STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215330	A. BUILDING _____ B. WING _____	07/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN LAKE HEALTHCARE POST-ACUTE CARE CENTER	5009 FRANKFORD AVENUE BALTIMORE, MD 21206

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on reviews of a closed medical record and staff interview, it was determined that the facility staff failed to honor a resident's new MOLST form after being readmitted from the hospital. The facility also failed to take steps during the readmission process to void the resident's older MOLST form. This was evident for 1 (Resident #8) of 14 residents reviewed during an infection control survey. The findings include: A Maryland MOLST (Medical Orders for Life-Sustaining Treatment) form is used for documenting a resident's specific wishes related to life-sustaining treatments. The MOLST form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. Review of Resident #8's closed medical record on [DATE] revealed a MOLST form dated [DATE] that was created by Resident #8's physician and Resident #8. The [DATE] MOLST indicated that Resident #8 wanted to be a full code and wanted all life sustaining treatments and care available. Resident #8's closed record also had two voided MOLST forms dated [DATE] and [DATE]. Further review of the [DATE] MOLST form revealed Resident #8's surrogate decision maker was contacted about what Resident #8 wanted regarding receiving CPR or not. On both of the [DATE] and [DATE] MOLST forms, the hospital physician did not complete page 2 on either form. Page two of a Maryland MOLST form discusses other life sustaining treatments such as medical testing, hospitalization , and receiving artificial nutrition and hydration. In an interview with the facility Director of Nurses (DON) on [DATE] at 1:50 PM, the DON stated the rationale for voiding the [DATE] and [DATE] hospital MOLST form was because the [DATE] and [DATE] MOLST forms did not have physician signatures on the second pages to show the hospital physician addressed what Resident #8 wanted regarding other life sustaining treatments. The DON stated that the facility was reverting to Resident #8's [DATE] MOLST form because both page #1 and #2 were completed and signed by Resident #8's attending physician. There was no indication that this process or method of reverting back to the old MOLST form was done with consultation with the resident or surrogate decision maker.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based observation and staff interview it was determined that facility staff failed to ensure medications were secured. This was true for one out of the five nursing units. The findings are: This surveyor was touring the facility on 7/29/20. Observation at 11:45 AM on the third floor of a laptop on top of the medication cart near the end of the long hall. The laptop was open and had resident information visible. The medication cart was unlocked. During interview of Staff #4, she was shown the computer screen and demonstrated that the drawer could be pulled open. She acknowledged that the computer screen was visible for anyone walking by the cart. She then denied that she failed to lock the cart. When the surveyor informed her that an attempt to open the drawer by the surveyor was successful, she stated ok. The Director of Nursing was informed of the findings on 7/29/20 at 2:00 PM.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review and interview it was determined that the facility failed to 1) ensure staff wore PPE appropriately as evidenced by observation of two GNAs wearing face masks below the nose; 2) failure to ensure an assessment of oxygen saturation via pulse oximetry as part of the daily screening for COVID signs and symptoms; 3) to take steps and isolate a resident that was exposed to the COVID19 virus and suffered with a fever and cough, and 4) change the resident's care plan and move the resident from the second shift to the third shift (residents on transmission precautions) for [MEDICAL TREATMENT]. This was found to be evident for 3 out of 6 residents (Residents #1, #10, #11,) reviewed for daily assessment of COVID signs and symptoms and for 3 (Residents #8, #14, #15) of 14 residents reviewed during an infection control survey. The findings include: 1) On [DATE] at approximately 12:20 PM GNA #10 was observed in the hallway at the meal cart wearing a mask that was not covering her nose. GNA #9 was then observed, also in the hallway, with a mask not covering her nose. Surveyor addressed the inappropriately fitting mask with GNA #9 who then adjusted the mask. On [DATE] at 12:25 PM GNA #9 was observed walking into the resident dining room with her mask, not covering her nose. The Director of Nursing (DON) was present at the time and surveyor informed the DON of the previous observation and that surveyor had addressed the issue with the GNA at the time of the original observation. 