STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215148	A. Building B. Wing	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Waugh Chapel	1221 Waugh Chapel Road Gambrills, MD 21054

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44441 Based on observations, interviews and record reviews it was determined that the facility failed to maintain a resident's dignity by not covering the urinary drainage bag when the resident was being transported to and from rehabilitation activities. This was evident for 1 (Resident #73) of 2 residents reviewed for urinary catheter during a recertification/complaint survey. The findings include: On 3/10/25 at 7:55 AM during the initial tour of the facility, Resident #73 was observed with a Foley catheter, a device that drains urine from the bladder. The catheter was observed attached to a urinary drainage bag 1/3 filled with urine hanging under the bed. The Resident was asleep in bed at the time. 03/10/25 at 11:19 AM the surveyor returned to check on the resident and observed Staff #31, a Certified Occupational Therapy Assistant (COTA) as she wheeled the resident back to their room in a wheelchair. The urinary bag was not covered in a dignity bag, it was hanging on the wheelchair. In an interview with staff #31 she stated that part of her job description was to transport residents to and from therapy. She was asked the process for covering the urinary bag with a dignity bag during transport. Staff #31 stated that residents with foley catheters would have a dignity bag covering the urinary drainage bag during transport and if the resident did not have a bag, she would contact nursing to provide one for the resident. Staff #31 was asked about the process for applying the dignity bag and stated that nurses were responsible for applying it and that she gets instructions from them to conceal the urinary bags prior to taking the residents out of their rooms. She acknowledged that the resident did not have the covering on when she took them to therapy, but should have. On 3/11/25 at 7:45 AM an interview with Staff #1 the acting Director of Nursing (DON), she was asked about the process for concealing the urinary bags during transport. Staff #1 stated that the facility provides each resident with a foley catheter, a leaf bag used to conceal the urinary bags during transport. Residents with foley catheter are offered leg bags as alternates during transport and leaf bags are provided if they decline to use the leg bags to ensure dignity. She was asked if residents with urinary drainage bags should be transported out of their rooms without the leaf bag covering and she said no. She was made aware of the concern and said she would go and check it out.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Waugh Chapel		STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Waugh Chapel Road Gambrills, MD 21054	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50904 Based on a review of facility investigative material and interviews with facility staff, it was determined that the facility failed to ensure that a resident remained free of physical abuse. This was evident for 1 (Resident #92) out of 2 residents reviewed for abuse during the Medicare/Medicaid recertification/complaint survey. The findings include: The Minimum Data Set (MDS) is a standardized and comprehensive assessment screening tool used to identify resident's individual needs and areas of concern. BIMS stands for Brief Interview for Mental Status. It is a screening tool used to assist with identifying a resident's current cognition and to help determine if any interventions need to occur. On 03/11/2025 at 12:09 PM, review of resident's record revealed that on 03/06/2023, Resident #92's BIMS assessments score was 13.0 out of 15.0 which indicated that the resident was cognitively intact around the time of the incident. On 03/11/2025 at 12:29 PM, during review of facility reported incident MD00190653 dated 03/29/2023, Resident #92 told Licensed Practical Nurse (LPN) #32 and Medical Doctor (MD) #33 that Geriatric Nursing Assistant (GNA) #7 slapped the back of his/her hand during care when he/she(resident) reached his/her hand toward perineal while asking GNA #7 question about his/her Foley catheter. On 03/11/2025 at 12:38 PM, upon further review of the investigation packet, the facility determined that statements were obtained from Resident #92, Geriatric Nursing Assistant (GNA) #7, Licensed Practical Nurse (LPN) #32, and Registered Nurse (RN) #34. Based on the statement provided by Resident #92, the facility noted that the resident mentioned GNA #7 repeatedly entered his/her room to apologize, and the behavior suggested that GNA #7 might have been aware of an error and was attempting to make amends with the resident. As a result of the investigation, the facility deemed that Resident #92's complaint was credible and validated while GNA #7's story had conflicting information & was not credible on interview. On 03/11/2025 at 3:35 PM, in a phone interview with the Director of Nursing, she was asked to clarify the reason for the termination of GNA #7. The DON stated that the facility had gathered sufficient evidence to substantiate that the GNA #7 had slapped a resident's hand with enough force for the resident to perceive it as a violation. Regarding whether the allegation of abuse had been substantiated, the DON confirmed that it had, which ultimately led to GNA #7's termination. