STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215189	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Calvert Manor	1881 Telegraph Road Rising Sun, MD 21911

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 14894 Based on observation, resident interview, staff interview, and record review it was determined that the facility staff failed to ensure residents received two showers a week per resident preference. This was evident for 2 (Resident #59, and #66) out of the 66 residents in the survey sample. The findings include: 1. When this surveyor entered the Resident #59's room on 3/25/25 at 8:25 AM, the resident was in bed and the resident's hair appeared to be greasy. This surveyor interviewed Resident #59 on 3/25/25 at 8:29 AM. This surveyor asked if the facility nursing staff honor a resident's preference for getting a shower. The resident stated that they would like two showers each week. The resident said a shower had been scheduled for that day but usually only gets one shower a week. A review of the resident's shower sheets on 3/27/25 at 1:35 PM for the months of January, February, and March revealed that the resident was not receiving two showers a week. The resident received 3 showers in January, 6 showers in February, and 5 showers in March. There were no indications that the resident refused showers. This surveyor interviewed the Unit Manager (Staff #16) on 3/28/25 at 8:36 AM. She said she would investigate whether or not the showers were not given and added that the resident does not usually refuse. She added that they have had issues in the recent past with residents not getting showers and that they are working on it. She requested to have some time to speak with the Geriatric Nursing Assistants (GNA's) and the nurses. Staff #16 was interviewed again on 3/28/25 at 1:55 PM. She confirmed that showers were not given on the assigned shower days of 1/7, 1/11, 1/21, 1/25, 1/28, 2/8, 2/11, 3/15, and 3/22 of this year. The Director of Nursing was interviewed on 4/2/25 at 1:04 PM. She was informed of the lack of showers. She was also informed that residents and complainants informed the survey team that showers are not being provided on a consistent basis. She replied that they are working on correcting the issue of residents not getting showers. If residents missed a shower during the week then they are supposed to get a shower on the weekend to make up for it. No evidence of weekend make up showers were found for this resident. (continued on next page)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #66 was interviewed on 3/24/25 at 9:12 AM. This surveyor asked if the nursing staff honor his/her preference in getting showers each week. Resident stated they are supposed to get a shower every Tuesday but have not for the past two weeks. If they don't get a shower today that would make it three weeks in a row. A review of Resident #66's clinical record on 3/24/25 revealed the resident was offered four showers in March of 2025. The resident received showers on 3/22/25 and 3/29/25. The resident refused a shower on 3/11/25. The Director of Nursing was interviewed on 4/2/25 at 1:04 PM. She was informed of the lack of showers. She was also informed that residents and complainants informed the survey team that showers are not being provided on a consistent basis. She replied that they are working on correcting the issue of residents not getting showers. If residents missed a shower during the week then they are supposed to get a shower on the weekend to make up for it. No evidence of weekend make up showers were found for this resident.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on observation and interview it was determined the facility failed to ensure resident information was protected from public view. This was evident for one computer screen observed to have resident information exposed during the facility's recertification/complaint survey. The findings include: On 3/26/25 at 1:19PM the surveyor observed a medication cart outside of room [ROOM NUMBER] with an open computer screen present which was observed to be unlocked and unattended and openly displayed the following information: resident names, resident medical record numbers, resident room numbers, and resident photos for the following residents: #17, #76, #21, #5, #381, #59, #23, #63, #379, and #103. The surveyor shared their concern with Unit Manager #16 who observed and acknowledged the surveyor's concern. On 3/26/25 at 1:21PM the surveyor shared their concern with Registered Nurse (RN) #29 who confirmed and acknowledged understanding of the surveyor's concern. At this time RN #29 reported to the surveyor that there was a resident fall and they had to answer the call light. When the surveyor inquired as to which resident fell , RN#29 stated to the surveyor that the resident had their call light on and almost fell . When the surveyor inquired as to what the facility's expectation was for the locking of the medication cart and computer screens if they need to leave the cart, RN#29 stated the following information: nurses are required to lock the cart and screen. At this time, RN #29 showed the surveyor how to depress the metal lock on the cart and how to lock the computer screen. On 4/2/25 at 8:20AM the surveyor shared the concern with the facility's Director of Nursing who acknowledged and confirmed understanding of the concerns. On 4/2/25 at 1:42PM the surveyor conducted an interview with the facility's Assistant Director of Nursing who confirmed with the surveyor that their expectation for when nurses have to leave their medication cart is that the cart be locked, everything be covered, and the computer screen be put onto a blank screen.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45131 Based on record review and interviews, it was determined that the facility failed to exercise reasonable care for protection of resident's property from loss or theft. This was true for one resident (Resident #24) of 66 residents reviewed during the recertification/complaint survey. Findings Included: On 03/25/25 at 10:43 AM, in a interview with Resident #24, it was revealed that a total of $840 in cash was stored in the resident's wallets and kept at the bedside. The resident stated that the $840 was stolen (date not provided), the resident stated that $135 of the money was later returned in February 2025 but the resident was unsure what happened to the remaining balance. Resident #24 stated that he reported it to the unit manager (unable to provide a name) but no-one came back to say what happened after they completed their investigation. They provided a locked drawer but the resident stated that anyone can open it with a small tool, if they really wanted to. On 03/31/25 at 11:35 AM GNA #53 was asked what do they do if an item for a resident went missing and she stated that the nurse would be notified and it would probably be documented on the inventory list, but the nurse would tell her what to do next. We usually fill out the inventory list when the residents are first admitted with all their belongings. On 03/31/25 11:40 AM, in an interview with LPN #17, she was asked if Resident #24 has an inventory list in the chart as it could not be located and after looking through the chart, she stated that she was unable to locate it as well. When asked LPN #17 stated that if there is a report of missing money she would asked them if we can search their room, we would notify social work, laundry, and housekeeping. We would also fill out the missing items list, that would go to social work depending on what the missing item was, something like money the social worker would be notified immediately. On 03/31/25 at 12:54 PM, in an interview with Social worker (SW#5), she was asked if she has any knowledge of missing money for a resident. She stated that there was a conversation that came about in regard to missing money; however, she was not involved in the investigation but she knows many staff members spoke to Resident #24 about the missing money. She stated different statements were obtained from the resident about how much money went missing. She stated that the resident was also confused during this time. When asked the process to investigate missing money she stated we usually talk to laundry, housekeeping, kitchen and receptionist and we would also talk to any responsible party to find out if they know anything about the money. After conducting an investigation were unable to substantiate the claim of the missing $840. SW #5 was asked if there was any documentation of the investigation conducted, and she said no, but she would look into it. On 03/31/25 01:00 PM, in an interview the Director of Nursing (DON) was notified of the above concerns and that the facility failed to provide a copy of the resident's inventory list to show that an assessment of the resident's possession was completed and maintained to account for any missing items during the resident's stay in the facility. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/31/25 04:10 PM, a review of the grievance form provided by the SW#5 revealed that the resident reported the money missing in 9/25/2024 to the facility. According to the grievance form the resident had a total of $465 in cash, $25 was given to the resident at bedside and the remaining $440 was kept in medication-cart under lock and key. However, there was no documentation to support that the resident inventory list was obtained and maintained to clarify if the resident brought cash or other belongings in the facility.

