STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215177	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Cherry Lane	9001 Cherry Lane Laurel, MD 20708

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interviews it was determined that the facility failed to maintain a resident's right to privacy. This was evident for 1 (Resident #137) out of 1 residents observed for privacy.The findings include: During an observation of the room for Resident #137 on 8/12/25 at 2:08 PM, it was observed that he/she was in the window bed, the roommate, Resident #22 was near the door lying in the bed with his/her eyes closed. There were no staff members in the room.During an interview with Resident #137 on 8/12/25 at 2:10 PM he/she began to express concerns to the surveyor at that point the Resident was asked do you want me to shut the door? The Resident replied yes.During an observation on 8/12/25 at 2:10 PM upon stepping from behind the curtain Geriatric Nursing Assistant (GNA) #19 was observed leaving the room from the side of Resident #22 on the door bed side. Resident #22 was still lying in the bed with his/her eyes closed and the curtain was open. There was no notification provided of GNA #19 entering the room.During a continued interview of Resident #137 on 8/12/25 at 2:16 PM GNA #20 made a rapid knock on the closed door and quickly walked in without a pause or invite. She walked into the bathroom. She was observed washing her hands. There was no opportunity for the Residents to invite or give the GNA permission to enter the room.During an interview at on 8/12/25 at 2:18 PM with GNA #20 reported I went in there to wash my hands and advised she was coming back from taking trays into the kitchen. During an interview on 8/12/25 at 2:50 PM with GNA #19 she reported she was not assigned to the room with Residents #137 and #22. She advised she went into the room for Residents #137 and #22 because she was looking for towels. During an interview with the Director of Nursing (DON) on 8/12/25 at 3:20 PM she reported the expectation is to knock and wait before entering the Resident's room and close the curtains if providing care.

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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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. Based on two complaints of alleged witnessed allegations of abuse and interview with facility staff, it was determined that the facility failed to report to the State agency no later than 2 hours after the allegation was made and results of all investigations were reported within 5 working days. This was evident for 2 of 2 allegations of abuse identified during a complaint survey for Residents # 158 and #72.The findings include:1. Review of complaints #MD337029 and #MD3370330 both submitted from separate visitors of residents both alleged observing staff GNA #2 forcefully and aggressively push Resident #158 back down into his/her chair in the dining room on 1/16/25 and then restrain him/her in their chair with a bedside table. Both individuals also independently reported that they reported their observations and concerns to nursing staff and Administration and continued to follow up with the outcome and they received no answers. Interview on 8/1/25 at 10:47 AM with complainant from MD337030 verbalized that they were afraid to have GNA #2 care for their family member and reported that too to administration with no response.On 8/1/25 at 12:30 PM this surveyor interviewed the NHA and DON facility regarding the concerns identified by the family and residents related to the nursing staff and reported interactions.Regarding the January incident, they were asked if they reported it to the state agency. They stated they didn't think it was a self-report as it wasn't reported to them as abuse. They were asked what they consider abuse. The DON stated that she just had a message about a concern about GNA and the way he spoke to the resident and that he was mean and rough. This was clarified and asked why again it was not reported. The DON stated that she interviewed the GNA and that he said it didn't happen the way it was reported. The facility was notified that this was a concern and would be cited. The Administrator asked how it could be cited if I did not review their investigation. This surveyor asked again if the allegation of abuse was reported and if the residents were kept safe during their investigation. The Administrator reported no. This surveyor stated that a review of the actual investigation has nothing to do with the reporting to the state, which they stated they did not do, and the state has no record of.2. Review of the resident council meeting minutes from the past 6 months revealed intermittent concerns related to staff responses. Specifically, on 3/26/25, Resident #72 verbalized a concern about how an aide had delivered the breakfast tray, the resident then requested for the aide not to be assigned to him/her and at one point the aide responded to Resident #72 by saying ?bring it on.' Review of this incident with the DON on 8/1/25 at 12:30 PM, she stated that the resident in question has behaviors. The Administrator then