STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215338	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN LAKE HEALTHCARE AT OAKVIEW	**2700 BARKER STREET SILVER SPRING, MD 20910**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor review of clinical records and interview with facility staff and an Ombudsman, it was determined the facility failed to accurately document in the medical record the status of a Maryland Order for Life Sustaining Treatment form (MOLST). This finding was evident for 1of 7 residents selected for review during the survey (Resident #1). The findings include: A do-not-resuscitate order (DNR order), is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating. The Maryland MOLST form is a two-page portable and enduring medical order form covering options for cardiopulmonary resuscitation (CPR) and other life-sustaining treatments. The medical orders are based on a patient's/patient representative's wishes about medical treatments and makes those treatment wishes known to health care professionals. On [DATE], surveyor review of the clinical record for Resident #1 revealed the resident was transferred to the hospital on [DATE] for elevated temperature consistent with Covid-19 symptoms. The resident was admitted to the hospital on [DATE]. During the resident's hospitalization , the hospital consulted with the resident's daughter and medical surrogate concerning palliative care options. According to the documentation, on [DATE] at 4:52 PM, after a consultation with hospital ethics department regarding the appropriateness of withholding medical treatment including an Intensive Care Unit transfer, The patient was made DNR. It was decided not to transfer the resident to the ICU. Further review of the clinical record for Resident #1 revealed a MOLST form for Resident #1 dated [DATE]. The MOLST was found to have question #1 No CPR, Option A-2, Do Not Intubate (DNI) initialed by the hospital physician. The hospital physician documented certification for the MOLST was based on the authority granted by the Health Care Decisions Act. A continued review Resident #1 ' s clinical record revealed the resident was discharged from the hospital on [DATE] and returned to the facility. Resident #1's treatment orders, dated [DATE], the day of the resident's re-admission to the facility, listed Resident #1's code status as full code. A full code means a person will allow all interventions needed to get their heart or breathing started. Full code was also documented on resident #1's face sheet under the advance directives section. On [DATE] at 11:30 AM, a telephone interview with the Ombudsman revealed that there was no discussion with family concerning code status during a care plan meeting held on [DATE]. On [DATE] at 3:30 PM, surveyor interview with LPN #1, the staff responsible for documenting the admission orders [REDACTED]. RN #1 stated, I thought the resident was full code. I do not recall the MOLST form. Not sure what happened there. On [DATE] at 4:00 PM, an interview with the attending physician revealed that the physician was not aware of any change to the family wishes. I was not aware of the change to MOLST done in the hospital. The resident had been a full code status. I would not have changed it without consulting the resident or the family first, which I had not yet done. The DNR from the hospital MOLST would need to be the document of record. On [DATE] at 11:30 AM, in an interview with the Director of Social Services confirmed that they had written a note concerning a care plan meeting on [DATE] which revealed that MOLST Form was reviewed. Resident #1 will remain a Full Code Status as per MOLST Form and family's request. The Director of Social Services was unable to account for the discrepancy. On [DATE] at 02:30 PM, a telephone interview with the Administrator did not reveal additional information.

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

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.