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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 - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 14894 Based on a facility reported incidents, record review, and interviews, it was determined the facility failed to timely report an incident of abuse to the Office of Health Care Quality (OHCQ). This was evident for 6 (#63, #52, #84, #24, #71, #64) of 10 residents reviewed for abuse during the recertification/complaint survey. The findings include: 1) An investigation into Facility Reported Incident (#MD00203162) on 3/26/25 revealed that Resident #63 told a staff person on 3/2/24 at 8:30 AM that a staff person approached them from behind, lifted them up then dropped them to the floor. The staff person who Resident #63 reported the incident to then informed the Director of Nursing (DON) on 3/2/24 at 8:50 AM. According to the facility's investigation file, the DON reported to the state agency (Office of Healthcare Quality - OHCQ) at 12:15 PM on 3/2/24. The Assistant Director of Nursing (ADON) was interviewed on 3/26/25 at 8:35 AM. When asked how long does a facility have to report allegations of abuse to the state agency she replied, we have two hours to report abuse. This surveyor interviewed the DON on 3/27/25 at 1:57 PM. Explained the timeline of events: Resident #63 told a staff member of alleged abuse, the charge nurse told the DON, and then the DON reported the incident to OHCQ four hours later. This surveyor said a resident telling a nurse that a staff member picked them up and then dropped them to the floor would be an accusation of abuse even if the word abuse was not used. She agreed. The DON was interviewed on 3/28/25 at 9:22 AM. She said she reviewed all of her notes and emails. She confirmed that the timeline was correct and said It's on me. 44441 2) On 3/28/25 at 9:20AM, review of a facility reported incident #MD00185488 documented that Resident #52 reported to a Geriatric Nurse Assistant (GNA) that another GNA allegedly screamed at her and was rough. Review of the facilities Investigation on 3/28/25 at 9:48 AM revealed that the incident happened on 11/7/22 at 6:30PM. The facility administrator was made aware on 11/8/11 at 3:00PM. The initial report was sent to OHCQ on 11/8/22 at 8:30 PM, which was more than 5 hours later (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/28/25 at 11:20 AM the Director of Nursing (DON) in an interview was asked about the timeline for reporting abuse allegations. She stated that the facilities protocol is for staff to report any observed incident of abuse immediately to their supervisors or unit managers. This in turn gets reported to the DON who forwards it to the administrator. She stated that once the administrator gets it, they must report it immediately to OHCQ because they have 2 hours reporting time window to do so per regulation. She was shown the reporting time of this incident and asked if it was timely. She checked it out and asked for time to reconfirm. On 3/28/25 at12:43 PM, the DON came back to report that she could not find any other document to indicate that the report was sent to the office timely. She confirmed that the report was sent late. 45131 3) On 03/31/25 at 02:47PM, a review of the Facility Reported Incident (FRI) MD00197463 revealed that on 9/25/23 at 10:00 PM, Resident #84 reported to RN#51 that Geriatric Nursing Aide (GNA) #50 was rough while providing care. The initial report was submitted to the Office of Healthcare Quality (OHCQ) on 9/26/23 at 1:47 PM and therefore failed to meet the 2-hour time frame reporting requirement. On 04/02/25 at 02:10 PM, in an interview with the Director of Nursing (DON), she was asked about the late report time and she acknowledged and stated that she was aware of the 2-hour report requirements for abuse allegation, and she will look into the above-mentioned issues related to late reporting. 4) On 3/31/2025 at 06:06 PM a review of a FRI MD00202953 revealed that on 2/25/24, Resident #24 reported to the facility that an unidentified person threatened to physically assault the resident. On 2/25/24 at 1:00 pm Staff #22 was made aware of the alleged incident; however, the documented evidence provided by the facility revealed that the incident was reported to the OHCQ on 2/25/24 at 3:46 PM and therefore failed to meet the 2-hour time frame reporting requirement. On 04/01/25 at 10:29 AM, in a DON interview, the DON was made aware that the reporting time for this FRI was not verifiable and the receipt of the initial report to OHCQ was requested from DON. On 04/02/25 at 02:10 PM, in an interview with the DON, she was asked about the late report time, and she stated that she was aware of the 2-hour report requirements for abuse allegation, and she will look into the above-mentioned issues related to late reporting. 5a) On 4/1/2025 at 10:48 AM a review of the facility reported incident MD00202052 revealed that on 1/30/2024 at 3:00 PM Resident #71 reported to Staff #17 that he/she was sexually assaulted by an unidentified person; however, the documented evidence provided by the facility revealed that the incident was reported to the OHCQ on 1/30/24 at 5:10 PM and failed to meet the 2-hour reporting requirement. On 04/02/25 at 02:10 PM, in an interview with the DON, she was asked about the late report time and she stated that she was aware of the 2 hour report requirements for abuse allegation and she will look into the above-mentioned issues related to late reporting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5b) On 4/1/2025 at 1230 PM a review of a facility reported incident MD00191298 revealed that on 4/11/23 Resident #71 reported to Staff #48 on 4/11/23 at 12:00 PM; that he/she was sexually assaulted/ touch inappropriately by an unidentifiable person; however, the documented evidence provided by the facility revealed that the incident was reported to OHCQ on 4/11/23 at 2:02 PM and therefore failed to meet the 2-hour reporting requirement. On 04/02/25 at 02:10 PM in an interview with the DON, she was asked about the late report time frame and she stated that she was aware of the 2 hour report requirements for abuse allegation and she will look into the above-mentioned issues related to late reporting. 51128 6) On 03/24/25 at 10:20 AM, during the survey screening, Resident #64 informed a surveyor that GNA#31 got a hold of my feet and legs and pull me on the side of the bed and since that day my legs have been hurting. The resident also stated that GNA #31 pinched her thighs while assisting with pulling up her pants and when the GNA assisted with rolling her over, the Resident hit her thigh on the rail. The Resident stated that the GNA seemed irritated. On 04/01/25 at 11:32 AM, on observation, Resident #64 was lying in bed in a hospital gown. This Surveyor conducted a follow up interview. The Resident stated that she informed the Unit Manager #17 that GNA#31 had pinched her thighs and rough handled her legs while assisting her back to bed three weeks ago. An interview was conducted on 04/01/25 11:47 AM with Unit Manager #17. The surveyor asked if there was an incident that was brought to her attention concerning resident #64. Unit Manager #17 stated that the resident complained about being pinched and that she had a sore sacral area. The Unit Manager stated that she and the Nurse Practitioner performed a skin assessment of the residents, and there were no open areas or redness noted. The Unit Manager also added that she asked the Resident to demonstrate how she was pinched and the Resident refused to demonstrate, so there was no further action taken. The interview with the Director of Nursing (DON) on 04/01/25 at 12:33 PM revealed that she was not notified of an alleged abuse of Resident #64. When the surveyor informed the DON of the Resident's complaint and asked if this was a reportable incident, DON stated yes, and that she would notify OHCQ.

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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. 51128 Based on resident and staff interviews and medical record reviews, it was determined that the facility failed to investigate an alleged abuse of a resident. This was evident for 1 (#64) of 66 residents reviewed during a recertification/complaint survey. The findings include: On 03/24/25 at 10:20 AM, during the survey screening, Resident #64 informed a surveyor that GNA#31 got a hold of my feet and legs and pull me on the side of the bed and since that day my legs have been hurting. The resident also stated that GNA #31 pinched her thighs while assisting with pulling up her pants and when GNA#31 assisted with rolling her over, the Resident hit her thigh on the rail. The Resident stated that GNA #31 seemed irritated. On 04/01/25 at 11:32 AM, on observation, Resident #64 was lying in bed in a hospital gown. This Surveyor conducted a follow up interview. The Resident stated that she informed the Unit Manager #17 that GNA #31 had pinched her thighs and rough handled her legs while assisting her back to bed three weeks ago. An interview was conducted on 04/01/25 11:47 AM with Unit Manager #17. The surveyor asked if there was an incident that was brought to her attention concerning resident #64. Unit Manager #17 stated that the resident complained about being pinched and that she had a sore sacral area. Unit Manager #17 stated that she and the Nurse Practitioner performed a skin assessment of the residents, and there were no open areas or redness noted. Unit Manager #17 also added that she asked the Resident to demonstrate how she was pinched and the Resident refused to demonstrate, so there was no further action taken. During the medical record review on 04/01/25 at 03:35 PM, the surveyor did not locate any documentation of change in condition concerning incidents. It was further noted that the resident was receiving physical therapy 3-5 times a week to strengthen her Lower extremities. On 04/2/25 at 08:59 AM, an interview was conducted with the Physical Therapist Aide (PTA), staff #47. The PTA stated that Resident #64 informed her that GNA #31 pinched her. The PTA stated that she informed Unit Manager #17 about the incident. On 4/2/2025 at 11:25, PTA provided documentation revealing that on 3/19/2025, Resident #64 informed PTA that the Resident's GNA was irate during her ADL and pinched her. The PTA documented that she called the Unit Manager to inform her and brought the Resident back to the unit along with the Social Worker (SW), staff #48. The PTA documented that Unit Manager #17 completed a skin assessment of Resident #64 in the shower room. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Interview was conducted with the SW Staff #48 on 04/02/25 at 11:23 AM who stated that the PTA, staff #47, brought Resident #64 to the Unit Manager's office where she stated that she was pinched on the top of her thigh. Resident #64 stated that she felt that the GNA #31 was irritated. Resident also commented that her hip made contact with the bedrail. SW also stated that Unit Manger #17 took the Resident across the hall to the bathroom to conduct a skin assessment. The SW further stated that the Unit Manger #17 notified the Resident #64's daughter and explained what occurred. The surveyor asked the SW if she/he thought that this was a reportable incident, and the SW stated that she did not report the incident to the DON or the Administrator. A Telephone interview was conducted on 04/02/25 at 11:40 AM with GNA #31. The surveyor asked GNA #31 if she was aware that she had been accused of pinching Resident #64 or being rough with assisting Resident #64. GNA #31 stated that she is not aware of any allegations. On 4/2/2025 at 2:25 PM, the DON agreed that this incident of alleged abuse was supposed to have been investigated by the facility and reported to OHCQ.