2) On [DATE], the Centers for Disease Control and Prevention (CDC) published updated guidance (from earlier [DATE], [DATE] and [DATE]) entitled Preparing for COVID-19 in Nursing Homes. The CDC directed to actively monitor all residents upon admission and at least daily for fever (T=100.0F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions. On [DATE] the Maryland Department of Health (MDH) issued updated guidance entitled Preparing for and Responding to COVID-19 in Nursing Homes and Assisted Living Facilities. The MDH provided that nursing homes must screen all residents at least daily, including performance of temperature checks, pulse oximetry checks, observing for signs and symptoms of COVID 19, and asking questions about signs and symptoms of COVID-19. On [DATE] the Director of Nursing (DON) reported the daily COVID assessments consist of respiratory status and other symptoms of COVID as well as vital signs including blood pressure, temperature and pulse ox (oxygen saturation level). She went on to report the assessments could be found either in the COVID evaluation assessment or the last portion of a skilled nursing note. Both of these nursing assessments were found in the electronic health record. On [DATE] at 12:30 PM the DON reported that the GNAs (geriatric nursing assistants) complete a form (on paper) that they are to show the nurse who signs off and then it is reviewed by the infection control nurse or herself. Review of the Screening Tool For COVID-19 revealed an area for the GNAs to document each shift the resident's temperature and if the following symptoms were present: cough, shortness of breath, sore throat, malaise or loss of appetite, diarrhea, dizziness or other symptoms. There were spaces for the GNA and nurse to sign off for each shift and an area for the reviewing nurse to sign off. Further review of the Screening Tool failed to reveal any documentation regarding the pulse ox level. 2a) On [DATE] review of Resident #1's medical record revealed the resident was admitted [DATE] with a

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) recent [DIAGNOSES REDACTED]. Further review of the medical record revealed a skilled nursing note, dated [DATE] at 2:26 PM which revealed a pulse ox level from [DATE] at 9:29 AM. On [DATE] at 3:05 PM surveyor reviewed the concern with the Director of Nursing that staff were not obtaining current pulse ox levels when completing assessments for a resident newly [DIAGNOSES REDACTED].#10's medical record revealed the resident was admitted to the facility in 2019. No documentation was found to indicate the resident had been diagnosed as COVID positive. Further review of the medical record, including the COVID evaluations and vital signs failed to reveal documentation of pulse ox levels for the month of July. 2c) On [DATE] review of Resident #11's medical record revealed the resident has resided at the facility for several years. No documentation was found to indicate the resident had been diagnosed as COVID positive. Review of a skilled nursing note dated [DATE] revealed the most recent 02 SATs (pulse ox) was from [DATE]. Further review of the medical record revealed documentation of only one pulse ox level for the month of July. 3) Resident #8 is a [AGE] year-old with a past medical history of [REDACTED]. The facility had a separate [MEDICAL TREATMENT] unit in the building. Resident #8 was last in the hospital on [DATE] for pneumonia. Resident #8 resided on a general population nursing unit from [DATE] thru until [DATE]. Review of Resident #8's closed medical record on [DATE] revealed that on [DATE] the nursing staff assessed Resident #8 to have a fever of 100.4 Fahrenheit orally and complained of a cough. Resident #8's physician was notified, and blood work and a stat chest x-ray was ordered. A test for COVID19 was also obtained at this time. The stat chest x-ray result came back and indicated Resident #8 suffered from atelectasis. Atelectasis is a complete or partial collapse of the entire lung or area (lobe) of the lung. It occurs when the tiny air sacs (alveoli) within the lung become deflated or possibly filled with alveolar fluid. On [DATE], Resident #8 was sent to the facility [MEDICAL TREATMENT] unit, during the second shift, for treatment. Nursing pre-[MEDICAL TREATMENT] documentation indicated Resident was stable but complained of pain at 11:45 AM. The nurse medicated Resident #8 with pain medication at this time. Post [MEDICAL TREATMENT] treatment documentation indicated Resident #8 completed the [DATE] [MEDICAL TREATMENT] treatment after 4 hours and was stable. Resident #8 was returned to her bedroom at 5:45 PM on [DATE]. In an interview with [MEDICAL TREATMENT] nursing supervisor on [DATE] at 12 PM, the [MEDICAL TREATMENT] nursing supervisor stated that Resident #8 had her [MEDICAL TREATMENT] treatments on [DATE], during the second shift, which was usually after 12 noon. The [MEDICAL TREATMENT] nursing supervisor stated that third shift is used for residents that are on observation for COVID19 or COVID19 positive. The [MEDICAL TREATMENT] nursing supervisor indicated that no third shift resident would start their [MEDICAL TREATMENT] treatment until all of the other residents had completed their [MEDICAL TREATMENT] treatment and left the [MEDICAL TREATMENT] unit. The [MEDICAL TREATMENT] nursing supervisor confirmed that Resident #8 usually received [MEDICAL TREATMENT] during the second shift. Further review of Resident #8's [MEDICAL TREATMENT] communication report, on [DATE], revealed a section at the top right of the page that is labeled COVID STATUS. This section is used as a communication tool to alert the [MEDICAL TREATMENT] staff to any COVID19 issues. On [DATE], this box was left blank on Resident #8's [MEDICAL TREATMENT] communication report. On [DATE], Resident #8's test result for COVID19 came back positive. The nursing staff then moved Resident #8 to the isolation unit of the facility on [DATE]. Resident #8 did receive a [MEDICAL TREATMENT] treatment on [DATE] that took place on the third shift. On [DATE], Resident #8 expired and Resident #8's death certificate listed the primary cause of death was [DIAGNOSES REDACTED]-COV2 infection. 