asked if they are supposed to put in a report for every allegation a resident with behaviors has. This surveyor stated that it is not up to another individual to tell someone what abuse is. This surveyor also referred the facility policy and regulations as to what the facility should follow and report. According to the Resident council concern form, the action taken was to talk to other residents-that were not listed or identified, and spoke to the GNA in question who stated that it did not happen the way the resident stated.Again, the concern that this abuse allegation was not reported to the state agency or interventions for the safety of the residents implemented during the investigation. The DON stated that Resident #72 has certain ?dynamics' and has issues with the staff. She said she spoke to the GNA, and he said that is not what happened, so she did not consider it a reportable, but they made a soft file for it. This surveyor then presented at what point and why are you believing staff and not investigating the concerns that your residents and families are bringing to you.The ongoing concern that the facility is not reporting allegations of abuse to the state agency was reviewed on 8/1/25 at 12:30 PM.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview it was determined that the facility staff failed to code a resident's discharge status accurately on the Minimum Data Set (MDS) assessment. This was evident for 1 (#152) of 3 residents selected for closed record review during the annual survey.The findings include: On 08/06/2025 at 10:06 AM, a review of Resident #152's clinical record revealed that a discharge MDS was completed on 5/21/2025. The resident was coded under MDS Section A2105 (Discharge Status) as discharged to short term general hospital. However, a review of progress notes on 08/06/2025 at 10:37 AM revealed a Discharge summary dated [DATE] which stated Resident #152 passed away in the facility.On 8/13/2025 at 2:34 PM, an interview was conducted with the MDS Coordinator #13 who confirmed that Resident #152 was a death in the facility and that the discharge status for Resident #152 was coded inaccurately.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and facility staff interviews, it was determined that the facility failed to initiate care plans. This was evident for 3 residents (#118, #156 and #161) out of 3 residents reviewed for care plan implementation during a recertification survey process.The findings include:A care plan is a comprehensive, individualized plan of care developed for each resident. It outlines the residents' medical, psychological, emotional, and social needs, as well as the goals, interventions, and services required to meet those needs. Care plans are created and maintained by the interdisciplinary care team.1) On 08/07/2025 at 10:18 AM, Resident #118's medical records and medication administration records (MAR) revealed physician's orders for Quetiapine Fumarate Oral Tablet 25 mg, to be given 1 tablet by mouth at bedtime for psychosis, and Sertraline HCl Oral Tablet 50 mg, to be given 1 tablet by mouth once daily for depression.Further review of the medical record revealed that on 08/07/2025 at 11:15 AM, the facility failed to initiate a care plan related to antidepressant and antipsychotic medications to reflect the plan of care for Resident #118.On 08/08/2025 at 8:58 AM, the surveyor interviewed the ADON regarding the process for initiating a care plan for a resident receiving antipsychotic and antidepressant medications. He stated that the process is to have a care plan in place. He confirmed that no care plan had been initiated for Resident #118's antipsychotic and antidepressant medications and stated, It was an oversight. The surveyor informed him of the concern, and he acknowledged receipt.Peripherally Inserted Central Catheter (PICC) is a long, thin, flexible tube inserted into a peripheral vein, usually in the arm, and advanced to a central vein near the heart, used for long-term intravenous therapy, including medications, fluids, or nutrition, and requires monitoring for potential infection.2) On 08/04/2025 at 7:15 AM, review of Resident #156's medical records revealed that the resident was admitted to the facility on [DATE] with physician's orders for a Peripherally Inserted Central Catheter for Intravenous therapy (PICC line) to the right upper arm for IV therapy.Further review of the medical record revealed that on 08/04/2025 at 9:15 AM, the facility failed to initiate a care plan related to PICC Line to reflect the plan of care for Resident #156.On 08/05/2025 at 1:11 PM, the surveyor interviewed Unit Manager/Educator #3 regarding the expectation for initiating care plans for residents receiving antibiotic therapy via Peripherally Inserted Central Catheter (PICC) line. She stated that the expectation is to initiate a care plan as per physician's orders. Unit Manager/Educator #3 confirmed that no PICC Line care plan was initiated for Resident #156 during antibiotic therapy. On 08/05/2025 at 1:30 PM, the surveyor notified Unit Manager/Educator #3 and the DON of the concern, and both acknowledged receipt. 