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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. 47200 Based on record review and interview it was determined the facility failed to ensure the care plan of a resident was comprehensive and person centered. This was evident for one (Resident #26) out of two residents reviewed for limited range of motion during the facility's recertification/complaint survey. The findings include: On 4/1/25 at 8:21AM the surveyor conducted a review of the medical record for Resident #26 which revealed the following medical order dated as beginning on 3/7/25 was in place for care of the resident: SPLINT ORDER: Order for R (right) elbow extension splint on R (right) elbow, wearing schedule: AM to PM shift or as tolerated Hygiene: Wash weekly or as needed; every shift for contracture prevention/management 1) Check splint cleanliness/condition 2) Check skin integrity pre/post application 3) Perform ROM as needed 4) Fasten straps, if applicable 5) Monitor device during use as needed, notify nursing/rehab/MD with any unusual findings. On 4/1/25 at 8:31AM the surveyor reviewed the medical record which revealed the care plan did not include information regarding Resident #26's splint use and management of their contracture. On 4/1/25 at 9:07AM the surveyor conducted an interview with Licensed Practical Nurse (LPN) #43 who confirmed the splint use of the resident. During the interview, the surveyor inquired as to the facility's process for how care interventions were placed onto the care plan by staff. LPN #43 reported to the surveyor that care information is discussed at morning meetings and unit managers were responsible for getting information onto the resident care plans. On 4/1/25 at 9:33AM the surveyor conducted an interview with Unit Manager #16 who confirmed with the surveyor that unit managers are responsible for ensuring care interventions are implemented on the care plan. At this time the surveyor shared their concern with Unit Manager #16 who reported to the surveyor that, by now, a splint with a medical order dated 3/7/25 should be reflected on the resident's care plan. On 4/1/25 at 9:38AM Director of Rehab #41 provided the occupational therapy discharge summary for Resident #26 for the surveyor's review which revealed the resident had the following discharge recommendation which was dated 3/21/25: Discharge recommendations: R (right) elbow extension orthotic AM to PM shift, restorative program established/trained= restorative splint and brace program, splint and brace program established/trained: edu (education) nursing and family on R (right) elbow extension splint including rationale, wear schedule, assessing adequate fit; orders completed in pcc (point click care: computer program for medical record documentation). On 4/2/25 at 8:20AM the surveyor shared the concern with the facility's Director of Nursing (DON) and provided opportunity for any further documentation and information to be provided to the surveyor regarding the concern. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 2:12PM the surveyor conducted an interview with the DON to follow up on the concern at which time they reported to the surveyor that they had reviewed Resident #26's care plan and found that there was an entry error in which the splint and associated care was not entered on the care plan, it had been entered on the kardex which was not triggering on the care plan. As of the time of surveyor exit conference, no further documentation was provided to the surveyor.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44441 Based on review of a complaint incident MD00198278, record review and staff interviews, it was determined that the facility failed to provide shower to a resident who was dependent. This was evident for 1 (Resident #140) of 24 complaints reviewed during the recertification/complaint survey. The findings include: On 3/28/25 at 1:48PM review of a complaint incident #MD00198278 had that the facility failed to give Resident #140 a shower for a month after admission to the facility. That resident was dependent on the staff for Activities of Daily Living (ADL). Review of the medical records on 3/28/25 at 1:48PM showed that Resident #140 was admitted on [DATE] to the facility for rehabilitation and review of the care plan with initiation date of 9/7/23 had the resident has an ADL Self Care Performance Deficit r/t Activity Intolerance, Fatigue, Musculoskeletal, Interventions include to assist with personal hygiene such as bathing and grooming. On 3/31/28 at 10:40 AM a review of the resident's shower schedule from September to December 2025 revealed that the resident did not get a shower in September, got one in October, one in November, and 2 in December. In an Interview with staff #46 a Geriatric Nursing Assistant (GNA) on 3/31/25 at 12:23PM, she was asked about shower schedules. She stated that residents are scheduled for showers two times a week. That showers are scheduled so that residents get them one time during the day and once during the evening shift on different days. She indicated that shower documentation is available on electronic medical records. She was asked about shower refusals and how that is documented. She stated that refusals are also documented, and that nurses are made aware verbally On 3/31/25 at 1:04 PM: The Director of Nursing (DON) was made aware of residents not getting their showers and was asked to verify the concerns. She came back to confirm that the resident did not get showers, and that the facility was aware of it, and had done a quality assessment plan to address this concern. She stated that shower schedules are being monitored and addressed. She was made aware that this was still a concern.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident’s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44441 Based on a complaint #MD00210759, record review and staff interviews, it was determined that the facility failed to accurately interpret a resident's MOLST form, evidenced by the initiation of Cardiopulmonary Resuscitation (CPR) on a resident with a documented Do Not Resuscitate order. This was evident for 1 (Resident #139) of 24 complaints reviewed during the recertification/complaint survey. The findings Include: Cardiopulmonary Resuscitation (CPR) is an emergency procedure that combines chest compressions and rescue breathing to restart a person's breathing or heartbeat when they've stopped. The Maryland Orders for Life Sustaining Treatment (MOLST) is a medical document that communicates a patient 's wishes or preferences regarding resuscitation when the patient has no pulse and/or is not breathing. Do Not Resuscitate (DNR) is a medical order that instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a patient's heart or breathing stops. Do not intubate (DNI) is a medical directive that instructs medical providers not to place a breathing tube into a patient's airway if they experience respiratory failure or cardiac arrest. On [DATE] at 11:04 AM review of a complaint intake #MD00210759 documented concerns regarding patient care observed when Emergency Medical Services (EMS) Personal responded to a call from this facility on [DATE] at 8:12 AM. They stated that when they arrived at Resident #139's room, about 6 facility staff were at the bedside performing CPR with supplemental ventilation. That it was at this time that the EMS officials noted rigor mortis in the jaw and arms of Resident #139 which is an obvious sign of death. The staff provided the residents MOLST form which revealed that the resident was a No CPR- Option A-2 DNI which meant that resident did not want to be resuscitated or intubated. The EMS officials pronounced the resident and CPR was discontinued. Review of the residents' closed records on [DATE] at 11:04 AM revealed the presence of two MOLST forms. The first one was dated [DATE] and had No CPR -Option A-2, Do not Intubate (DNI). The second one was dated [DATE] with No CPR, Option -B Palliative and supportive care checked off. A line was drawn across the top and Void per protocol [DATE]' was written across the line, it was signed with a signature. On [DATE] at 11:21 AM a review of the facilities policy on residents' rights, regarding treatment and advanced directives dated [DATE] did not indicate that CPR must be attempted on all residents regardless of their MOLST status. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:25 PM with staff #19 a Registered Nurse (RN), she was shown the residents MOLST form and asked what the No CPR option A-2 Do Not Intubate (DNI) meant. She stated that she will not initiate CPR on this resident but will notify the physician and will not call 911 if the resident was found with no pulse or breathing. She was asked to explain No CPR, option B Palliative and supportive care. She stated that this means no CPR, no intubation, only comfort care. On [DATE] at 3:02 PM the Assistant Director of Nursing was asked about the facilities process for when a resident was found with no pulse or respiration. She said that if a resident was found unresponsive, staff should first check their MOLST form, then call a code which alert others of an emergency, but if the resident was a Do Not Resuscitate -DNR, then staff would call her to check and confirm the resident. She was given the residents MOLST and asked what NO CPR Option A-2, Do not Intubate meant. She stated that it means do not start CPR or call 911, notify the physician and family members. She was made aware of the above concern.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 44441 Based on multiple complaint intakes, record review and staff interviews it was determined that the facility failed to 1) implement an intervention on a resident's care plan, 2) arrange for a resident with fractured arm to go for an orthopedic appointment, 3A/B) fail to timely administer prescribed medications to residents, 4) Promptly report a positive lab result to the physician and hold laxative for a resident with diarrhea. This was evident for 4 (#132, #140, #230 , #142) of 24 complaints reviewed during the recertification/complaint survey. The findings include: 1) On 3/25/25 at 11:00 AM review of a complaint intake #MD00202774 had that Resident #132 was admitted to the facility and was having multiple falls secondary to a medical condition and that the facility was not willing to use other measures to keep the resident safe while being rehabilitated. Review of the Change in Condition Concurrent Review Forms on 3/25/25 at 11:22 AM document that resident fell 5 times in February 2024 and 7 times in March 2024. Dates reviewed include 2/12, 24,18,19 x2, 3/6, 7,10,11, 22, 25, and 31. A review of the resident's care plan with initiation date of 2/13/24 documented a fall care plan with interventions that stated that hipsters and soft helmets would always be on to keep the resident safe. Further review of the Physicians order and the treatment administration Record (TAR) for the months of February and March 2024 on 3/26/25 at 9:00 AM did not reveal that the hipster or soft helmets were ordered for staff to implement and monitor. On 3/16/26 at 1:25 PM In an interview with staff #17 a unit manager, she was asked about the hipsters and soft helmets. She stated that for hipsters and soft helmets, the nurse would obtain a verbal order from the Physician which is reflected in the Treatment Administration Record (TAR) and the nurse aids Kardex. She confirmed that if there were no orders from the doctor for the soft helmet or the hipsters, then the nurse would not implement or monitor the interventions. 