4) Review of Resident #15's closed medical record on [DATE] revealed Resident #15 was admitted to the facility on [DATE] and was placed on the facility observation unit. The facility determined that Resident #15 was asymptomatic and transferred Resident #15 off of the observation unit to the general nursing unit, room [ROOM NUMBER], on [DATE] at 1:30 PM. On [DATE] at 8:08 AM, Resident #15 was assessed to have a temperature of 101.7 Fahrenheit. The nursing staff did not identify a route for this temperature. At 4:12 PM on [DATE], Resident #15 was assessed to have a temperature of 102.9 Fahrenheit, a pulse of 151, and an oxygen saturation of 77% on room air. The nurse documented Resident #15 also had crackles and wheezing upon auscultation. Resident #15's physician was contacted, and new orders were given that included obtaining a chest x-ray and starting Resident #15 on oral antibiotics and initiating oxygen therapy. Resident #15 was moved to the facility isolation/COVID19 unit and then subsequently died on [DATE]. Resident #15's death certificate indicated the secondary cause of death was COVID19. 5) Review of Resident #14's medical record on [DATE] revealed Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #14 resided on the facility observation unit until [DATE] when he/she was moved to room [ROOM NUMBER] A. Resident #14 resided with Resident #8 from [DATE] until [DATE]. Resident #8 was identified as being COVID 19 positive on [DATE]. In an interview with the facility infection control preventionist (ICP) and the director of nurses (DON) [DATE] at 5 PM, the DON stated that Resident #8 was not placed on any transmission-based precautions prior to moving to the facility isolation/COVID19 unit on [DATE]. Resident #8 was the roommate of Resident #15 from [DATE] thru [DATE] and the roommate of Resident #14 from [DATE] thru [DATE]. From [DATE] thru [DATE], the facility staff did not initiate or document any transmission-based precautions for Resident #8. In fact, after Resident #15 was transferred to the COVID19 unit, the facility staff admitted Resident #14 to room [ROOM NUMBER] with Resident #8 on [DATE]. The nursing staff also failed to initiate or document any transmission-based precautions for Resident #14 from ,[DATE] thru [DATE].
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and staff interview, it was determined that the facility staff failed to notify residents and their representatives of confirmed cases of COVID-19. This was evident for 2 (Resident #8, #14) of 15 residents reviewed during an infection control survey. The findings include: 1) Review of Resident #8's closed medical record on 07/30/20 revealed Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #8 resided on the general nursing unit until 07/05/20 when the resident was moved to the facility isolation/COVID-19 unit due to having a positive COVID-19 result. Resident #8 resided with Resident #15 from 06/25/20 until 06/29/20. Review of Resident #15's closed medical record on 07/31/20 revealed Resident #15 was admitted to the facility on [DATE] and was placed on the facility observation unit. The facility determined that Resident #15 was asymptomatic and transferred Resident #15 off of the observation unit to the general nursing unit, room [ROOM NUMBER], on 06/26/20 at 1:30 PM. Resident #15 was identified as being COVID-19 positive on 06/29/20. Further review of Resident #8 closed medical record on 07/30/20 failed to reveal that Resident #8 nor Resident #8's family were notified of a COVID-19 positive resident in the building on or around 06/29/20. 2) Review of Resident #14's medical record on 07/30/20 revealed Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #14 resided on the facility observation unit until 07/01/20 when she was moved to room [ROOM NUMBER] A. Resident #14 resided with Resident #8 from 07/01/20 until 07/05/20 when Resident #8 was identified as being COVID 19 positive. Review of Resident #14's medical record on 07/31/20 failed to reveal that Resident #14 nor Resident #14's family were notified of a COVID-19 positive resident in the building on or around 07/05/20. In an interview with the facility Director of Nurses (DON) on 08/04/20 at 2:30 PM, the facility DON stated that the facility was not required to notify residents or their families when a Resident is determined to be COVID-19 positive in the building and that this would be a HIPPA violation.