to 3/14/24 hospital stay were requested by the State Office, received and reviewed by the surveyor on 11/18/24. In an ED note on 3/9/24 at 3:22 PM, the physician documented Resident #16 that Resident #16 presented to the ED for altered mental status and it had been reported that the resident was at his/her baseline when initially seen at 9:00 AM, and the resident was typically ambulatory and alert and oriented x 2. The physician wrote that Resident #16 ' s nurse checked on the resident around 12:45 PM and found him/her obtunded (diminished responsiveness to stimuli), in bed and hypoxic (too little oxygen). (continued on next page)

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	215215	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Alice Manor	2095 Rockrose Avenue Baltimore, MD 21211

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #16 ' s hospital discharge documentation dated 3/15/24, revealed, in a hospitalization summary, the physician documented Resident #16 presented from the nursing facility after being found lethargic, that upon presentation to the emergency department, s/he was hypoxic (deprived of oxygen), bradycardic (slow heart rate), and hypertensive (high blood pressure. The physician wrote that Resident #16 was given naloxone empirically, s/he started to regain consciousness, and the resident was placed on naloxone drip. Resident #16 ' s urine toxicology test came back positive for methadone and the resident was admitted to the Intensive Care Unit (ICU). Further review of the ED documentation revealed a Toxicology report on 3/9/24 at 8:03 PM, documented Methadone was detected in Resident #16 ' s urine. Review of Resident #16 ' s electronic medical record (EMR) revealed, on 3/9/24 at 2:25 PM, in a change in condition note, Staff #33, RN (Registered Nurse), agency nurse, documented that during lunch, Resident #16 was observed with excess saliva, sweating profusely, and high blood pressure, and the physician and resident representative were made aware. Staff #33, RN further documented on 3/9/24 at 7:58 PM, in a general nurses note, that Resident #16 had a change in condition and was sent to the emergency room (ER) for further evaluation. The nurse wrote that at 12:45 PM, though alert and breathing normally, Resident #16 was noted to be very lethargic, sweating profusely, with excessive salivation, high blood pressure (BP) reading of 195/75 and a heart rate (HR) of 33; the physician was notified and ordered Resident #33 be transferred to the ER for further evaluation. Also, on 3/9/24 at 11:02 PM, in a general nurses note, Staff #33 documented that Resident #16 was admitted to the Intensive Care Unit (ICU) for trouble breathing and hypoxia and indicated the ER physician had called the facility to make an inquiry on the resident ' s baseline status. Review of Resident #16 ' s March 2024 Medication Administration Record (MAR) revealed on 3/9/24 at 9:00 AM, Resident #16 was administered Acetaminophen (Tylenol) 1000 milligrams (MG) and an inhaler, Breo Ellipta. There was no other documentation in the MAR, to indicate that while s/he was in the facility, Resident #16 received any other medication on that day. Continued review of Resident #16 ' s medical record revealed no evidence to indicate the resident was on a methadone treatment program. On 11/15/24 at 11:38 AM, during an interview, the Nursing Home Administrator stated that he was aware Resident #16 was sent to the hospital when s/he had a change in condition, and at some point, the resident had a toxicology screen that was positive. The NHA indicated that an investigation into this had occurred, and would see what he could find. On 11/15/24 at 1:58 PM, Staff #16, the previous Director of Nurses (DON) confirmed s/he was the DON at the time of the above incident. During an interview, Staff #16 stated s/he had received a call from the facility ' s night shift nurse who reported s/he received a call from the hospital, asking clinical questions about the resident who had been admitted to the intensive care unit (ICU), and the physician was asking questions about the medication Resident #16 was prescribed. Staff #16 reported that the next morning, s/he received a call from a case manager at the hospital, who reported that a lab test found methadone in Resident #16 ' s system, and asking similar questions about the resident in reference to the methadone. Staff #16 indicated that at that time, they had no other information, except what was reported to him/her by the hospital. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Staff #16 stated that once s/he was aware of the report from the hospital that Resident #16, who was not prescribed methadone, had methadone in his/her system, an investigation into the incident was initiated. The DON stated she reviewed medical records and confirmed Resident #16 was not prescribed Methadone. The DON stated that statements were received from the nurses who worked on that date (3/9/24) and received a statement from the nurse, Staff #33, RN, who was assigned to Resident #16 on that date. Staff #16 stated that Staff #33, the nurse assigned to Resident #16 that day was an agency nurse and that was the only day s/he had worked at the facility. The DON stated that Staff #33 reported Resident #16 was baseline at the beginning of the shift, ambulating back and forth to the bathroom, and noted to have a change in condition around mid-shift and was then sent to the hospital. Staff #16 reported that during the investigation, s/he identified Resident #24, who was the roommate of Resident #16, had been prescribed methadone. Staff #16 stated s/he re-interviewed the nurse, Staff #33 and asked if s/he remembered administering methadone to any residents and asked him/her to describe the resident who received the methadone. Staff #33 recalled administering the methadone, and described Resident #24, who was in a Geri-chair at that time, as the resident who had been administered the methadone. Staff #16 stated s/he was not able to substantiate that Resident #16 was inadvertently administered methadone his/her assigned nurse, Staff #33, that morning. Staff #16 stated that statements were also obtained from the nurses who cared for the resident in the days prior to the incident. Staff #16 stated that at the time of the incident, there were 2 residents in the building who were prescribed methadone, one was the resident ' s roommate, and the other resident was on another floor. Staff #16 stated that the facility was unable to determine how Resident #16 had gotten the methadone, however the resident's nurse on that day, Staff #33 was suspended during the investigation, and because s/he was an agency nurse, it was requested Staff #33 not return to the facility. Staff #16 stated that along with the investigation, an abatement plan was implemented which included the medication administration training of all nurses, including agency nurses, looking at medication transcription, completing audits and forwarding audit results to the facility's Quality Assurance and Performance Improvement (QAPI). Following the interview, Staff #16 provided the surveyor with a binder labeled, Medication Error, and indicated the binder contained documentation of the facility ' s investigation, and actions implemented to correct the deficient practice. Review of the binder revealed evidence of the facility ' s investigation, and correction plan that included the following provisions: 1. An audit of all resident ' s identification to assure all residents were validated with 2 identifiers per protocol. Completed 3/12/24. 2. Actions to prevent occurrence/recurrence implement: - All applicable facility policies and procedures (medication administration) were reviewed. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	- Re-educated licensed nurses on facility policies regarding medication administration as well as medication administration identification and transcription order guidelines. All nurses were educated and validated by test. - Educated the admission team on the importance of having the resident identifiers in place upon admission. Completed date 3/12/24. - Educate all orientees as part of the new hire process on medication administration identification and transcription orders. - The DON implemented a QAPI AD-Hoc to gather and process information from the audit with findings reported at the monthly QAA meeting for a minimum of 3 months. - Inservice Training Guide for Regulation F760 reviewed. The facility asserted likelihood for serious harm no longer existed 3/15/24. Included in the binder were:: - audits of all residents for 2 identifiers. - audits of medication orders for transcription errors, - Evidence of Medication administration observation of staff. - Evidence of licensed nurse training on facility policies regarding medication administration, and medication administration identification and transcription order guidelines, validated by medication errors policy review tests. The facility staff failed to ensure that Resident #16 was free from a significant medication error when the resident was administered medication (Methadone) that had not been prescribed, which caused the resident harm, and resulted in the resident ' s hospitalization . Based on the above actions taken by the facility and verified by surveyors on site, it was determined that the facility's deficient practice was past-noncompliance with a compliance date of 3/15/24 On 11/20/21 at 1:50 PM, the Nursing Home Administrator (NHA), the Director of Nurses, and Staff #6, [NAME] President of Operations were made aware of the above concerns, that the deficient practice had the potential to rise to a level of harm, and the concerns would be brought to the State Office for review. The NHA and Staff #6 acknowledged the concerns with no further comments offered at that time.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18819 Based on reviews of a closed medical record and staff interview, it was determined that the facility staff obtained a laboratory specimen on a resident without a physician's order. This was evident for 1 (Resident #14) of 20 complaints reviewed during a complaint survey. The findings include: A review of Resident #14's closed medical record on [DATE] at 10 am, revealed a laboratory result, dated [DATE] at 9:33 am, that indicated Resident #14's TSH and Free T4 levels were within normal limits. Further review of Resident #14's closed medical record indicated that Resident #14 was readmitted to the facility on [DATE] and Resident #14's physician instructed the nursing staff to obtain a TSH level on [DATE] to measure Resident #14's Thyroid function (TSH). The facility laboratory staff obtained a blood specimen on [DATE] and reported on [DATE] that Resident #14's TSH level was 59.35 (normal 0.45 - 4.50) Resident #14's physician was notified and Resident #14's thyroid medication was adjusted. Resident #14's physician also instructed the nursing staff to obtain a TSH and Free T4 level in six weeks. On [DATE], Resident #14 was sent to the hospital due to a change in condition. Resident #14 did not return to the facility and subsequently died at the hospital on [DATE]. In an interview with the facility Director of Nurses (DON) on [DATE] at 2:15 PM, the facility DON stated that S/he spoke with the contracted laboratory representative who stated Resident #14 had a physician's order for the Thyroid studies from [DATE]. The laboratory representative could not determine what resident the laboratory staff obtained the thyroid specimen from on [DATE]. The DON stated that S/he believes the laboratory staff obtained the thyroid specimens from a resident who was residing in the facility on [DATE] and labeled the specimen with a pre-printed label that was created by the laboratory. A review of the laboratory policy for specimen collection and processing, dated [DATE] instructs the phlebotomist to obtain 2 patient identifiers - patient name and date of birth and if the resident is unable to speak then check the resident's wrist band. If there is no wrist band on the resident, then contact the nurse to verify the resident before starting the procedure and document the nurses name on the requisition.