2) On 3/27/25 at 12:00 PM review of a complaint intake #MD00211341 had that Resident #140 fell and fractured their right elbow and the facility failed to initiate a follow up surgeon appointment as ordered by the physician. Review of the physician order on 10/26/25 at 11:10 AM found two orders in September and one in October 2024 related to the fracture and request for surgical appointment. It read: -8/26/24: F/U with ortho following ulna fracture x ray results. -8/27/24: F/U with ortho following ulna fracture x ray results everyday shift. Obtain name of ortho from family and schedule appt. -10/1/24: F/U with ortho following ulna fracture x ray results (Family requesting no f/u) every shift every shift, Splint for Arm/Elbow Edema & Stabilization Document every shift (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the health status note dated 10/26/24 had Right elbow x-ray results show an acute mildly displaced fracture coronary process of ulna without dislocation. Results sent to third eye. Orders are as follows. obtain elbow splint and apply, consult ortho as outpatient, PCP to assess patient today and f/u with ortho, Notify clinician of any further change in condition. On 3/27/25 at 3:57PM in an Interview with Staff #16 a unit manager, she was asked if resident went for their orthopedic appointment as ordered by the physician. Staff #16 stated that the facility was made aware of the doctors' order for Resident #140 to go for orthopedic appointment, but the resident ended up not going. The Director of nursing (DON) said, the facility called the resident's spouse to let them know about the appointment and to obtain the name of the surgeons they would prefer the resident to see. That when the appointment was finally made, the resident's spouse said they could not keep the appointment, and that the surgeon said to take the resident to the emergency room (ER). The DON was asked if they took the resident to the ER as recommended and she said they did not. She was made aware that this was a concern. 3A) On 3/27/25 at 3:57 PM a review of the same complaint Incident #MD00211341 also had that Resident #140 was sent to the hospital on 9/4/24 for agitation. The resident came back to the facility with no explanation of the cause of the agitation. The family believed that it was a medication issue as this happens often when residents' medications were not given accurately. On 3/27/25 at 3:15PM: Review of the actual medication administration time for the month of June 2024 from 6/26-6/30 revealed that Resident #140's morning medications scheduled to be given at 8:00 am were administered after 10:00AM and 11:00AM which was more than 2 -3 hours late. Review of the facilities medication administration policy, however, stated that meds are to be given an hour before and an hour after the administration time. 3B) Review of another complaint incident #MD00185809 On 4/1/25 at10:30AM had that resident #230 was hospitalized twice because the facility did not have enough staff to administer timely breathing medications including resident's regular medications. That the pulmonologist (Lung doctor) has stressed the importance of these treatments being on a timely schedule. Review of the physician's order on 4/1/24 at 11:50 AM reveal orders written on 11/17/22: Tobramycin Inhalation Nebulization Solution 300 MG/4ML (Tobramycin), 1 inhalation inhale orally every 12 hours 7 days on and 7 days off for recurrent respiratory infection pulmonology recommendation: long-term use, orders written on 11/29/22: Budesonide Suspension 0.5 MG/2ML 1 vial inhale orally two times a day related to UNSPECIFIED ASTHMA, may be co-administered with Formoterol, and orders written on 11/29/22: Formoterol Fumarate 20 MCG/2ML Nebulization solution, Give 1 vial by mouth two times a day related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA (J96.01) may be co-administered with Budesonide. On 4/1/25 at 12:15 PM review of the medication admission audit report revealed that the resident got their medications 2-3 hours late on the following days in November 2023: 11/13/22: Tobramycin inhalation solution was scheduled for 8am, given at 11:08 AM Budesonide suspension inhaler was scheduled for 8am, given at 11:07 11/12/22 the Formoterol fumarate nebulizer scheduled for 9am, given at 15:45 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/15/22 Tobramycin solution scheduled for 8am, given at 10:18 The inhalers were also late on 11/15,11/16, 11/18, given after 10AM On 11/17/22, and 11/20/22, residents 8am medications were given at 11:22 AM. On 4/1/25 at 12:30 PM Staff #1 the Assistant director of nursing (ADON) in an interview regarding late medication pass was asked if residents complain about getting their medications (Med) late and she said they do. She was asked if staff complain that they have too many residents and can't get to them timely during med. pass and she said, yes. She was asked the policy for medication pass and she said it's supposed to be given an hour before and an hour after the scheduled medication administration time. She was made aware of the late medication pass concerns and said she was not aware of medications given 2-3 hours late, that it could be due to poor time management and other emergency reasons. 4) On 3/28/25 at 1:48PM review of a complaint incident #MD00198278 had that the facility failed to take action to hold a laxative for Resident #142 who was having diarrhea stool for 5-6 days. That the facility only contacted the physician to have the stool tested after the family made the supervisor aware of it. Review of the Physician order on 3/28/125 at 1:48PM revealed an order that read: 9/6/23: Senokot S Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 2 tablet by mouth one time a day for Constipation" Further review of the health status note revealed a note dated 9/13/23 at 17:23 that had: Residents emergency contact aware of STAT C. diff and stool sample order Related to (r/t) diarrhea. Stool sample collect. Diamond labs contacted, reported sample to be collected today. Continuing review of the laboratory test result dated 9/13/23 showed that Clostridium-difficile (C-diff), a bacterium that causes intestinal infections including diarrhea and colon inflammation testing was done and came back positive the same day. A review of September 2023 Medication Administration record (MAR) showed that the resident was given the laxative, Senna, two times a day from 9/7 -9/16 while still having diarrhea stool. On 3/28/25 at 2:15 PM further review of the health status note dated 9/18/24 at 22:00 documented that the physician was made aware of the positive C-diff. result on this date and he ordered Vancomycin, a medication for the treatment of C-diff. Vancomycin was started on the 19th of September 2023 which was 6 days later after the facility was made aware that resident was positive for c-diff. On 3/31/25 at 3:52 PM in an Interview with staff #1 the Assistant director of nursing (ADON), she was made aware that Senna was given when Resident #142 was still having diarrhea stool and that the positive stool sample was not communicated to the physician in a timely manner leading to a delay in starting the treatment. She was asked about their process. She stated that the laxative should have been held, and the physician notified when diarrhea was noted. She explained that positive results are communicated to the physician right away to initiate treatment per policy. She confirmed the delay in treatment with vancomycin and said it should not have taken one week after the diagnosis of a positive C-diff to initiate treatment. She was made aware that this was a concern. (continued on next page)

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	215189	A. Building B. Wing	04/02/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	47200

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200 Based on record review and interview it was determined the facility failed to ensure a complete medical order for a foley catheter was re-instituted for a resident upon their return from hospitalization , and failed to ensure that complete medical orders were verified and obtained for the foley catheter upon re-insertion of the catheter. This was evident for one (Resident #115) out of two residents reviewed for catheters during the facility's recertification/complaint survey. The findings include: On 3/31/25 at 11:29AM the surveyor reviewed the medical record of Resident #115 which revealed the following medical order was in place dated as beginning on 2/17/25: Foley Cath 22 FR/Balloon size 10ML Dx (diagnosis) Stage 4 Wound Care every shift, and the following order dated as beginning on 12/4/24: Change foley catheter prn (as needed) if dislodged or leaking as needed. On 3/31/25 at 11:29AM the surveyor reviewed the medical record and observed orders in place for care of a foley catheter for Resident #115 which were dated as beginning on 12/4/24. Further review of the medical order history for the foley catheter revealed there was an active medical order in place from 10/7-12/3/24 and then again beginning on 2/17/25. On 3/31/25 at 12:00PM the surveyor conducted an interview of Licensed Practical Nurse (LPN) # 44 who reported to the surveyor that the gap in the foley orders was due to the resident being in and out of the hospital and reported they recalled documentation in the medical record that the resident had pulled their foley catheter out in December of 2024. Review of the medical record by the surveyor on 3/31/25 12:15PM revealed hospitalization documentation in which the resident was documented as having a foley catheter upon arrival to the hospital and upon discharge from the hospital. Review of the medical record by the surveyor on 3/31/25 at 12:23PM revealed census information that the resident returned to the facility from hospitalization on [DATE] and there was no medical order for the foley catheter specifying the size and balloon information in place upon their return. Further review of the medical record at this time revealed a progress note by RN #29 on 12/4/24 at 4:25PM which documented that Resident #115 had been consistently pulling out his/her colostomy appliances, foley cath, and wound vac this shift, and the writer applied clean dry dressing on the colostomy site and reapplied a foley cath. The surveyor noted that there was no active medical order found in the medical record specifying the sizes of the foley catheter and balloon information from 12/4/24 through 2/17/25. On 4/1/25 at 7:48AM the surveyor shared their concern with the facility's Assistant Director of Nursing (ADON) who stated the following: Okay, I understand. At this time the concern was also shared by the surveyor with the Director of Nursing (DON) and the surveyor provided an opportunity for the facility to provide any further documentation for review. