STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215165	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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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 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. 40927 Based on record review and interview, it was determined that the facility failed to have a process in place to ensure that allegations of abuse, were reported to the state agency (SA) and within the required timeframe. This was evident for 1 (R40) of 32 residents reviewed for abuse. The findings include: A review of the facility's investigation file for the facility reported incident MD00207668 on 2/11/25 at 2:34 PM revealed a statement written by LPN 5. According to his statement he became aware of R40's allegation of abuse against Geriatric Nursing Assistant (GNA)12 on 7/13/24 at 3:20 PM. On the incident report LPN5 reported that he reported it to Registered Nurse (RN)6. Further review revealed the initial report form, and the facility documented they became aware of the abuse allegation on 7/14/24 at 12N and reported to SA 7/14/24 at 1:30 PM. No confirmation email included. On 2/13/25 at 2:58 PM a review of the email confirmation for sending the initial report confirmed it was sent to the SA on 7/14/24 at 1:27 PM. An interview with LPN5 on 2/13/25 at 3:44 PM confirmed that he was made aware of the abuse allegation at the beginning of the evening shift and he reported it to RN6, who was the supervisor on duty. On 2/13/25 at 3:52 PM RN6 was interviewed and reported that she was the supervisor for the 3-11 pm shift on 7/13/24. She confirmed that she was made aware of the allegation of abuse and notified the previous DON and the Nursing Home Administrator (NHA) that evening. However, she was unable to provide documentation of the date, time, and manner in which she contacted them. During an interview with the NHA on 2/13/25 at 4:25 PM, he reported he was made aware of R40's allegation of abuse when the previous DON contacted him on 7/14/24. He denied that he had been notified by RN6 on 7/13/24. He stated that staff often will not report allegations of abuse to him immediately because he was not in the building, and they cannot call him in the middle of the night. When asked if he was aware of the regulatory requirements to report within the 2-hour timeframe he stated that he was aware.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 40927 Based on record review and interview, it was determined facility staff failed to ensure that an alleged perpetrator had no further access to vulnerable residents during an investigation and to conduct a thorough investigation of the allegation. This was evident for 1 (R40) of 32 residents reviewed for abuse. The findings include: On 2/5/25 at 10:30 AM a review of the facility's policy titled Abuse, Neglect, and Exploitation with no implementation date but was reviewed on 11/13/23. In the section for definitions, Misappropriation of resident property is included as abuse. In section IV B the facility identifies Resident reports of theft of property, or missing property is an indicator of possible abuse. In section V the facility states that identifying and interviewing all involved people including witnesses as part of a thorough investigation and to focus the investigation on determining if abuse has occurred and to what extent. In section VI the facility's expectation for protecting the residents includes room or staffing changes. In section VII, the Administrator is responsible for defining how care provisions will be changed or improved to protect residents. 1) A review of the facility's investigation file for the facility reported incident MD00207668 on 2/11/25 at 2:34 PM revealed a statement written by LPN 5. According to his statement he became aware of R40's allegation of abuse involving Geriatric Nursing Assistant (GNA)12 on 7/13/24 at 3:20 PM. He stated that he separated the GNA from the resident by assigning a different GNA to R40. On the incident report LPN5 documented that he reported it to Registered Nurse (RN)6. However, further review of the investigation file revealed no statement or documentation of the actions she took regarding this allegation. According to GNA12's statement she went into R40's room on 7/13/24 at 4 pm and he/she refused care. It was after this that she was informed by the supervisor that they were switching rooms because R40 had filed a complaint about GNA12, saying that she hit him/her. There were interviews with residents documented, however the residents were asked if they were aware of what happened between R40 and GNA12. There were no questions to determine if other residents had been abused by the accused GNA. Furthermore, staff