

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Birch Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 7309 Second Avenue Sykesville, MD 21784	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>51903</p> <p>F584 - S483.10(i) Safe Environment S/S: E</p> <p>Regulation: S483.10(i) mandates a safe, clean, comfortable, and homelike environment, which includes exercising reasonable care for the protection of residents' property from loss or theft. This requirement obligates the facility to document and secure residents' belongings through an inventory system upon admission, during the resident's stay, and at discharge, with a signed acknowledgment by the resident or their representative.</p> <p>F584 - Honor the resident's right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>NOTE - TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY</p> <p>Based on observation, record review, and interviews during a complaint survey, the facility failed to ensure the protection of residents' personal property for 2 (Residents #61 and #55) of 12 residents reviewed. Specifically, the facility did not adhere to its own policy requiring an inventory and tracking process for resident belongings upon admission and discharge leading to missing personal property, and failed to document grievances regarding missing items.</p> <p>The findings include:</p> <p>Resident #61:</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident # 61 was admitted on [admitted]. Upon discharge, the facility did not have a documented inventory or a signed acknowledgment of the resident's belongings, as required by its policy on safeguarding personal property. On 10/29/2024 at 4:00 PM, the complainant for MD00204148 reported that upon discharge, the resident 61's phone, prescription glasses, and several articles of clothing were missing. Despite multiple follow-up attempts, the complainant stated that the facility had not provided any resolution or communication regarding these items. During an interview conducted on 10/31/2024 at 11:00 AM, the Director of Social Services disclosed that he was unaware of the policy requiring an inventory to be completed, reviewed, and signed by the resident's representative upon discharge. The facility was also unable to provide any documentation indicating a grievance related to the resident's missing items, as stated by the complainant. The Administrator, who was present during this interview, interjected frequently but did not offer any evidence to substantiate adherence to the policy, nor return of the personal property.</p> <p>Resident #55:</p> <p>During the same investigation, it was determined that Resident #55, discharged on [discharge date], similarly lacked a documented inventory of personal belongings being returned upon discharge with the resident being discharged with another resident's clothing, as required by facility policy. Staff interviews revealed an inconsistent application of the inventory process, with no signed acknowledgment verifying that belongings were returned to the resident or their representative. This failure to uphold policy standards for personal property protection was not isolated, underscoring a systemic issue within the facility's procedures.</p> <p>Ombudsman Interview: On 11/04/2024 at approximately 3:30 PM an interview was conducted with the Ombudsman, who reported having heard of other instances of missing personal property at the facility, particularly clothing items. However, she was unable to provide specific, tangible examples. This anecdotal information further suggests a pattern of issues related to the management of residents' personal belongings, raising additional concerns about the facility's ability to consistently safeguard resident property.</p> <p>These findings collectively indicate a failure to comply with regulatory expectations under F584, which mandates that the facility provide a secure, clean, and homelike environment, including reasonable measures to protect resident belongings from loss or theft. The lack of documentation and acknowledgment upon discharge directly contravenes the facility's own policy and demonstrates an ongoing issue in safeguarding resident property effectively. This deficiency reflects inadequate operational controls in the facility's systems for managing resident belongings and responding to grievances, which may compromise the resident ' s right to a homelike environment that respects their dignity and property.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's failure to implement and enforce its policy on personal belongings inventory, coupled with its inability to document the grievance process related to lost items, substantiates the finding of non-compliance with F584. This deficiency is particularly concerning as it reflects a broader issue of systemic inadequacy, potentially exposing residents' personal items to risk and undermining the facility's commitment to providing a secure and respectful environment for its residents. The absence of effective documentation and inventory practices directly impacts the resident's sense of safety, autonomy, and satisfaction within the facility, failing to align with federal standards designed to uphold a dignified and homelike environment that has the potential to cause more than minimal psychosocial harm for residents and has been demonstrated to be a non-compliance in a pattern leading to a S/S of E.</p>		