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 8:34AM the surveyor requested to the DON to provide all documentation regarding physician notification and responses regarding the resident having pulled out their foley catheter. On 4/2/25 at 7:38AM the surveyor conducted an interview with the ADON who reported to the surveyor that there was a discontinuation of the foley order on 12/4/24. The surveyor confirmed with the ADON that the facility's expectation was for residents who have a foley catheter to have a complete medical order in place outlining the specifics of the catheter to include the size and type of the catheter and other important information. On 4/2/25 at 8:02AM the surveyor conducted an interview with RN #29 who reported to the surveyor that if a resident's condition changes or they pull out a foley catheter, the facility's expectation is that the nurse completes a change in condition form after assessment and notifies the physician and family member. On 4/2/25 at 12:57PM the surveyor conducted an interview with RN #29 who reported the following information regarding the re-insertion of Resident #115's foley catheter on 12/4/24 without a standing medical order to provide specification of catheter size and balloon information: I remember the nurse that was leaving their shift they told me they didn't have time to put it back in, I put it back in with the prn (as needed) order to replace it, I assumed we put the same one back. RN #29 further confirmed with the surveyor that every resident with a foley catheter should have a medical order in place specifying the catheter size and balloon information. RN #29 further stated to the surveyor during the interview that they believed the order for the foley catheter had been discontinued, but then when the resident was unable to urinate, the catheter was put back in place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42507 Based on observation, medical record review, and interview, it was determined the facility failed to 1) properly date label oxygen tubing when changed, 2) follow physician's orders for the administration of oxygen, and 3) develop and implement a person-centered comprehensive care plan with resident centered goals for respiratory care to include oxygen therapy. This was evident for 1 (Resident #57) of 4 residents reviewed for respiratory care during a recertification/complaint survey. The findings include: Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider. On 3/25/2025 at 10:55 AM, surveyor observed Resident #57 sitting in a wheelchair in their room. The resident was wearing a nasal cannula (a device that delivers extra oxygen through a tube and into your nose) that was connected to a humidifier (water) bottle connected to an oxygen concentrator set at 2LPM (liters per minute). The LPM oxygen flow rate of 2 indicates that 2 liters of oxygen should flow into the resident's nose in 1 minute. The humidifier bottle was almost empty and dated 3/16/2025. However, the oxygen tubing/ nasal cannula was not dated. When asked, the resident was unable to recall when the oxygen tubing was last changed. On 3/25/2025 at 11:05 AM, Infection Preventionist (IP) in-training/ Staff Development (Staff #4) observed and verified that the humidifier bottle was dated 3/16/2025 and the oxygen tubing had no date/time on it. Staff #4 stated that the humidifier bottle and Oxygen tubing were supposed to be changed weekly by the 11p - 7a (night shift) nurses. However, Staff #4 stated that she was going to change the humidifier bottle and Oxygen tubing right away. Regarding labeling, Staff #4 stated that the expectation was that all oxygen tubing should be labeled with the date and time they were hung. During a review of Resident #57's medical record conducted on 3/26/2025 at 8:47 AM, surveyor noted an active physician order dated 3/26/2025 for: Oxygen continuously @ 2LPM via NC r/t COPD every shift. There were additional orders dated 3/23/2025 for Change O2 Humidification Bottle on Wednesday 11-7 Shift and Change O2 and Neb tubing on Wednesday 11-7 shift. On 3/26/2025 at 10:42 AM, review of Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2025 did not reveal any staff documentation that O2 and Neb tubing nor the humidification bottle were changed as ordered. The Oxygen tubing had no date label, and the humidifier bottle was dated 3/16/2025 (more than a week old) when surveyor did their observation on 3/25/2025. On 3/26/2025 at 11:03 AM, a review of Resident #57's care plan did not reveal a care plan focus for Oxygen therapy with goals and interventions. The care plan was not comprehensive and resident centered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/2025 at 1:44 PM, in an interview with the Director of Nursing (DON), surveyor reviewed resident's orders for Oxygen, staff documentation on the MAR/TAR, oxygen care plan, and surveyor's observations on 3/25/2025. DON reviewed and verified that there was no staff documentation on the MAR and/or TAR that they were changing the O2 tubing and humidifier bottle as ordered. DON stated she was going to check if staff were documenting someplace else. Regarding care plans, DON stated that she would expect to see Oxygen therapy addressed on the care plan with goals and interventions. On 3/26/2025 at 2:45 PM, in a follow up interview with the DON, she stated that she could not find any documentation that staff were changing the Oxygen tubing and humidifier bottle as ordered. DON further stated that she has put in orders so staff would be able to document when they change the Oxygen tubing and humidifier bottle.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER: Autumn Lake Healthcare at Calvert Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 1881 Telegraph Road Rising Sun, MD 21911	

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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. 42507 Based on medical record reviews and interviews, it was determined the facility staff failed to ensure that a resident was given pain medication consistent with professional standards of practice, and failed to ensure pain mangement was effective. This was evident for 3 (#231,#33, #71) of 4 residents reviewed for pain management during a recertification/complaint survey. The findings include: 1) During an initial pool screen of Resident #231 on 3/25/2025 at 8:17 AM, the resident was observed in bed crying and complaining of pain. Resident #231 rated the pain at 8/10 (severe pain) to the right hip and 7/10 right foot. The resident stated s/he had been waiting for pain medication since 3 AM that morning and was just given pain med by the day shift nurse. The resident added that s/he had asked for ice pack to be placed on their right hip but the night nurse told them none was available. Resident #231 further stated that they messed up my meds and s/he waited for over 12 hours when s/he was admitted before they could give him/her pain medication. The resident stated that the nurses were not giving the pain meds routinely as ordered and when s/he complained the night nurse told him/her they were not going to wake them up to give pain meds. On 3/31/2025 at 9:56 AM, a review of physician orders for Resident #231 revealed the following active pain medication orders: - Hydrocodone-APAP Oral Tablet 325-10 MG (Hydrocodone-Acetaminophen) Give 2 tablet by mouth every 6 hours for Severe pain, order date 3/24/2025 - Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to right foot top and bottom topically three times a day for Moderate Pain 4 grams, order date 3/26/2025 (order placed after surveyor's observation on 3/25/2025), and - Non-Pharmacological Interventions (NPI) attempted prior to administering any prn pain med. As needed Document the number that corresponds to the Non-Pharmacological 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 NPI, order date 3/21/2025. Of note: There were no active orders for pain meds for mild to moderate pain prior to 3/26/2025. Moreso, the non-pharmacological interventions ordered were prior to administering PRN (as needed) pain meds, however, there were no active orders for PRN pain meds. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review on 3/31/2025 at 10:21 AM of Resident #231's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March 2025, revealed that the resident was given PRN Hydrocodone-Acetaminophen Oral tablet 10-325 mg (2 tabs) at 00:34 (12:34 AM) on 3/22/2025 for pain level of 8/10 (This PRN order was later discontinued). However, there was no documentation that non-pharmacological (use of non-chemical methods to reduce pain without medications) interventions were attempted prior to administering PRN pain meds as ordered. There was no pain med administration noted for 3/21/2025 (day of admission) even though a review of Admission Assessment on 3/21/2025 at 19:23 (7:23 PM) revealed that the resident's numeric pain rating was 5/10 and the verbal descriptor scale was noted as Severe. On 3/31/2025 at 11:36 AM, a review of the actual medication administration time for March 2025 was completed: There was no pain med administered to the resident on 3/21/2025. Also, on 3/28/2025, Hydrocodone- Acetaminophen 10-325mg scheduled to be given at 00:00 (12:00 midnight) was given at 1:50 AM, almost 2 hours past the scheduled time. During an interview with the North/South Unit Manager (UM #17) on 4/1/2025 at 8:15 AM, surveyor reviewed Resident #231's MAR and TAR for March 2025: UM #17 verified that the resident on admission at 7:23 PM had a pain score of 5, but the first dose of pain med was given at 00:34 (12:34 AM) on 3/22/2025 (almost 5 hours from when resident was admitted) and their pain score at that time had gone up to 8/10. UM #17 acknowledged that 5 hours was a bit long for a resident who had hip surgery to be medicated for pain. An interview was conducted with the Assistant Director of Nursing (ADON) on 4/1/2025 at 9:50 AM. Surveyor reviewed Resident #231's MAR for March 2025: ADON verified that the resident was not given any pain med on 3/21/2025 and that pain med administration on 3/28/2025 at 1:50 AM was given late (almost 2 hours past the scheduled time and 50 minutes past the window for the med administration). ADON stated that the nonpharmacological interventions for PRN pain meds were standing orders in the system, reviewed and verified that the resident was not on any PRN pain meds and there were no orders for mild and/or moderate hip pain. She stated that if the resident had mild/moderate pain, they would call the doctor and get orders to address the pain. 2) During an initial pool screen of Resident #33 on 3/25/2025 at 9:46 AM, the resident complained of pain to her/his left leg below the knee cap and rated the pain at 9/10 (severe pain). Resident #33 stated that s/he last got pain medication yesterday 3/24/2025. S/he added that no one has been in to check on me since breakfast this morning. On 4/1/2025 at 11:40 AM, a review of physician orders for Resident #33 revealed the following PRN (as needed) pain medication orders: - Morphine Sulfate Tablet 15 MG, Give 1 tablet by mouth every 6 hours as needed for moderate-severe pain Please document in the Progress Notes all non-pharmacologic interventions made, order