3) On 08/11/2025 at 3:30 PM during a medical record review, it was revealed that Resident #161 experienced a fall on 04/21/2024. Review of Resident #161's care plan documented, Resident is at risk for falls related to poor balance. Date Initiated: 04/05/2024. Revision on 04/06/2024. Goal: Resident will remain free of falls through next review. Date Initiated: 04/06/2024. Target Date: 07/05/2024. Further review of the medical record revealed that on 08/11/25 at 3:40PM, the facility failed to initiate an actual fall care plan to reflect Resident #161's fall on 4/21/24.On 08/12/2025 at 9:56 AM, the surveyor interviewed the ADON regarding the process for updating a care plan after a resident fall. The ADON stated it is the expectation that the manager and supervisor ensure the care plan is updated and interventions are implemented whenever there is a change in condition. He acknowledged this expectation was not met. The surveyor informed him of the concern, and he acknowledged receipt

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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. Based on record review and interview, it was determined that the facility failed to hold care plan meetings of the interdisciplinary team for residents at the time of the quarterly revision of their care plan. This was evident for 1 (Resident #115) of 7 residents reviewed for care planning.The findings include: Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). Resident #115 was admitted to the facility in November 2023 with diagnoses including Hypertension and Diabetes Mellitus. The surveyor reviewed Resident #115's clinical record on 8/01/25 at 07:15 PM. The review revealed that Resident #115 had quarterly MDS assessments completed on 9/01/24 and 11/30/24. Review of the resident's care plans revealed that all care plan goals were revised on 12/13/24. There was no evidence in the clinical record that a care plan meeting was held with the resident and the interdisciplinary team around the time of either quarterly MDS assessment or at the time of the care plan revision. The surveyor interviewed Social Services (SS) Staff #7 on 8/05/25 at 10:30 AM. During the interview, SS Staff #7 indicated that social services staff were responsible for coordinating the care plan meetings with residents. Further, care plan meeting notes were documented in the resident's electronic records the same day or a day after the care plan meeting was held. The surveyor enquired whether care plan meetings were held for Resident #115 for the months of August 2024 and November 2024. SS Staff #7 reviewed the resident's electronic record and Hard Chart in the presence of the surveyor and confirmed that there was no documentation of care plan meetings for those months. SS Staff # stated I did not find any documentation. The surveyor requested SS Staff #7 to provide the survey team with any evidence that care plan meetings had taken place for Resident #115 around the time when the quarterly MDS assessments were completed on 9/01/24 and 11/30/24. On 8/06/25 at 6:58 AM the Director of Nursing was made aware of the surveyor's findings. At the time of exit no additional information was provided to the survey team

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of employee personnel files and staff interview, it was determined that the facility failed to complete annual performance reviews for the Geriatric Nursing Assistants (GNA). This was identified for 1 (#18) of 5 GNA staff members reviewed during the annual survey. The findings include: Performance appraisals are to be completed at least every 12 months to identify in-service education needed to address competencies of the geriatric nursing assistants. On 08/07/2025 at 1:47 PM, a review of GNA #18's employee file revealed that GNA #18 was hired on 06/18/2014. Further review of the employee file revealed that a performance appraisal for GNA #18 was completed on 06/18/2017, however there was no evidence that performance appraisals were completed before or after this date. An interview with the facility Administrator on 08/07/2025 at 2:35 PM confirmed that performance appraisals for GNA #18 had not been completed at least annually from the date of hire. At the time of exit, the facility did not provide any additional documentation to show that performance appraisals for GNA #18 were completed annually as required.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and staff interview, it was determined that the facility failed to provide adequate monitoring of residents on psychotropic medications for side effects. This finding was evident for 1 (Resident #2) of 5 residents reviewed for unnecessary medications during the recertification survey.The findings include:Resident #2 was admitted to the facility in December 2022 with diagnoses which included Dementia, Major Depressive Disorder and Diabetes Mellitus. On 08/06/25 at 8:59 AM a review of Resident #2's clinical record revealed that the resident had been receiving Seroquel 125mg daily at bedtime for Dementia from 06/30/25. Further review of Resident #2's clinical record revealed that a care plan was initiated on 12/15/22 addressing the resident's mood problem relating to