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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>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41274</p> <p>F609: Reporting</p> <p>S/S= D</p> <p>Based on observation, record review and interviews during a complaint survey, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but not later than two hours to the state survey agency (Office of HealthCare Quality) for 2 (Residents #5 and #33) of 12 reportable incidents reviewed. Specifically, when Resident #33 was observed with an injury of an unknown origin on 1/4/22, it was not reported to the state survey agency until 1/6/22 and when Resident #5 was observed with injuries of an unknown origin on 10/9/24, the facility did not report the injury.</p> <p>The findings include:</p> <p>The Policy and Procedure titled Abuse, Neglect and Exploitation last revised 11/13/23 documented in pertinent part it was the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Training topics for staff included the reporting process for abuse, neglect, exploitation, misappropriation of resident property and injuries of unknown sources. Identification of abuse, neglect and exploitation included identifying potential indicators of abuse such as physical injury to a resident which was of an unknown source. Reporting of alleged violations to the Administrator, state survey agency, adult protective services and all other required agencies (such as law enforcement when applicable) was to be completed immediately but not later than two hours after the allegation was made if the events that cause the allegation involved abuse or resulted in serious bodily injury.</p> <p>Resident #33</p> <p>Resident #33 was admitted to the facility with diagnosis which included unspecified dementia with behavioral disturbances, major depression with psychotic symptoms and hypertension (high blood pressure). The Minimum Data Set (MDS, an assessment tool) dated 1/13/22 documented the resident had a Brief Interview for Mental Status (BIMS) score of 9/15, indicative of cognitive impairment.</p> <p>On 10/29/24, review of the facility investigation (case #MD00180805) revealed on 1/4/22 at 12:37 PM, Resident #33 was observed with swelling to their left hand and complained of pain. The resident had not had any recent falls or trauma. X-ray findings noted the resident had a minimally displaced acute fracture to the fourth metacarpal bone. The date of the facility report was 1/6/24 (two days after the resident was observed with injury of unknown origin).</p> <p>Resident #5</p> <p>(continued on next page)</p>		

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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>Resident #5 was admitted to the facility with diagnosis which included dementia with behavioral disturbance, Alzheimer ' s disease and bipolar disorder. The MDS assessment dated [DATE] documented the resident had a BIMS score of 0/15; indicative of severe cognitive impairment.</p> <p>On 10/28/24 at 2:00 PM, Resident #5 was observed walking in the hallway of the third-floor memory care unit with green and yellow colored bruising on their forehead, across the bridge of their nose and below their right eye. Licensed Practical Nurse (LPN) #12 was present in the hallway and stated that Resident #5 had been found like that recently.</p> <p>A Change in Condition assessment dated [DATE] documented at approximately 5:50 AM, Resident #5 was observed in their bed with purple bruising and swelling to the right side of their forehead above the right eyebrow and to the bridge of their nose. The resident was unable to state what happened to them due to cognitive impairment.</p> <p>A Care Plan Note dated 10/9/2024 documented Resident #5 had bruising to their forehead and nose. The note documented the resident enjoyed wandering/pacing and the incident was not witnessed. The physician was notified, and staff were to monitor the bruising and apply an ice pack as needed.</p> <p>Upon request, the facility produced documentation of statements obtained from facility staff on 10/9/24 to investigate the source of Resident #5 ' s facial injury. The investigation did not determine the cause of the injury, and the incident was not reported to the state survey agency.</p> <p>On 10/29/24 at approximately 2:00 PM, during an interview with the Regional Director of Nursing (RDON), they stated Resident #5 ' s facial bruising was investigated but not reported because they did not think the injury met the criteria for reporting.</p> <p>On 10/31/24 at 11:04 AM, during an interview the Nursing Home Administrator (NHA) stated that all staff were responsible for reporting allegations of abuse or injuries of unknown origin that were suspicious. They stated when an allegation of abuse was made or a resident was observed with a suspicious unknown injury, it should be reported immediately, per the facility policy. They stated that the clinical team did not feel Resident #5 ' s injury met the criteria for reporting due to behaviors included in the resident ' s care plan.</p>		