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/17/2025 at 9:31 AM, in an interview with Human Resource Director #23, when asked to describe the process following an allegation of resident abuse, she stated that regarding the process followed in cases of resident abuse, she explained that the staff member involved is suspended during the investigation. Once the investigation was completed, the findings of the investigation were discussed with the staff and if the allegation was not substantiated the staff member was reinstated. She also noted that it served as an opportunity to provide additional training, depending on the outcome of the investigation. However, if the allegation was substantiated, the employee was informed that their employment would be terminated based on the investigation's findings. She added that disciplinary documentation indicating termination was issued immediately, and a formal termination letter was mailed to the employee.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42507 Based on record review and interviews, it was determined the facility staff failed to report an allegation of abuse within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 1 (Resident #29) of 3 residents reviewed for abuse during a recertification/complaint survey. The findings include: On 3/11/2025 at 8:38 AM, a review of the investigation report of Facility Reported Incident (FRI) #MD00202441, revealed that on 2/10/2024 Resident #29's daughter notified facility staff that the resident reported that on the previous evening care, the GNA (Geriatric Nursing Assistant) hit her/him on the buttock after s/he by self-admission punched the GNA. A review of the timeline of events revealed that the Director of Nursing (DON) was made aware of the allegation of abuse on 2/10/2024 at 3:00 PM and the Nursing Home Administrator (NHA) on 2/10/2024 at 4:50 PM. However, further review of the investigation report of the FRI revealed documentation that the initial self-report of the allegation of abuse was submitted to the State Survey Agency (OHCQ) on 2/10/2024 at 5:30 PM, more than 2 hours past the time the facility staff were made aware of the allegation. However, the investigation report packet did not include any confirmation receipt for when the initial self-report of the allegation of abuse was submitted to OHCQ. On 03/11/2025 at 10:37 AM, during an interview with a surveyor, the Nursing Home Administrator (NHA) was asked about the facility's procedure for reporting allegations of abuse. He stated that any allegation of abuse must be reported to the State Agency within two hours of its occurrence and that substantiation was not required before reporting to the State Agency. On 3/12/2025 at 7:35 AM, surveyor requested and received from the NHA the email confirmation receipt for when the initial self-report of the FRI was submitted to OHCQ. On 3/12/2025 at 8:10 AM, A review of the email confirmation receipt revealed the initial self-report of the allegation of abuse was submitted to OHCQ on 2/10/2024 at 6:13 PM, more than 3 hours from when facility staff were made aware of the allegation of physical abuse. Thus, failing to meet the 2-hours reporting requirement for any allegation of abuse. On 3/12/2025 at 8:48 AM, An interview was conducted with the Nursing Home Administrator (NHA). Surveyor shared concerns regarding the investigation report of the FRI with date and time the initial self-report was submitted to OHCQ noted as 2/10/2024 at 5:30 PM and the email confirmation receipt of the initial self-report with date and time report was sent to OHCQ noted as 2/10/2024 at 6:13 PM: NHA verified and affirmed that the date and time on both documents were more than 2 hours from when the facility staff were made aware of the allegation of abuse. Thus, the facility failed to report an allegation of abuse to the State Agency within the 2 hours required by regulation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/2025 at 1:10 PM during the exit conference, the Director of Nursing (DON) confirmed that the initial self-report of the above allegation of abuse was submitted to the State survey Agency (OHCQ) later than the 2- hour time frame required for such submissions. DON stated that she was made aware of the allegation on a Saturday and she had to rush home to submit the report. She added that when she got home and submitted the initial self-report, she realized that it was late (past the 2-hour window). Thus, admitting the facility's failure to timely report an allegation of abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49409 