date 2/27/2025. - Acetaminophen Oral Tablet 325 MG (Acetaminophen), Give 2 tablet by mouth every 6 hours as needed for Mild Pain (1-3), order date 2/6/2025, and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Calvert Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1881 Telegraph Road Rising Sun, MD 21911	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Non-Pharmacological Interventions attempted prior to administering any prn pain med. As needed Document the number that corresponds to the Non-Pharmacological 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 NPI, order date 2/6/2025 A review on 4/1/2025 at 11:48 AM of Resident #33's MAR and TAR for March 2025, revealed that the resident was given PRN Acetaminophen (2 tabs 325 mg) on the following dates when the pain score was greater than 3: On 3/2/2025 at 10:52 PM for a pain score of 4; On 3/5/2025 at 6:36 PM for pain score of 5; On 3/7/2025 at 3:44 PM for pain score 9; On 3/11/2025 at 9:38 PM for pain score of 6; On 3/18/2025 at 2:22AM for pain score of 5, at 11:15AM for pain score of 5, and at 9:09 PM for pain score of 5; On 3/22/2025 at 5:59PM for pain score of 7; On 3/26/2025 at 7:02PM for pain score of 8; On 3/27/2025 at 4:12AM for pain score of 8; On 3/28/2025 at 3:56PM for pain score of 5; On 3/29/2025 at 6:02PM for pain score of 9; and On 3/31/2025 at 4:17PM for pain score of 7. Moreso, there was no documentation that non-pharmacological interventions were attempted prior to administering PRN pain meds on most of the dates/times the resident was given Acetaminophen (except for the following dates: 3/2, 3/5, 3/10, and 3/11/2025 only). Further review of the MAR revealed that Resident #33 was given PRN Morphine sulfate on multiple dates/times but no staff documentation that non-pharmacological interventions were attempted after 3/11/2025 through 3/31/2025. On 4/2/2025 at 8:50 AM, In an interview with Licensed Practical Nurse (LPN #27), Surveyor reviewed Resident #33's MAR and TAR for March 2025. LPN #27 verified that the resident was given Acetaminophen on multiple dates outside the ordered parameters. She also reviewed the non-pharmacological interventions and verified that there was no staff documentation after 3/11/2025 through 3/31/2025 that staff were attempting non-pharmacological interventions prior to giving the resident prn pain meds. In an interview with the North/South Unit Manager (UM #17) on 4/2/2025 at 9:00 AM, she stated that staff were expected to give pain meds following ordered parameters after assessing the resident's pain and attempting non-pharmacological interventions. UM #17 further stated that if a resident asked for a pain med that was indicated for a lesser pain score, the nurse was expected to document in the progress notes and/or put a supplementary note on the med being given. Surveyor reviewed Resident #33's MAR and TAR for March 2025 with UM #17. UM #17 verified that Acetaminophen was given on multiple dates outside the ordered parameters. After review of the nurses' progress notes, UM #17 confirmed that there was no staff documentation that Acetaminophen was given for pain scores greater than 3 per Resident #33's request. UM #17 further reviewed nurses' progress notes for documentation that non-pharmacological interventions were attempted prior to PRN pain med administration after 3/11/2025 but could not find any. On 4/2/2025 at 9:05 AM, in an interview with the ADON, surveyor reviewed Resident #33's MAR and TAR for March 2025: ADON verified that Acetaminophen was given outside parameters (pain score higher than 3) on the dates noted above and that non-pharmacological interventions were not documented on the MAR after 3/11/2025. ADON stated that the expectation was that staff should document each time a PRN pain med was given either in the check box and/or progress notes which non-pharmacological interventions were attempted prior to med administration. She further stated that staff should document when a resident refuses a pain med and/or requests a med that did not match their pain score. She added that staff could even contact the physician for appropriate orders. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/2025 at 9:25 AM, surveyor reviewed Resident #33's MAR / TAR with the DON and share concerns regarding staff administering Acetaminophen outside ordered parameters and not documenting non-pharmacological interventions that were attempted prior to giving prn pain meds after 3/11/2025 through 3/31/2025. 45131 3) On 03/25/25 at12:24 PM, in an interview with Resident #71, when asked if he/she had pain he/she rated her shoulder pain at 4 out of 10 and he/she was unaware if he/she took anything for pain as he/she takes a lot of pills. On 03/31/25 at 10:21 AM, a review of Resident #71's Medication Administer Record revealed that the resident has an order for aspercreme Lidocaine External Cream 4 % (Lidocaine HCl) Apply to right shoulder/ elbow topically every 12 hours as needed for pain for 10 Days -Order Date 03/24/2025, However, it was never administered for pain based on the documentation provided. On 03/31/25 at 10:55 AM, in an interview with License Practical Nurse (LPN#52), when asked where the pain level assessment was documented she stated on the MAR. However, when asked to show the surveyor where the pain level was being documented. LPN #52 stated that the pain level would be documented with pain medication administration, but she was unable to demonstrate how the nurse documented pain assessment. On 03/31/25 at11:00 AM, a review of the MAR revealed that there was no documentation of pain level assessment and/or pain scale used to assess the resident's pain. On 03/31/25 at 02:33 PM, a pain policy assessment review revealed that the facility will use pain assessment tool which is appropriate for resident's cognitive status to assist staff in consistent assessment of a resident's pain. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team may necessitate gathering the following information: identifying the key characteristic of pain (duration of pain, frequency, location, timing, pattern and radiation of pain. On 03/31/25 03:50 PM, a review of the documentation provided. Revealed that there was no evidence that the pain level was assessed or re-assessed, though resident was receiving naproxen ATC, tylenol, and lidocaine cream for pain PRN (as needed) in the month of March. The Resident was still reporting right shoulder pain 3/31/2025 but there was no administration of pain medication. On 03/31/25 at 03:50 PM in an interview with the Assistant Director of Nursing (ADON), she was asked about the documentation assessment for pain and she stated it was on the Treatment administration Record (TAR) but she was unable to provide the documentation. On 03/31/25 at 04:06 PM, in an interview with the ADON, she stated that the resident was sent to the hospital in July and the order for pain assessment was not renewed and therefore the pain assessment was not completed on each shift for Resident #71.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51128 Based on clinical record reviews, Resident (R) and staff interviews, it was determined that the facility failed to have sufficient staff to meet the needs of the residents for 8 of 29 sampled residents (Residents #3, #110, #64, #14, #231, #116, #24, #51) and 15 complaints (MD00210759, MD00185809, MD00207746, MD00198916, MD00211341,MD00202774, MD00195025, MD00214748, MD00203187, MD00208031, MD00200792, MD00203145, MD00206608, MD00206731, MD00209653) that identified staffing issues and concerns reviewed during the recertification/complaint survey. The findings include: During resident and family interviews, the resident and or family were asked about sufficient nursing staff. An example of a question asked was: do you feel that there is enough staff to meet your needs and concerns without having to wait a long time? Is there a problem with staffing during the week or on weekends? In addition, based on a investigation of complaints there was evidence to support staffing issues. BIMS stands for Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well an individual is functioning cognitively at that moment. A BIMS score can range from 0 to 15, with lower scores indicating a decline in cognitive performance. During an interview on 03/24/25 at 10:09 AM, Resident (R) #64 stated, no one came to help me on Saturday, no body showed up. I am wearing my night gown from the previous day, mostly on the weekend from Thursday night until Monday morning. I have laid in body waste at times before they come and clean me up. They never have enough help, especially on weekends. Review of R#64 clinical record on 3/24/25 at 10:30 AM revealed that resident has a BIMS score of 14. On 04/01/25 at 11:32 AM the surveyor observed Resident #64 was lying in bed in hospital gown. On 03/24/25 at 10:46 AM during an interview with R#14, Resident stated, I don't get enough help here, staff don't have time to do you., if you press your call bell, you have to wait for 1hour to get help, and you don't change. They use a lot of Agency who don't want to do any work, they don't want to give you a shower, they give you a bath instead. On 03/24/25 at 12:43 PM a review of the investigative notes for #MD00202284, revealed that a family member for Resident #3 complained that when I went to the facility to feed my family member breakfast, I learned that there were so many call offs or no shows of Agency persons that there were only 2 people to take care of 4 halls of residents and people there for rehab. The people were the nurse director for that wing and 1other full time employee. That would be 29 patients for each, to get them up, dress, pass out breakfast trays and feed those dependent diners, of which my family member is one. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/24/25 at 01:17 PM R#110 stated during an interview that staffing varies and facility short staff most of the time. On 03/25/25 at 08:25 AM R #231 stated he/she had waited for about 40 minutes for staff to assist him/her to the bathroom: They say to me we are short staffed, and we have a lot of people to care for. On 03/25/25 at 09:32 AM R #116 stated not sure if there is enough staff all the time. On 03/25/25 at 11:56 AM R #24 stated, They usually have low staff on the day and evening shifts on weekends, it happens often. During an interview on 03/25/25 at 12:46 PM, family member of Resident #51 stated, staff never have time to help him/her get out of bed, I would like to have him/her dressed so we can have lunch in the dining room but today I don't know what happened. They never have enough help especially on weekends. On 04/01/25 at 08:49 AM, an interview was conducted with Staffing Coordinator, Staff #15 who agreed that there is an issue with call outs on the weekends and that facility have used Agency staff to fill in vacancies on the staff schedule. An interview of GNA #25, who has been employed at facility for [AGE] years. She/he stated that the facility is short staffed at times, and it is hard to complete daily tasks. When asked if facility use Agency staff, she/he stated that the facility used Agency staffing a lot in the past, but the facility has cut back and absorbed some of the agency staff so that they have more regular staff now. On 3/28/25 at 11:45 AM, an interview was conducted with GNA# 33, who has been employed at the facility for 3 yrs. When the surveyor asked about staffing, GNA #33 stated that low staffing at times can cause a ratio of 2 GNA's to 30 residents per GNA. She/he said they have 4-6 GNA's on the floors some days, but most days, its 4 GNA's which equals to 15 residents. When GNA #33 was asked how often the facility has 1 GNA to 30 residents, she/he stated it happened at least one day a month mostly on the weekends on the evening and night shifts. GNA #33 further added that she/he worked as the only GNA on the whole floor around the middle of 2023 and said this has happened to other GNA's on night shift. GNA #33 stated that she/he is not able to complete all the GNA tasks when the facility is not adequately staffed. On 4/2/2025 at 2:25 PM, the surveyor made the DON aware of the staffing concerns.