failed to conduct interviews with other staff to determine the type of care that GNA12 provided to residents. A review of GNA12's time punches on 2/13/24 at 4:00 PM revealed that on 7/13/24, she clocked in at 1446 (2:46 PM) and out at 2304 (11:04 PM), on 7/14/24, she clocked in at 1500 (3:00 PM) and out at 2300 (11:00 PM), then she was absent on 7/15/24 and 7/16/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/11/25 at 3:43 PM an interview, by phone, with LPN5 confirmed that he had reported the allegation of abuse to RN6, who was the evening shift supervisor on 7/13/24. He stated that GNA12 was allowed to continue to work that evening, but did not care for R40, however, she cared for other vulnerable residents. He reported he remembered this because R40 complained that s/he was still seeing GNA12 in the hallway and that upset him/her. When asked if he was familiar with the facility's abuse policies and procedures, he stated that he was familiar with them and was aware that a staff member accused of abuse was to be suspended. He stated that he must have been wrong and GNA12 was suspended that evening. An interview with GNA12 by phone on 2/11/25, at 3:58 PM revealed she remembered the incident because she was suspended from work. However, on 7/13/24, she was allowed to continue to work until the end of her shift. During a subsequent interview with LPN5 2/13/25, at 3:44 PM, he confirmed that GNA #12 worked until the end of her shift on 7/13/24. RN6 was interviewed on 2/13/25, at 3:52 PM regarding the allegation of abuse reported on 7/13/24. She stated that she was the supervisor that evening and recalled LPN5 reporting the allegation to her. RN6 reported that she called the Director of Nursing (DON) who was employed at the time and the Nursing Home Administrator (NHA) that evening. She stated she obtained a statement from GNA12 and then sent her home. She reported she did not document the actions she took and did not provide a statement because LPN5 was working on that information. When presented the with staff interviews and GNA12's time punches which revealed GNA12 had finished her shift that evening, she stated she knew she told GNA12 to go home, but she had not walked her out of the building. She stated that if GNA12 worked she was unaware she had and she would have thought the nurse would have reported it to her. An interview with the NHA on 2/13/25, at 4:25 PM revealed that if a staff member was accused of abuse they are suspended immediately for 3 days. Reviewed with him that concerns with the investigation, and he offered no rationale for those findings. He stated he recalled the incident and that the GNA was suspended when he was made aware on 7/14/24. He was shown the time punches for GNA12 and that she continued to work 7 hours and 40 minutes after the allegation of abuse was reported. He stated that just because staff had time punches does not mean they worked because if the allegation was unfounded staff were paid for that time. The Director of Human Resources was interviewed on 2/13/25, at 4:45 PM regarding how to distinguish between the time entered by Human Resources (HR) for back pay for an allegation of abuse or when a staff member was actually clocking in and out. She stated that this was their old system and there was no way to enter codes. She stated that she would look at the time punch times and the ones that were specific for 1500 (3:00 PM0 - 2300 (11:00 PM) were more than likely entered by HR. The days that staff clocked in and out would vary from 1500 (3:00 PM - 2300 (11:00 PM) because staff rarely clock in and out at the exact times. GNA12's time punches for 7/13/24 revealed she had clocked in at 1446 (2:46 PM) and out at 2304 (11:04 PM). The Director stated she clocked in and out that day and it was not entered manually because of the variances in the time. However, it did show that on 7/14/24, GNA12's time was manually entered by HR, which indicated that she was suspended on the day the NHA was made aware of the allegation of abuse. Subsequently, these findings were reviewed with the NHA. The concerns were reviewed with the NHA and Regional DON at the time of exit on 2/20/25 at 12:45 PM.