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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215017 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/26/2025 |
| NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Long View | | STREET ADDRESS, CITY, STATE, ZIP CODE 3332 Main Street Manchester, MD 21102 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of abuse to the state survey agency for 1 (Resident #1) of 4 sampled residents reviewed for abuse. The facility further failed to report an allegation of abuse to the state survey agency for 1 (Resident #13) of 4 sampled residents reviewed for abuse.</p> <p>Findings included:</p> <p>A facility policy titled, Abuse Neglect and Exploitation, revised 11/13/2023, indicated, 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 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, or b. Not later than 24 hours- if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury.</p> <p>1. An admission Record indicated the facility admitted Resident #1 on 10/06/2024. According to the admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, muscle weakness, anxiety disorder, and delusional disorders.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.</p> <p>Resident #1's Care Plan Report included a focus area initiated 11/04/2024, that indicated the resident had delirium or acute confusional episodes with accusations related to their acute disease process.</p> <p>Registered Nurse (RN) #1 written statement dated 04/12/2025, indicated Resident #1, tearful at the time, reported to her at approximately 6:30 PM on 04/12/2025, that a nurse [later identified as Geriatric Nursing Assistant (GNA) #12] pushed them in the head and they fell back into the bed.</p> <p>Email correspondence dated 04/13/2025 at 9:38 PM, indicated the state survey agency were informed of an allegation of abuse. The Facility Reported Incident Initial Report Form indicated the facility notified the state survey agency of an allegation of abuse that involved Resident #1 on 04/13/2025 at 9:12 PM. Per the Facility Reported Incident Initial Report Form, the alleged incident occurred on 04/12/2025 at 6:30 PM.</p> <p>(continued on next page)</p> |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a telephone interview on 06/24/2025 at 9:47 AM, RN #1 stated the allegation was not reported because Resident #1's story was inconsistent.</p> <p>During an interview on 06/24/2025 at 10:41 AM, the Assistant Director of Nursing (ADON) stated she was informed about what the resident alleged from RN #1. The ADON stated the alleged incident was not reported because the resident's story was inconsistent and the resident had a history of accusatory behaviors.</p> <p>During an interview on 06/24/2025 at 10:54 AM, the Director of Nursing (DON) stated for any allegation of abuse the staff would notify the Administrator and do a report to the state, but in that situation, the staff determined it was a behavioral issue since the resident's story was inconsistent. The DON then stated that however, when the resident was triggered on 04/13/2025 after they saw GNA #12, the resident called 911 and subsequently the Administrator was notified. According to the DON, it was typical of the resident to accuse someone of taking things, but not typical of resident to accuse anyone of pushing their head during care.</p> <p>During an interview on 06/24/2025 at 2:30 PM, the Administrator stated she encouraged her staff to call her when incidents like that happened; however, she was not aware of the situation until 04/13/2025.</p> <p>During a follow-up interview on 06/26/2025 at 9:46 AM, the Administrator stated she would expect that staff would not judge any incident but send the incident to her and inform her. The Administrator stated she would have expected to have been informed of the incident on the day the alleged event occurred so a report could be made to the state agency.</p> <p>2. An admission Record indicated the facility admitted Resident #13 on 05/22/2025. According to the admission Record, the resident had a medical history that included diagnoses of muscle weakness, abnormalities of gait and mobility, and muscle wasting and atrophy.</p> <p>A Grievance Form dated 06/16/2025, revealed Resident #13 shared a concern with the Social Worker (SW) that a male staff was rough during a chair-to-bed transfer at 3:00 PM on either 06/13/2025 or 06/14/2025. The Grievance Form indicated Resident #13 indicated they informed the male staff that their legs were sensitive, and the staff mocked them and said they were a crybaby. Per the Grievance Form, the SW made the Director of Nursing (DON) aware.</p> <p>During an interview on 06/23/2025 at 3:23 PM, the SW stated Resident #13 did not use the word abuse, only the term rough and because of that she did not believe the event needed to be reported.</p> <p>During an interview on 06/26/2025 at 9:12 AM, the DON stated any suspicions of abuse or neglect should be reported as the facility did not tolerate abuse in any form.</p> <p>During an interview on 06/26/2025 at 9:46 AM, the Administrator stated Resident #13 had a grievance filed on 06/16/2025. The Administrator stated more questions should have been asked about the situation and it should have been reported as an allegation.</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>Based on interview, record review, facility document review, and facility policy review, the facility failed to protect all residents from potential abuse when they allowed Geriatric Nursing Assistant (GNA) #12 to continue to care for other residents after 1 (Resident #1) of 4 sampled residents reviewed for abuse, reported an allegation of abuse that the GNA pushed them in their head during the provision of care on 04/12/2025.</p> <p>Findings included:</p> <p>A facility policy titled, Abuse Neglect and Exploitation, revised 11/13/2023, indicated, VI. Protection of Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; F. Providing emotional support and counseling to the resident during and after the investigation, as needed; G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.</p> <p>An admission Record indicated the facility admitted Resident #1 on 10/06/2024. According to the admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, muscle weakness, anxiety disorder, and delusional disorders.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition.</p> <p>Resident #1's Care Plan Report included a focus area initiated 11/04/2024, that indicated the resident had delirium or acute confusional episodes with accusations related to their acute disease process.</p> <p>Registered Nurse (RN) #1's written statement dated 04/12/2025, indicated Resident #1, tearful at the time, reported to her at approximately 6:30 PM on 04/12/2025, that a nurse [later identified as Geriatric Nursing Assistant (GNA) #12] pushed them in the head and they fell back into the bed. The written statement indicated the resident was assessed and found to have no injuries and GNA #12 was removed from the assignment for Resident #1 and their roommate.</p> <p>During a telephone interview on 06/23/2025 at 5:06 PM, GNA #12 stated RN #1 reassigned her to another room after the resident alleged they were pushed in their head by them. GNA #12 stated she finished working her shift that evening and returned to work on 04/13/2025.</p> <p>During a telephone interview on 06/24/2025 at 9:47 AM, RN #1 stated once Resident #1 informed her of the incident, she assessed the resident and reassigned GNA #12 to another room.</p> <p>(continued on next page)</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 06/24/2025 at 2:30 PM, the Administrator stated GNA #12 was reassigned on 04/12/2025 to care for other residents.</p> <p>RN #1's written statement dated 04/12/2025, indicated when she arrived to work on 04/13/2025 for the 3:00 PM - 11:00 PM shift, she observed Resident #1 at the nurses station calling 911 to report the incident that occurred on 04/12/2025. Per the written statement, at this time GNA #12 was removed from the facility and placed on suspension pending the results of the investigation.</p> | | |