Dementia. In the care plan there was an intervention Administer medications as ordered. Monitor/document for side effects and effectiveness. A review of Resident #2's Medication Administration Record (MAR) and Treatment Administration Record (TAR) failed to reveal evidence that the resident was monitored for side effects of the medication, Seroquel. On 08/06/25 at 10:11AM in an interview the Unit Manager#3 stated that residents who are administered psychotropic medications are monitored for side effects, and the results are documented on the MAR or TAR. The surveyor asked the staff member to review Resident 2's clinical record to ascertain whether the resident was being monitored. Unit Manager#3 reviewed the clinical and confirmed that Resident #2 was not being monitored for side effects of Seroquel.After the surveyor's intervention, on 08/07/2025 at 7:01 AM a review of Resident #2's clinical record revealed that a physician order was initiated on 08/06/25 to monitor the resident for side effects of the medication Seroquel. The monitoring started on 08/06/25. 08/08/2025 at 7:26 AM the Director of Nursing was notified of the surveyor's findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, it was determined that the facility failed to properly label and store drugs. This was found to be evident in 1 of 1 medication cart observed during the survey recertification process.The findings include:08/05/2025 at 7:39 AM during environmental rounds on the 1st Floor A wing, the surveyor observed a medication cart left open and unattended. Inside the cart, the following items were noted; one bottle of Acetaminophen 325 mg, one bottle of Acetaminophen 500 mg, and one bottle of Stool Softener 100 mg. All three bottles were opened and did not have documented dates indicating when they were initially opened. On 08/05/2025 at 7:42 AM, RN #5 was interviewed in the presence of the Director of Nursing (DON) regarding expectations for the medication cart and labeling of opened medications. RN #5 stated that the medication cart is expected to remain locked at all times and that opened medications must be labeled with the date they are opened. RN #5 confirmed, in the presence of the DON, that the medication cart had been left unlocked and that the above medications were not labeled with a date of opening. On 08/05/2025 at 8:10 AM, the surveyor informed the Director of Nursing (DON) of the concern, and the DON acknowledged receipt.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews it was determined that the facility failed to store food in a manner that maintains professional standards of food service safety. This was evident in the Kitchen and in 2 (2A/B and 1A/B) of 4 Nutrition Rooms in the facility. This practice had the potential to affect all residents that eat food prepared by the facility's kitchen and that store food in nutrition rooms. The findings include:1. During the initial tour of the Kitchen with [NAME] #1 on 7/30/25 at 8:43 AM there were food products found open in the walk-in freezer with no label showing opening or expiration dates. The following foods were identified as being opened and unlabeled: An opened bag of chocolate chip cookies An opened bag of Charbroil Pattie for Salisbury An opened Bag of Salisbury steaks An opened bag of Tilapia Fillets An additional bag of Salisbury steaks/burgers An opened bag of Frozen Cookie Dough During an interview with [NAME] #1 on 7/30/25 at 8:58 AM he reported the items found were supposed to be labeled after opening with dates showing an opening and expiration date. He removed the opened and unlabeled items from the freezer. During an interview with the Food Service Director on 7/30/25 at 9:27 AM she confirmed the items found open in the freezer should have been labeled and advised Everything is supposed to labeled after opening. During a review of the Food Receiving and Storage Policy on 7/30/25 at 12:23 PM it was revealed that All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). 2. During an observation of the refrigerator for residents in the 2A/2B Nutrition Room with the Unit Manager/Staff Educator on 7/30/25 at 11:31 AM it was discovered to have undated and unlabeled foods stored inside. The following items were identified:A plastic container with an unknown food stored inside for Resident #39 with no dates A tied-up plastic bag of food for Resident #43 with no dates A blue lunch bag with food stored inside with no Resident identification or datesDuring an interview with the Unit Manager/Staff Educator RN on 7/30/25 at 11:36 AM, she reported that the kitchen staff monitors the nourishment refrigerators. She confirmed the refrigerator was for the residents and the items inside should've been labeled with the name of the Resident and an expiration date.During an observation of the 1 A/1 B Nourishment room on 7/30/25 at 11:52 AM with the First Floor Unit Manager it was discovered to have expired and unlabeled food stored inside.The expired food items included:Great Value Original Vanilla Yogurt that expired June 14, 2025Fat Free skim milk for Resident #146 that expired July 08, 2025The unlabeled items included:A plastic bag tied closed with food containers