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 40927 Based on record review and interview it was determined that the facility failed to provide a baseline care plan to the resident's representative. This was evident for 1 (#12) of 9 residents reviewed for care to prevent pressure ulcers. The findings include: Baseline care plan - must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. During a review of a complaint regarding Resident (R)12 on 2/5/25 at 9:55 AM, it was revealed that the complainant reported they were not given a copy of the resident's baseline care plan or made aware of the medications the resident was taking. On 2/18/25 at 1:03 PM, a review of the closed record for R12 revealed no evidence that the baseline care plan or list of medications were given to the resident or resident representative. A review of the electronic medical record for R12 on 2/20/25 at 11:57 AM, revealed under the miscellaneous tab that there was no evidence that the resident or resident representative was given a copy of the baseline care or a list of the medications prescribed. The Regional Director of Nursing confirmed the findings on 2/20/25 at 11:40 AM. On 2/20/25 at 12:40 PM the concerns were reviewed with Nursing Home Administrator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 40927 Based on record review and interview, it was determined that facility staff failed to ensure the resident's medical records were complete and accurate. This was evident for 2 (R630 and R12) of 92 residents reviewed during the survey. Findings include: 1) During a review of a complaint regarding Resident (R)12 on 2/5/25 at 9:55 AM, it was revealed that the complainant reported concerns that staff were not turning and repositioning the resident to prevent skin breakdown. On 2/20/25 at 8:41 AM a review of geriatric nursing assistance (GNA) documentation for turning and repositioning of the resident for the dates of 10/20/21 - 11/17/21 revealed the resident was dependent on staff for turning and repositioning. However, staff documented that they had not turned and repositioned the resident on the following dates: 10/21/21, 10/22/21, 10/24/21, 10/25/21, 10/26/21, 10/28/21, 10/30/21, and 10/31/21. The findings were reviewed with the Regional Director of Nursing (DON) and she stated she would review the medical record. The Regional DON reported on 12/20/25 at 12:10 PM that she found the nurses were documenting on the Treatment Administration Record (TAR) that the resident was being turned and repositioned on the days that the GNAs documented s/he was not and provided a copy of the record. An interview with GNA #11 on 12/20/25 at 12:13 PM revealed that she documented in the electronic medical record when she turned and repositioned a resident. When asked if she reported to the nurses how often she turned and repositioned the residents and she stated she had not. She was unable to recall specific details regarding the care of R12 due to the time that had lapsed. A subsequent interview with the Regional DON on 2/20/25 at 12:33 PM, revealed the nurses were supposed to ask the GNAs if they were able to turn and reposition the residents every two hours to document it on the TAR. She had no rationale as to why the information documented by the GNAs and the nurses was conflicting. The findings were reviewed with the Nursing Home Administrator on 2/20/25 at 12:40 PM. 37586 2) On 2/13/25 at 8:45 AM, a medical record review was conducted for Resident (R) 630. Family stated the resident has not been changed on a regular basis R630 came to the facility for rehab, was unsteady on feet and needed assistance with activities of daily living. Upon review of bowl and bladder records, it was noted that bowel and bladder were not signed off as being done on the following dates: 8/1/24 night shift not signed off (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/5/24 evening shift not signed 8/23/24 night shift not signed 8/28/24 evening, shift not signed off Resident care record indicated personal hygiene was not signed off as completed on the following dates: 8/24/24 day shift 8/5/24 evening shift 8/28/24 evening shift 8/1/24 night shift 8/23/24 night shift During interview on 2/13/25 at 11 am, the Regional Director of Nursing and administrator confirmed the tasks were not signed off, therefore it could not be confirmed if resident was changed or given personal hygiene or the nurse failed to sign off on care record.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on observations and staff interview, it was determined that the facility failed to maintain a safe and sanitary environment for residents, visitors, and staff. This was evident for the parking lot and the East hallway during the survey. The findings include: On 2/4/25, at 9:45 AM upon entry to the parking lot area in front of the facility's front doors, there were masks, gloves, and various paper packaging littering the ground. The same observations were made on 2/5/25 at 8:50 AM, 2/5/25 at 3:00 PM, 2/7/25 at 7:00 AM, 2/7/25 at 1:00 PM, 2/10/25 at 8:00 AM, 2/10/25 at 4:10 PM, 2/11/25 at 8:30 AM. On 2/11/25 at 1:00 PM, a pile of nonsterile clear gloves was found in a parking spot, as well as the other trash noted previously. On 2/13/25 at 9:30 AM, there was a piece of cardboard laying in a parking spot, dirty masks, gloves, a