

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Lake Healthcare at Patuxent River		STREET ADDRESS, CITY, STATE, ZIP CODE  14200 Laurel Park Drive Laurel, MD 20707	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record reviews, and interviews, it was determined that the facility failed to: 1.) maintain infection prevention designed to prevent the development and transmission of communicable diseases and infections. This was evident for 1 (Resident #1) of 2 residents reviewed for Trach Care; 2.) maintain proper infection control practices to prevent cross-contamination with Foley catheters. This was evident for 1 (Resident #7) of 3 residents reviewed for Foley Care; and 3.) ensure infection control precautions were followed. This was evident for 2 residents (Resident #117, and Resident #125) of 2 residents reviewed for infection control precautions during the survey. The findings include:</p> <p>1. On 07/30/25 at 7:57 AM the surveyor observed Resident #1 supine in bed with Trach Collar intact to neck and Trach Collar Oxygen mask, dated 07/23/25 laying lateral to the left side of the resident bed on the floor.</p> <p>On 07/30/25 at 8:16 AM during follow-up observation rounds of Resident #1 with LPN Unit Manager staff #03, the resident remained supine in bed with Trach Collar intact and Trach Collar Oxygen mask, dated 07/23/25, again observed on the floor lateral to the left side of the resident bed.</p> <p>On 07/30/25 at 8:18 AM the surveyor conducted an interview with Unit Manager #03 who confirmed with the surveyor that Resident #1 Trach Collar Oxygen mask was found on floor. The surveyor shared the concern for the importance of maintaining infection prevention to prevent the development and transmission of potential infections. After surveyor discussion and intervention, Unit Manager #03 stated that the Trach Collar Oxygen mask would be replaced. The surveyor observed Unit Manager #03 remove the Trach Collar Oxygen mask from the floor.</p> <p>2. On 8/1/25 at 11am, during a follow-up observation of Resident #7's room, a used Foley catheter with visible urine in the drainage tubing and collection bag was observed placed directly on the bedside table next to personal care items. The Foley catheter was not contained in a biohazard bag or other appropriate receptacle for contaminated medical waste.</p> <p>An interview was conducted at the time of the observation with the Registered Nurse (RN) staff #17 who stated, I meant to come back and throw it away after I finished with the resident, but I forgot. Staff #17 acknowledged that placing a contaminated Foley catheter on a bedside table was against infection control policy and could expose the resident and others to harmful pathogens.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Infection Prevention and Control Program Policy, updated last 2019, revealed staff are to immediately discard used medical equipment, including Foley catheters, into appropriate biohazard receptacles after use to prevent contamination of the resident's environment.</p> <p>In an interview on 8/6/25 at 1pm, the Infection Preventionist (IP) and the DON (Director of nursing) confirmed that used Foley catheters should never be left on bedside tables and should be discarded immediately following use. The IP stated that leaving the contaminated catheter in the resident's environment was a direct violation of infection control protocols and posed a risk of infection spread.</p> <p>3. On 7/30/25 at 9:02AM the surveyor observed the following signage on the door to the room of Resident #117: Stop, Contact Precautions, Everyone must: Clean their hands, including before entering and when leaving the room, Providers and staff must also: put on gloves before room entry, discard gloves before room exit, put on gown before room entry, discard gown before room exit, do not wear the same gown and gloves for the care of more than one person, use dedicated or disposable equipment, clean and disinfect reusable equipment before use on another person. The trach tubing connected to Resident #117 was observed by the surveyor to be laying directly on the facility floor surface.</p> <p>On 7/30/25 at 9:02AM the surveyor observed Geriatric Nursing Assistant (GNA) #9 walk past the contact precautions signage on the door to the room of Resident #117 and enter the room with no hand hygiene performed and no personal protective equipment (PPE) donned, and they proceeded to walk over to the resident's bed and pick a towel up off of the floor from underneath the bed with their bare hands, and then carried it out of the room with no hand hygiene or ppe and retrieved a trash bag and placed the towel into the trash bag. At this time, the surveyor conducted an interview with GNA #9 and Registered Nurse Supervisor (RN) #10. GNA #9 and RN #10 visualized the contact precaution signage on the door and the trach tubing laying on the floor with the surveyor and confirmed that the resident was to be on contact precautions. GNA #9 stated to the surveyor during the interview that PPE should be worn when in the resident's room. At this time, the surveyor shared their concern and GNA #9 acknowledged understanding of the concern. RN #10 acknowledged and confirmed understanding of the surveyor's concern and stated to the surveyor that Gown and gloves have to be worn for contact precautions. RN #10 further stated to the surveyor that they did not know why Resident #117 was on contact precautions.