

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/26/2024
NAME OF PROVIDER OR SUPPLIER  Autumn Lake Healthcare at Ruxton		STREET ADDRESS, CITY, STATE, ZIP CODE  7001 Charles Street Towson, MD 21204	

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)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>50573</p> <p>Based on record review, resident interview and staff interviews, it was determined that the facility failed to ensure interventions for a care plan focus were revised with interventions to address residents' medication refusals. This was evident for 1 (#MD00209998) of 1 complaint reviewed.</p> <p>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. It should be revised to reflect the resident's plan of care.</p> <p>The findings include:</p> <p>Review of Resident #2 's medical record revealed that she/he had a past medical history schizophrenia (a mental illness which affects thinking, behavior, and emotions), bipolar type (causes extreme mood swings), and type 2 diabetes (a health condition when the body does not produce enough insulin which regulates blood sugar level).</p> <p>On 9/25/24 at 5:13 AM, a review of complaint #MD00209998 revealed an allegation that Resident #2 called 911 on the night of 9/16/24 from the facility because he/she had not received insulin all day.</p> <p>On 09/25/24 at 8:48 AM, a review of the medication administration record for Resident #2 revealed that, on 9/16/24, the resident refused the 6:00 AM Levemir medication injection documented by Licensed Practical Nurse (Staff #4).</p> <p>Levemir is used to improve blood sugar control in people with diabetes mellitus. (Levemir is a long-acting insulin that starts to work several hours after injection and works evenly for up to 24 hours).</p> <p>On 09/26/24 at 10:48 AM, an interview with Licensed Practical Nurse, (LPN, Staff #3) revealed that, if a resident refuses insulin, he would call the doctor and try his best to encourage the resident and educate on the importance of taking medication as ordered by the primary care provider. He further stated that he would look at the residents' care plan for interventions.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further interview with Staff #3 revealed that Resident #2 often has mood swings; he explained he would encourage him/her to take the medication. Staff #3 indicated that Resident #2 is very familiar with him and he knows what she/he likes. He noted that the resident likes pudding so an example of a strategy used when the resident refuses medication would be to offer pudding and indicated that the strategy had worked previously.</p> <p>Review of Resident 2's care plan on 09/26/24 at 11:07 AM, revealed a care plan focus indicating that the resident refuses medication but failed to reveal any interventions used to encourage the resident when he/she was refusing medication such as offering pudding to the resident.</p> <p>On 9/26/24 at 2:40 PM, the surveyor reviewed the concern with the Director of Nursing regarding the failure to ensure that the interventions used on the resident when he/she is refusing medication are included in the care plan.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45733</p> <p>Based on record review and interview it was determined that facility staff failed to ensure the safety of a Resident by not providing adequate supervision as evidenced by the fact that the Resident fell and was found on the floor 5 times in a 4-month period and making rounds. This was evident for 1 (# MD00210090) of 1 complaint reviewed.</p> <p>Care plan - is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident ' s care.</p> <p>The findings include:</p> <p>A complaint #MD 00210090 alleged that Resident #1 fell on [DATE] around 2 a.m. and was left on the floor for hours crying for help. The roommate could not get anyone and subsequently the police had to come in to assist the resident around 5 a.m.</p> <p>This Resident was admitted to the facility, on 12/19/23, with the diagnosis of delirium, right-side stroke, osteoarthritis, depression, and heart failure.</p> <p>Record review, on 9/25/24 at 8:58 a.m., of nurse Staff #6 ' s progress note, dated 9/10/24 at 7:11 a.m., revealed that Resident #1 was found on the floor mat at the Resident ' s bedside without injury. Then, 9 days later, on 9/19/24, Staff #6 documented that the Resident was found on the floor again after the night supervisor came to the floor. Further review of Resident #1 ' s care plan revealed that he/she was a high risk for falls and a goal was initiated that the resident would be free of falls through the next review period. Additionally, the following interventions were implemented: psychiatric evaluation for restlessness at night, reinforce use of a call bell when he/she needs assistance and wait for staff assistance and staff to monitor this resident at night every 2 hours.</p> <p>During an interview, on 9/25/24 at 10:22 a.m., Resident #1 stated, I could not sleep that night so I sat at the edge of the bed and somehow ended up on the floor. During further interview, on 9/25 at 10:38 a.m., nurse staff #2 stated that staff made rounds but that it was hard to monitor Resident #1 ' s hallway area in the back of the unit. She revealed that the back hallway corner nurse ' s station did not have anyone to sit there on evening or night shifts to monitor the area.</p> <p>Interview with the Unit Manager Staff #7, on 9/26/24 at 9:18 a.m., revealed that during evening and night shifts one staff member should be sitting in the back corner station for the purpose of monitoring and listening. However, on 9/19/24, Resident #1 fell and was left for hours on the floor.</p> <p>During a phone interview, on 9/26/24 at 1:38 p.m., Staff #6 stated that she was not aware of Resident #1 and the roommate were calling for help until the night supervisor and the police came to the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 9/26/24 at 2:05 p.m., the Director of Nursing (DoN) confirmed that Resident #1 had 2 falls in September 2024. The DoN could not explain why on 9/19/24 the staff did not hear the Resident calling for help nor why they had not done their required rounds. This resident ' s fall records were requested from June 2024 to August 2024.</p> <p>Record review, on 9/26/24 at 2:10 p.m., found that Resident #1 had 3 more falls on 6/10, 6/22, and 8/14/24.</p> <p>During the exit conference, on 9/26/24 at 2:32 p.m., the administrator and DoN were informed that the facility staff failed to provide adequate supervision by not following care plan's interventions as resulting in 5 falls in a 4-month period.</p>		