

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 10/24/2024
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26006</p> <p>Based on interview, record review, and policy review, the facility failed to ensure a grievance was adequately documented and investigated to ensure satisfactory resolution for one of 32 sampled residents (Resident (R) 97). This failure had the potential to cause dissatisfaction with care, feelings of helplessness, and fear for R97.</p> <p>Findings include:</p> <p>Review of R97's Admission Record, located under the Profile tab of the electronic medical record (EMR) revealed s/he was admitted to the facility on [DATE].</p> <p>Review of R97's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/12/24 and located in the MDS tab of the EMR, revealed the facility assessed the resident to have a Brief interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. S/he did not exhibit any mood or behavioral symptoms.</p> <p>Review of R97's Care Plan, dated 11/07/23 and located in the Care Plan tab of the EMR, revealed, Problematic manner in which resident acts characterized by ineffective coping;</p> <p>Demands attention related to: repeatedly using call light to get staff into room, calls [family member] on phone repeatedly [with] unfounded complaints, reporting staff not caring for him/her when care is provided. The approaches included: Document summary of each episode and Maintain standard routines. Do not allow resident to dictate schedule.</p> <p>During an interview with R97 on 10/22/24 at 9:54 AM, s/he stated the last time s/he saw Certified Nurse Aide (CNA) 6, which was right after a state agency complaint investigation, CNA6 entered his/her room and stated, You need to watch what you say to people outside of here because I know people. R97 added, I don't know why she said that. I told her I don't talk to anyone besides my [family member]. I'm not afraid but I'm sure she's mad at me. R97 reported this to his/her family member, who filed a grievance with the facility. R97 stated CNA6 had not worked with him/her since then.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R97's Complaint/Grievance Form, dated 09/25/24 and provided on paper by the facility, revealed R97's family member (F1) filed a grievance with the Assistant Director of Nursing/Infection Preventionist (ADON/IP). The form documented, Expressed mother does not want [CNA] working with him/her because she has a poor attitude. The specific allegations and details were not documented. The grievance was referred to the Somerset Unit Manager (SUM) for follow up, and the SUM documented, Resident did not voiced [sic] any concerns at this time. Under Resolution was documented, [CNA6] will no longer be assigned to work with [R97]. Education provided on professionalism and customer service. The form was signed by the Administrator on 09/25/24.</p> <p>An attached statement from CNA6, dated 09/25/24, documented, On Tuesday night I went to go answer [R97's] light. She asked to be changed. I checked her she wasn't [sic] wet. I ask [sic] my nurse to check her as well as she confirmed she wasn't [sic] wet but I still changed her. Once I was completed, she said thank you an [sic] I left.</p> <p>An attached statement from Licensed Practical Nurse (LPN) 5 dated 09/25/24 documented, I charge nurse [LPN5] was in the room with assigned aide while changing [R97's incontinence brief]. Assigned aide did changed [sic] the [incontinence brief] with no any concern or issues. Resident [incontinence brief] was not wet, however I personally asked the aide to change her anyway, and she did changed [sic] her as instructed.</p> <p>There was no additional investigation documented, including interviews with other residents who received care from CNA6, or specific information provided by F1.</p> <p>In an interview on 10/24/24 at 10:47 AM, the SUM stated he did not speak with F1, he only interviewed R97. He stated he asked R97 if she had any concerns regarding care, and she stated she did not. The SUM stated he did not ask specifically about CNA6 and R97 never mentioned CNA6. The SUM stated he did not interview any other residents who CNA6 had worked with.</p> <p>In an interview on 10/24/24 at 11:00 AM with F1, she stated she had reported to the ADON/IP that CNA6 had made threats to R97 about keeping quiet to outside visitors, as she knew the state surveyors had been in to talk to the resident and CNA6 stated, You better not get me fired. She stated she felt this was verbal abuse and made R97 fearful of retaliation from CNA6. F1 stated the facility told her that CNA6 would be assigned to work on a different unit and would no longer work with R97. She stated she spoke with the Administrator at this point and told him the resolution was unacceptable because CNA6 could continue to abuse other residents or freely go up to R97's unit and retaliate against R97. F1 stated she told the administrator the CNA needed to be walked out of the building and not allowed to return due to her abusive behavior. F1 stated she was not satisfied with the resolution to the grievance and felt like the facility did not take her report seriously.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/24/24 at 12:49 PM, the ADON/IP stated she did not recall the specifics of the grievance from R97's daughter, but stated she thought it was something to do with the resident requesting CNA6 to take out the trash, and CNA6 responded that housekeeping staff would do that and left the room. The ADON/IP stated, I don't recall exactly; it had to do with the trash can and poor attitude. The ADON denied hearing a complaint regarding CNA6 threatening R97 not to speak with people outside of the facility. When this allegation was reported, the ADON/IP stated she would consider this verbal abuse due to the threatening nature, and she would follow all the steps to suspend CNA6 pending investigation, report the allegation to authorities as required, and complete a thorough investigation. The ADON/IP stated she would have expected the SUM to ask questions specifically regarding CNA6 to R97 and other residents, as she was named in the grievance.</p> <p>During an interview on 10/24/24 at 4:17 PM, the Director of Nursing (DON) stated R97 was a very difficult resident because she could be manipulative by making false accusations. The DON stated at times, what R97 reported to the facility and reported to her daughter have differed. The DON stated additional residents should have been interviewed regarding this grievance; however, they were now being done as part of the abuse investigation.</p> <p>The Administrator was unavailable for interview on 10/24/24.</p> <p>Review of the facility policy titled, Resident and Family Grievances, dated 12/23/22, revealed, The facility will not prohibit or in any way discourage a resident from communicating with external entities including federal and state surveyors or other federal or state health department employees . The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form . [and] take any immediate actions needed to prevent further potential violation of any resident right . The Grievance Official will take steps to resolve the grievance, and record information about the grievance and those actions on the grievance form . The grievance official will issue a written decision on the grievance.</p>