</p> <p>On 7/30/2025 at 9:03AM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #11 who was assigned care of the resident who stated to the surveyor that the resident was to be on contact precautions and confirmed there was an active medical order for contact precautions for Resident #117. The surveyor shared their concerns with LPN #11, and after surveyor intervention, they responded, performed hand hygiene, donned ppe, and addressed the resident's trach tubing.</p> <p>On 7/30/2025 at 11:20AM the surveyor shared the concerns with the facility Administrator who acknowledged and confirmed understanding of the concerns.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/25 at 11:50AM the surveyor conducted an interview with the Director of Nursing (DON) and Infection Preventionist (IP) #12. During the interview, the DON reported their expectation of staff for adhering to contact precautions was for them to perform hand hygiene and gather items needed items before going into the room, to gown and glove prior to entering the room, and if they are on contact precautions then they need to use that PPE. The DON and IP #12 confirmed with the surveyor that Resident #117 required contact precautions. At this time, all infection control concerns were shared by the surveyor and both the DON and IP #12 acknowledged the surveyor's concerns.</p> <p>4. On 8/5/25 at 9:17AM the surveyor observed following signage on the door to the room of Resident #125: Stop, Contact Precautions, Everyone must: Clean their hands, including before entering and when leaving the room, Providers and staff must also: put on gloves before room entry, discard gloves before room exit, put on gown before room entry, discard gown before room exit, do not wear the same gown and gloves for the care of more than one person, use dedicated or disposable equipment, clean and disinfect reusable equipment before use on another person. During the surveyor's review of medication administration, Licensed Practical Nurse (LPN) #13 was observed walking past the contact precautions signage posted on the door to the room of Resident #125 and entered the room to pass medications with no personal protective equipment (PPE) donned and was standing against the side of the bed with their clothing touching the resident's bed linens as they passed medications.</p> <p>On 8/5/25 at 9:21AM Geriatric Nursing Assistant (GNA) #14 was observed walking past the contact precautions signage on the door to the room of Resident #125 and entered the room without performing hand hygiene or donning PPE, performed a task in the resident's bathroom and then re-entered the resident's room before exiting the room. At this time, the surveyor conducted an interview and shared the concern with GNA #14 who reported the following information to the surveyor: Yes, I have to have PPE on when providing care.</p> <p>On 8/5/25 at 9:26AM the surveyor conducted an interview with LPN #13 who observed the contact precautions signage on the resident's door with the surveyor and stated to the surveyor that PPE only needed to be worn when providing care. When the surveyor further inquired as to what contact precautions meant, LPN #13 further stated: I wear PPE if I am changing a dressing for a wound. When the surveyor asked LPN #13 what reason the resident had been placed on contact precautions for, they reported they did not know what the reason was for the contact precautions in place for Resident #125. Review of the medical record with LPN #13 revealed the resident required contact precautions for more than one multi drug resistant organism.</p> <p>On 8/5/25 at 9:31AM the surveyor conducted an interview and shared concerns with Registered Nurse Supervisor, Unit Manager (RN UM) #15 who confirmed that Resident #125 was to be on contact precautions and acknowledged understanding of the surveyor's concerns. When the surveyor inquired as to what their expectation was for staff when caring for a resident on contact isolation they reported their expectation was that the signage was there on the room so the staff can follow it and use the PPE that is there in the cart. After surveyor intervention, RN UM #15 stated the following to the surveyor: I am going to do an in-service right away.</p> <p>On 8/6/25 at 11:50AM all infection control concerns were shared by the surveyor with both the DON and IP #12 who acknowledged the surveyor's concerns.</p>		