paper cup with trash in it. At the doorway was a plastic bag used for produce at a grocery store, that looked like it had been ran over. An interview with the Maintenance Director on 2/13/25, at 9:54 AM revealed that they were supposed to clean up the parking lot every day. Reviewed the concerns with him and he reported that they have addressed the staff, and they are not sure if visitors were throwing their mask on the ground. On 2/4/25, at 1:25 PM an observation of the East hallway where the dietary doorway is located there was a ceiling vent that had a 1/2 (inch) gap between the vent and the ceiling tile. The vent was white and had black spots on it. There was a ceiling vent outside the office door labeled, NP/Educator that was white and had black spots on it. There were multiple ceiling tiles in the hallway that had brown spots on them and the carpet had multiple stains on it. Once of the flooring tiles near the dietary doorway had an area that was about 3 by 2 where it was torn away to the white part. The resident rights picture frame outside the storage room was hanging crooked. On 2/4/25, at 1:26 PM entering the hallway where the Dialysis center was located, there was a dummy waiter that had boxes piled up next to it. The boxes were medical supplies. The same boxes were there during subsequent observation on 2/5/25, at 11:50 AM. On 2/13/25, at 9:48 AM there were boxes in the same location, but they were different supplies. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further down that same hallway were brown spots scattered on the wallpaper to the right of room [ROOM NUMBER]'s doorway all the way to where the picture was located. A dried reddish-brown substance was on the handrail to the left of room [ROOM NUMBER]. The same reddish-brown stain that was on the handrail was across the hallway under the computer BOC-Kiosk01 located across from room [ROOM NUMBER] it measured about 4 down the wall onto the handrail and some below the handrail. On the same wall under the kiosk, to the left, and above it were scrapes in the wallpaper down to the white. Under the hand sanitizer dispenser located beside the bulletin board were 5 staples in the wallpaper. Above the hand sanitizer dispenser were two black marks. The telephone hanging on the wall outside room [ROOM NUMBER] was crooked. Additional observations of these findings revealed that they were still there on 2/5/25, at 11:49 AM and again on 2/13/25, at 9:48 AM. On 2/13/25, at 9:49 AM during an interview with Environmental Services (ES)4 she reported that they were supposed to wipe down the walls and handrails every day when they cleaned. When asked about the dirty handrails and walls she stated she had not been working since last Thursday (2/6/25). However, the areas were observed before she worked last Thursday. She stated that sometimes the nurses' carts and other equipment block them from getting all the areas wipes. When asked if she was expected to move equipment to clean she stated she was. An interview with the Director of Environmental Services on 2/13/25 at 10:02 AM revealed that staff were supposed to wipe down walls and handrails every day. He was shown the areas. He reported there were some issues between environmental staff and nursing, so he told his staff not to engage them if they were in the hallway. He stated it should not have stayed on the walls and handrails since 2/4/25. On 2/13/25, at 9:54 AM an interview with the Director of Maintenance was conducted and he was shown concerns with the vents, ceiling tiles, and flooring. He reported that the facility was being renovated. When asked if there was a contract for the renovations, he stated he would check with the Administrator. He reported he was responsible for cleaning the vents but offered no rationale for why they were not clean. An interview with the Unit Clerk (UC) 1 on 2/13/25, at 10:14 AM revealed that vendors who deliver supplies will lay the boxes on the floor near the dummy waiter or in front of her desk. She stated that those boxes stayed there until staff were able to get them to put them away. The concerns about the facility cleanliness and safety were discussed with the Nursing Home Administrator on 2/13/25, at 10:25 AM. He reported that they were aware of the trash in the parking lot and had told staff and visitors to use the trash receptacles provided. He was made aware that there were multiple observations on multiple days of trash all around the parking lot. He offered no rationale for the housekeeping concerns. He reported that the facility was going under extensive renovations, but he would check on a contract. Later he provided a contract that was a proposal from the building company that was not signed by facility staff or dated.