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44441 Based on a complaint #MD00210759, record review and staff interviews, it was determined that the facility staff lacked proper knowledge required to interpret the MOLST form and on steps to follow in an emergency, as evidenced by performing Cardiopulmonary Resuscitation (CPR) on a resident with a documented Do Not Resuscitate order. This was evident for 1 (Resident #139) of 24 complaints reviewed during the recertification/complaint survey. The findings Include: Cardiopulmonary Resuscitation (CPR) is an emergency procedure that combines chest compressions and rescue breathing to restart a person's breathing or heartbeat when they've stopped. The Maryland Orders for Life Sustaining Treatment (MOLST) is a medical document that communicates a patient 's wishes or preferences regarding resuscitation when the patient has no pulse and/or is not breathing. Do Not Resuscitate (DNR) is a medical order that instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if a patient's heart or breathing stops. Do not intubate (DNI) is a medical directive that instructs medical providers not to place a breathing tube into a patient's airway if they experience respiratory failure or cardiac arrest. On [DATE] at 11:04 AM review of a complaint intake #MD00210759 documented concerns regarding patient care observed when Emergency Medical Services (EMS) Personal responded to a call from this facility on [DATE] at 8:12 AM. They stated that when they arrived at Resident #139's room, about 6 facility staff were at the bedside performing CPR with supplemental ventilation. That it was at this time that the EMS officials noted rigor mortis in the jaw and arms of Resident #139 which is an obvious sign of death. The staff provided the residents MOLST form which revealed that the resident was a No CPR- Option A-2 DNI which meant that resident did not want to be resuscitated or intubated. After the resident was pronounced dead by EMS, staff reported to the EMS personnel that they thought that MOLST A-2 just meant the patient did not want to be intubated and did not realize that it meant that the resident was to receive no resuscitative efforts. The staff also reported that it was the facility's policy to attempt resuscitation regardless of any valid MOLST or DNR paperwork that a patient had. The EMS crew attempted to educate the staff about signs of obvious death and MOLST/DNR paperwork, and the staff expressed interest in more training on these topics. Review of the Maryland Orders for Life-Sustaining Treatment (MOLST) form on the residents' chart on [DATE] at 11:04 AM revealed the presence of two MOLST forms on the chart. The first one was dated [DATE] and had No CPR Option A-2, Do not Intubate (DNI) checked off. The second one was dated [DATE] with No CPR, Option -B Palliative and support care checked off. A line was drawn across the top and Void per protocol [DATE]' was written across the line with a signature. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:21 AM a review of the facilities policy on residents' rights, regarding treatment and advanced directives dated [DATE] did not state that CPR must be attempted on all residents regardless of the MOLST status. On [DATE] at 2:01 PM an interview was conducted with Staff #27, a License Practical Nurse (LPN). She was asked to describe the process of responding to an unresponsive resident. Staff #27 stated that she would activate the emergency response, check for pulse and breathing and if absent would start CPR, ask someone to call the emergency services (911) and do the paperwork. She did not mention checking the MOLST form first. When asked if after resuscitating the resident, she discovered that s/he was a DNR as she did not check initially, she stated that she would inform the supervisor. In an interview with staff #28 an LPN and agency Nurse on [DATE] at 2:18 PM She was asked what she would do if during her rounds she found a patient unresponsive. She stated that she would first assess the resident to ascertain unresponsiveness, then call for help. If there was no pulse, she would get the person in a position for CPR. When help arrives, she would instruct that person to grab the crash cart before starting CPR. Again, she did not mention checking the MOLST form. She was asked what she would do when her patient was resuscitated. Staff #28 then said that she should have told the surveyor that she would check the chart to check the MOLST before initiating CPR. On [DATE] at 3:27 PM, the Assistant Director of Nursing (ADON) was made aware of the concerns with staff not stating that they would check the MOLST form before initiating CPR. The ADON stated that she was surprised and would educate the nurses.

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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. 51128 Based on review of staff records and interview with facility staff, it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) received a performance review in 2023. This was evident for 1 (Staff #49) out of 3 GNAs randomly selected nursing staff records reviewed for annual training requirements during the recertification/complaint survey. The findings include: The employee files of three GNAs were reviewed on 03/31/25 at 1:30 PM. There was no performance evaluation found for staff # 49 during the review. On 04/01/25 11:21 AM an interview was conducted with the DON regarding performance evaluation. When asked by the surveyor who is responsible for ensuring staff have an annual performance evaluation, the DON stated that it's the responsibility of the DON and unit managers. The DON did not provide any further documentation of the evaluation and stated that the employee worked as needed (PRN) and was overlooked.

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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. 47200 Based on record review and interviews, it was determined that the facility failed to ensure medication order parameters were followed and ensure a resident was free from unnecessary medication. This was evident for one (Resident #42) out of one resident reviewed for insulin during the facility's recertification/complaint survey. The findings include: On 3/31/25 at 8:59AM the surveyor conducted a review of the medical record for Resident #42 which revealed the following active medical order for insulin administration dated 8/24/24 was in place which included parameters: Lyumjev KwikPen 100 UNIT/ML Solution pen-injector (Insulin); Inject 15 unit subcutaneously with meals for DM (Diabetes Mellitus) Hold for BS (blood sugar) <150. On 3/31/25 at 9:01AM the surveyor reviewed the medical record which revealed a medication administration record (MAR) for March 2025 in which RN #29 documented administration of insulin to Resident #42 in their right arm on 3/23/25 at 5:20PM with a documented blood sugar of 134 despite the parameter in the medical order for the medication to be held for a blood sugar of less than 150. The surveyor additionally noted that the resident was documented on the March 2025 MAR the day prior, on 3/22/25 as having a blood sugar of 138 in which the insulin was marked as held (not administered) by Licensed Practical Nurse #45. On 3/31/25 at 9:13AM the surveyor conducted an interview with Unit Manager #16 who confirmed with the surveyor that the insulin was signed off as administered to Resident #42 by RN #29 on 3/23/25. At this time, Unit Manager #16 showed the surveyor the difference in documentation whereas on 3/22/25 the medication had been documented as held. At this time, the surveyor shared their concern with Unit Manager #16 who acknowledged and confirmed understanding of the concern. On 3/31/25 at 9:16AM the surveyor conducted an interview of the Assistant Director of Nursing (ADON) and showed them the administration documentation on the March 2025 MAR and the blood sugar that was documented and shared the concern. The ADON stated the following to the surveyor during the interview regarding the insulin: It looks like it was given. At this time the ADON acknowledged and confirmed understanding of the surveyor's concern. On 4/2/25 at 12:57PM the surveyor conducted an interview with RN #29 who reported to the surveyor that the medication administration was a typo. When the surveyor inquired as to the additional documentation of the location of the injection administered, they responded: yeah.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER: Autumn Lake Healthcare at Calvert Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 1881 Telegraph Road Rising Sun, MD 21911	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894 Based on observation and interview it was determined the facility failed to: 1) ensure secure storage of medications, and 2) ensure a nutritional supplement was not expired. This was evident for: 1) 3 out of 8 medication carts and 2) 1 out of 3 medication room refrigerators containing nutritional supplements during the facility's recertification/complaint survey. The findings include: 1) While touring the facility on [DATE] at 10:40 AM a medication cart on the ground floor nursing unit a medication cart was observed to be unattended with keys in the lock. Staff #43 came out of a resident's room at 10:42 AM, went to the cart, removed the keys, and locked the cart. She was informed of this observation, and she confirmed it. The Director of Nursing was interviewed on [DATE] at 2:15 PM. She was informed of the unlocked medication cart. She said she would address the issue. 2) While reviewing a clinical record at the 1 south nursing station an unlocked medication cart was observed in the hallway across from the station. Staff # 27 was sitting in the station at the desktop computer. She stood up and went right up to the cart then locked it with the palm of her hand. She was informed of the observation. 