Based on record review and interviews with facility staff, it was determined that the facility failed to initiate and develop a comprehensive person-centered care plan for Residents who had frequent urinary tract infections (UTI). This was evident for one Resident (Resident #35), out of one Resident reviewed for urinary tract infections during the recertification/complaint survey. The findings include: On 03/11/25 at 10:15 AM medical record review revealed that Resident #35 had UTIs and used antibiotic therapy on 01/19/24: Keflex, on 05/22/24: Cipro, on 06/05/24: Cipro and on 12/30/24: Bactrim. The care plan was not initiated for risks and prevention of UTI. On 03/11/25 at 9:57 AM, an Interview with Social Services staff # 4 revealed that the Care plans are conducted regularly. The social worker documents the overview of the care plan meeting notes, and individual departments initiate and revise their care plans. On 03/12/25 at 03:59 PM, Reviewed with Infection Preventionist Staff # 1 and validated that Resident #35 ' s care plan did not include the risks and prevention for getting frequent urinary tract infections.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on staff Interviews and medical record reviews, it was determined that the facility failed to review and revise the Resident's comprehensive care plan by an interdisciplinary team (IDT). This was evident for 2 Residents (Residents #13 and #35) out of forty-four Residents reviewed for care plan revisions during the recertification/ Complaint survey. A care plan is used to assess, plan, and evaluate the effectiveness of the resident's care, and it flows from each Resident's unique list of diagnoses. It should be organized according to the Resident's specific needs. The care plan is a means of communicating and organizing the actions and assuring the Resident's needs are attended to. The care plan is to be reviewed and revised at each assessment time of the Resident to ensure the interventions on the care plans are accurate and appropriate for the Resident. The findings include: 1) Resident # 13 was admitted to the facility on [DATE] and received long-term care, with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the left side. On 03/10/25 at 10:55 AM, the surveyor observed Resident #13 with left arm contracture without having the bolster in place. On 03/14/25 at 11 AM medical record review revealed that Resident #13 had an order for a soft bolster for LEFT arm positioning r/t contracture. Gently place bolster between elbow and ribs for abduction and between forearm and bicep to allow the antecubital space to allow airflow every shift, dated 09/13/2023. (As per the National Institutes of Health (NIH), Bolsters are cushions that elevate a part of the body) On 03/14/25 at 11:10 AM, in an Interview with the unit manager, staff # 3 confirmed that Resident #13 had an order for a bolster. The care plan did not reflect the intervention of Bolster usage. The care plan was last revised on 08/21/23. On 03/14/25 at 11:30 AM, Infection Preventionist Staff # 1 validated that the care plan for Resident #13 did not reflect the intervention for contracture management. 2) Resident # 35 was admitted to the facility on [DATE], receiving long term care. On 03/12/25 at 09:42 AM, a medical record review of the Medication administration record (MAR) for January and February 2025 revealed that resident #35 had an order dated 12/22/23 for Non-pharmacological interventions were attempted prior to administering any PRN pain med. as needed. Document the number corresponding to the NonPharmacological Interventions attempted: 1. Warm beverage offered 2. Repositioned 3. Soft music played 4. Lights dimmed 5. Other (document in a progress note) 6. The resident refused. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/25 at 11:30 AM, Infection Preventionist Staff # 1 validated that the care plan was revised on 08/21/23 and the revised care plan does not reflect the intervention of nonpharmacological interventions prior to administering the pain medication.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409 Based on the interview of the facility staff and review of the medical records, it was determined that the facility failed to provide needed care and services that are resident-centered, in accordance with the resident's goals for care and professional standards of practice that will meet each resident's physical needs. This was evident for one Resident (Resident #13) out of 44 residents reviewed for quality of care during the recertification/complaint survey. The findings include: Resident # 13 was admitted to the facility on [DATE] and received long-term care, with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the left side. On 03/10/25 at 10:55 AM, the surveyor observed Resident #13 with left arm contracture without any pillow or device in place to treat the contracture. On 03/14/25 at 11 AM medical record review revealed that Resident #13 had an order for a soft bolster