inside and was not datedA black bag tied shut with food containers inside and it had no dates or Resident identificationA plastic storage container with food inside that had no dates or Resident identification.A brown bag of food from Chido's Tex-Mex Grill had no date labeledDuring an interview on 7/30/25 at 11:59 AM with the 1st floor Unit Manager, she confirmed the items in the refrigerator should've been labeled with the name of the Resident and an expiration date. She also reported the expired items should have been removed from the refrigerator.During an interview with the Food Service Director on 07/30/2025 at 12:11 PM she reported she checks the refrigerators and the nursing supervisor's help to monitor the refrigerators. She advised items are checked for labeling with expiration dates and the resident's name. She reported anything not labeled properly or expired should be thrown away. During a review of the Food Receiving and Storage Policy on 7/30/25 at 12:23 PM it was revealed, All foods belonging to residents must be labeled with the resident's name, the item and the use by date.During a review of the Use and Storage of Food Brought in by Family or Visitors Policy on 7/30/25 at 12:32 PM it revealed, All food items that are already prepared by the family or visitor brought in must be labeled with content and dated and must be consumed by the resident within 3 days. If not consumed within 3 days, food will be thrown away by facility staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews and record review, it was determined that the facility failed to ensure appropriate infection control practices. This was evident for 1 (Resident #16) of 59 residents reviewed for infection control during the recertification survey.The findings include:On 07/30/25 at 11:39 AM during initial rounds the surveyor observed a pair of sneaker-like black shoes on the bedside table of Resident #16. The inner soles of the shoes were marked with the resident 's name. Next to the shoes, was an unopened 4oz container of apple juice.While the surveyor was in the room, GNA #10 came into the resident's room to provide care. The surveyor interviewed GNA #10 and enquired about the black shoes. GNA #10 stated that she received training on infection control and that she was not responsible for the shoes on the bedside table. GNA #10 in referring to the shoes stated, I did not put it there, I met it there. Later at 11:45 AM on 07/30/25, Charge Nurse #9 entered the room and was interviewed by the surveyor. Charge Nurse #9 stated that the shoes should have been placed in the closet. Charge Nurse #9 removed the shoes from the bedside table and placed the container of apple juice in the trash. On 07/31/25 at 12:30 PM a review of Resident #16's clinical record revealed that the resident has multiple diagnoses including Dementia and is dependent on the nursing staff for dressing, grooming and personal hygiene. On 08/05/25 at 8:44 AM the Director of Nursing was notified and did not comment on the surveyor's findings.

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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)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews it was determined that the facility failed to screen and offer vaccinations to residents. This was evident for 2 (Residents #20 and #138) out of 5 residents screened for immunizations.The Findings include: During a medical record review on 08/12/2025 at 3:46 PM it was discovered that Resident #20 had been admitted on [DATE] and was offered the Pneumonia Vaccination which he/she refused. Resident #20 was still a resident in the facility and there was no documentation that Resident #20 was reoffered the Pneumonia vaccine. During additional medical record review on 8/12/25 at 3:59 PM it was revealed that Resident #138 was offered and refused the pneumonia vaccine on 8/31/2018. Resident #138 was still a resident in the facility and had no documentation of additional Pneumonia vaccines being offered. During an interview with the Infection Preventionist (IP) on 8/13/2025 at 8:06 AM he reported we would offer it again this year if you refused last year. He reported vaccinations are reviewed when it's time for flu vaccinations and pneumonia vaccines would be offered again if they were previously refused. He confirmed the Electronic Medical Records (EMR) showed the last time Resident #20 was offered the pneumonia vaccine was 8/19/20 and Resident #138 was last offered on 8/31/18. He advised he would check the Resident's paper chart because it may be in there since it's not in the EMR. During an observation with the IP reviewing the Resident's Charts on 8/13/25 at 8:23 AM there was no documentation of additional pneumonia vaccinations being offered to Resident #138 and he reported, I don't see the one we offered last year. There was also no documentation of additional offerings of the pneumonia vaccine for Resident #20, he reported I don't have it after reviewing the Resident's Chart.During an interview with the Director of Nursing on 8/13/25 at 9:04 AM she confirmed that Resident's that refuse the pneumonia vaccination should be offered the vaccine again in the future.