47200 3) On [DATE] at 8:49AM the surveyor requested and conducted a dual observation of the facility's medication room refrigerator on the East Nursing Unit with Unit Manager #16 at which time one container of Nutren 2.0 calorically dense complete nutrition supplement with a use by date of [DATE] was observed. On [DATE] at 8:52AM the surveyor shared the concern and conducted an interview with Unit Manager #16 who stated the following information: I'm going to remove that. On [DATE] at 8:53AM the surveyor observed Unit Manager #16 remove the expired supplement from the medication room refrigerator and proceed to throw it away. On [DATE] at 1:19PM the surveyor observed an unattended medication cart outside of room [ROOM NUMBER] with the metal lock protruding from the cart indicating that it was unlocked. The computer screen present on the medication cart was additionally observed to be unlocked and unattended, openly diplaying resident information. Upon further inspection of the unattended and unlocked cart at this time, the surveyor was able to open the drawers to the medication cart in which medications were held. The surveyor shared their concern with Unit Manager #16 who observed and acknowledged the surveyor's concern. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:21PM the surveyor shared their concern with Registered Nurse (RN) #29 who confirmed and acknowledged understanding of the surveyor's concern. At this time RN #29 reported to the surveyor that there was a resident fall and they had to answer the call light. When the surveyor inquired as to which resident fell , RN #29 stated to the surveyor that the resident had their call light on and almost fell . When the surveyor inquired as to what the facility's expectation was for the locking of the medication cart and computer screens if they need to leave the cart, they stated the following information: nurses are required to lock the cart and screen. At this time, RN #29 showed the surveyor how to depress the metal lock on the cart and how to lock the computer screen. On [DATE] at 8:20AM the surveyor shared the concern with the facility's Director of Nursing who acknowledged and confirmed understanding of the concerns. On [DATE] at 1:42PM the surveyor conducted an interview with the facility's Assistant Director of Nursing who confirmed with the surveyor that their expectation for when nurses have to leave their medication cart is that the cart be locked, everything be covered, and the computer screen be put onto a blank screen.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50904 Based on complaints, observations, record reviews and interviews with facility staff, it was determined that the facility failed to ensure that residents were served a meal according to a predetermined menu that incorporated the resident's preferences. This was evident for 4 residents (Residents #25, #59, #65, and #109) out of 14 residents reviewed during the facility's Medicare/Medicaid recertification/complaint survey. The findings include: On 03/25/2025 at 07:18 AM, the breakfast menu list showed scrambled eggs, oatmeal, toast (jelly and Margarine) and breakfast ham. On 03/25/2025 at 09:08 AM, during a random visit to Resident # 59, his/her meal ticket showed scrambled eggs, coffee/creamer, milk, orange juice, oatmeal, toast (jelly/margarine) and breakfast ham. On the actual meal tray the surveyor saw French toast, cranberry juice, coffee, milk and egg patty. On 03/25/2025, at 9:10 AM, in an interview with Resident #59, when asked if he/she had requested the meals on his/her meal tray and not the one on his/her meal ticket, he/she stated that he/she ate whatever they served him/her even when that meal was not on the menu if it was edible. On 03/25/2025 at 09:13, the surveyor also visited Resident #65 who had told another surveyor that the facility kept serving her what he/she stated that he/she did not want. A copy of his/her meal ticket was requested, and it showed that he/she was to have scrambled eggs, regular hot tea, skim milk, orange juice, oatmeal, toast (jelly and margarine), sugar/pepper and breakfast ham for breakfast but his/her actual meal tray had French toast, cranberry juice, coffee, milk and egg patty. On 03/25/2025 at 09:15 AM, in an interview with Resident #65 when he/she was asked if he/she had requested the meal on his/her tray, he/she stated that he/she did not request that and would have preferred the scrambled eggs and breakfast ham because he/she had looked forward to having it for breakfast. He/she also added that he/she likes orange juice and not cranberry juice. On 03/25/2025 at 09:36 AM, in an interview with Staff #7 when she was asked why the residents got different meals and drinks on their meal trays, she stated that orange juice stopped working that morning, she also added the facility started using eggs patty because eggs were expensive. She added that residents on pureed diets and chopped meals were given scrambled eggs while those on regular diets get an egg patty. When informed that breakfast ham was not on the meal trays, she stated that she would have to talk to the cook and added that if the chief cook wanted to change the menu, she should have informed her so that another meal tickets would be printed. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/2025 at 01:26 PM, Resident #65 was seen as his/her meal tray was set before him/her and when asked what he/she had on her ticket he/she stated that the meal ticket said carrots, chili and steamed rice but he/she was glad that rice was not there because he/she had told the facility kitchen staff noy to serve rice to him/her which they have been done in the past. The surveyor looked at the meal tickets which showed: no rice, Brussel sprouts, red pepper or asparagus, no fish (on top of the meal ticket). Then showed regular chili (no fish or Rice) 4 oz, carrots 4 oz, regular cup of ice x 2 8 oz, skim milk 8 oz, iced tea x 2 4 oz and steamed rice. The surveyor noted carrots, mashed potatoes, chili, iced tea, cup of ice and skimmed milk on the actual meal tray. On 03/25/25 at 01:48 PM, in an interview with Staff #7, when she was shown the Resident #65's meal ticket and asked to clarify what the surveyor should expect to see in the actual meal tray, she stated that the surveyor should see carrots, regular chili, cup of ice, skim milk, Iced tea and steamed rice. The surveyor then pointed to the No fish or [NAME] on the meal ticket, and she stated that she did not see it and stated it was an error to have served the resident rice. The surveyor informed her that the resident was given mashed potatoes and not rice and that mashed potatoes were not on the resident's meal tickets. She stated that she would fix the error with the meal tickets. On 03/26/2025 at 09:11 AM, Resident #25's daughter complained to another surveyor that the meal tickets indicate items the resident should not receive, yet they continue to be served. Additionally, some items listed on the meal ticket were sometimes missing from the tray. On 04/01/25 at 12:44 PM, in a follow up visit to the kitchen while lunch was being served, the surveyor asked Staff #7 what the menu was, and she stated that it was: Hungarian pork stew, winter blend vegetables, fruit cup, dinner roll and yellow rice. On 04/01/2025 at 12:53 PM, while on the unit, the surveyor randomly examined Resident #109's meal ticket and observed that it listed vegetable blend and other meals; however, the actual lunch tray served to the resident contained mixed vegetables. On 04/01/25 at 01:23 PM, in an interview with Staff #7, when the surveyor asked why what was on the menu was different from what was served, she stated that the ingredient for the winter blend vegetable was not available and that was why it was substituted with carrots, peas and green beans vegetable. When asked whether residents were informed of menu changes, she stated that the updates were only made on their meal tickets. She acknowledged that the menu list should have been updated to reflect the actual meal being served and that residents should have been notified of the changes. On 04/02/2025 at 4:15 PM, the concerns were presented to the Nursing Home Administrator (NHA), the Director of Nursing (DON), and two additional staff members during the facility's exit conference.

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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. 50904 Based on the surveyor's observation and interviews with staff members, it was determined that the facility failed to ensure that food in the storage and refrigerator was labeled and dated with preparation and expiration dates. This was observed during the initial tour of the kitchen during the facility's Medicare/Medicaid recertification/complaint survey. The findings include: On 03/24/25 at 08:51 AM, during the initial tour of the kitchen, the surveyor observed that one of the 10 shelves in the storage area contained two bags of dry pasta without dates or labels. On 03/24/2025 at 08:55 AM on the same day, the surveyor requested dual observation and shared concerns with Staff #8. Staff #8 removed the bags and stated that they would be discarded, as the date they were received, the date they were opened, and the expiration date were unknown. On 03/24/2025 at 09:02 AM, during the tour of the walk-in refrigerator, the surveyor observed six trays of Tater Tots (small, crispy, bite-sized potato nuggets typically made from shredded and seasoned potatoes, then deep-fried or baked until golden brown) in the refrigerator without the dates they were prepared. On 03/24/2025 at 09:06 AM, the surveyor requested dual observation and shared concerns with Staff #7, who confirmed that the six trays of Tater Tots were not dated. Staff #7 stated that she did not know why they were not dated and asked Staff #18 to label them. She added that they should have been dated, as she was unaware of when they were prepared, making it impossible for anyone to determine their preparation date and the date it should be out of the refrigerator. On 04/02/2025 at 4:15 PM, the concerns were presented to the Nursing Home Administrator (NHA), the Director of Nursing (DON), and two additional staff members during the facility's exit conference.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 42507 Based on review of facility documentation and interview, it was determined the facility failed to have the required members participate on the facility's Quality Assessment and Assurance (QAA) committee meetings. The findings include: On 4/2/2025 at 11:25 AM, the Assistant Director of Nursing (ADON) provided the quality assurance committee meeting attendance sheets from January 2024 through February 2025. Review of the attendance sheets failed to reveal that the following staff routinely attended the quality assurance committee meetings: The medical director failed to attend the meeting for February 2024 (2/27/2024). The Nursing Home Administrator (NHA) failed to attend the meetings for April 2024 (4/23/2024), September 2024 (9/24/2024), and October 2024 (10/22/2024). Both the Director of Nursing (DON) and the ADON failed to attend the meeting for August 2024 (8/27/2024). On 4/2/2025 at 1:31 PM, an interview was conducted with the QAPI (Quality Assurance and Performance Improvement) representative, Staff #14. Staff #14 reviewed the attendance records and sign-in sheets from January 2024 through February 2025 and confirmed the surveyor's findings. On 4/2/2025 at 4:15 PM during the survey exit conference, the NHA affirmed that she did not attend some of the meetings due to health reasons.