for LEFT arm positioning r/t contracture. Gently place bolster between elbow and ribs for abduction and between forearm and bicep to allow the antecubital space to allow airflow every shift, dated 09/13/2023. (As per the National Institutes of Health (NIH), Bolsters are cushions that elevate a part of the body) On 03/14/25 at 11 AM, an Interview with Licensed Practical Nurse (LPN) staff #29 revealed that he/she did not see a bolster or pillow being used during the medication administration earlier that morning. He/she stated that the staff used a folded pillow sometimes in place of a bolster. On 03/14/25 at 11:10 AM, in an Interview with the unit manager, staff # 3 confirmed that Resident #13 had an order for a bolster, but the staff used a folded pillow. On 03/14/25 at 11:11 AM , in an interview, the Infection Preventionist Staff # 1 validated that Resident #13 used the bolster for contracture management, and the bolster was found in the resident's closet.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49409 Based on resident interview, staff interviews and medical record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, recognition and management of Pain. This was evident for one resident (Resident # 35) out of two residents reviewed for pain management, during the recertification/Complaint survey. The findings include: On 03/12/25 at 09:42 AM, a medical record review of the Medication administration record (MAR) for January and February 2025 for Resident #35 revealed that Pain medication was administered without attempting to offer any nonpharmacological interventions. Further review of physician's orders revealed: - Acetaminophen Tablet 325 MG, Give 2 tablets by mouth every 8 hours as needed for Mild Pain 1-4, Order Dated 06/20/2024. - Non-pharmacological interventions were attempted prior to administering any PRN pain med. as needed. Document the number corresponding to the NonPharmacological Interventions attempted: 1. Warm beverage offered 2. Repositioned 3. Soft music played 4. Lights dimmed 5. Other (document in a progress note) 6. Resident refused, Order dated 12/22/23. Resident # 35 received Acetaminophen Tablet 325 MG 2 tablet for mild pain On 01/11/25 at 9:17 PM from License Practical Nurse (LPN) staff # 36, on 02/06/25 at 4: 39 PM from LPN, Staff # 28, and on 02/07/25 at 4:03 PM from LPN staff #28. There was no documentation that the resident # 35 was offered any non pharmacological interventions, before administering the medication for pain. Further review of medical records revealed a medication order for OxyCODONE HCl Tablet 10 MG Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain, order dated 01/02/2025. Resident # 35 received Oxycodone 10mg, on 01/18/25 at 5:57 PM by LPN staff #28, on 01/19/25 at 08:01 PM from LPN staff # 28, on 02/08/25 at 11:30 AM from LPN staff # 29, and on 02/23/25 at 9:12 PM from LPN staff # 28. There was no documentation that the resident # 35 was offered any non pharmacological interventions, before administering the medication for pain. On 03/12/25 at 03:00 PM, an interview with License Practical Nurse (LPN) staff # 29 revealed that he/she administered pain medication after assessing the pain but was unable to confirm if any nonpharmacological interventions were offered to the Resident before administering the pain medication. On 03/14/25 at 11:01 AM, Reviewed with Infection Preventionist Staff # 1 and validated that PRN Acetaminophen and Oxycodone were administered without offering nonpharmacological interventions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49409 Based on observation and interview with facility staff, it was determined that the facility failed to maintain the safety of the food items to prevent foodborne illness. This was evident for two nourishment room refrigerators out of two nourishment room refrigerators audited during the recertification/complaint survey. The findings include: During the surveyor's tour of the facility on 03/13/25 at 12:10 PM, the surveyor observed a large zip-lock bag with cooked food items dated 03/08/25 and an uncooked cauliflower, brown to black in color in a plastic bag dated 03/08 in the refrigerator, located in the nourishment room, close to the 400-unit Nurses' station. Licensed Practical Nurse (LPN) staff # 29 validated the findings and removed the resident's food from the refrigerator. The surveyor's further observation on 03/13/25 at 12:20 PM noted apple sauce dated 03/08/25 in the refrigerator, located near the 200-unit Nurses station. Unit secretary staff #37 witnessed and validated the findings and removed the apple sauce from the refrigerator. On 03/13/25 at 12:10 PM, an interview with LPN staff # 29 revealed that the food brought from outside the facility for the residents was dated and saved in the refrigerator for three days, and the resident's food should have been out of the fridge, as it was past three days. On 03/13/25 at 1 PM, Reviewed with the Infection Preventionist (Staff #1), and Staff # 1 validated the concerns.