STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215199	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Braddock Heights	6012 Jefferson Boulevard Frederick, MD 21703

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 40927 Based on record review and staff interview it was determined that the facility failed to investigate a grievance regarding care concerns for a resident. This was evident for 1 (#14) of 8 residents reviewed for complaints. The findings include: An observation on 8/12/24 at 1:35 PM revealed Resident #14 turned on his/her call light. When the call light came on there was 2 geriatric nursing assistants (GNA) sitting in the nurses' station that had a notification that the call light was on. There was 1 activity assistant (AA) in the common area (across the hallway from Resident #14's room) providing an activity to the residents. The 2 GNAs, later identified as GNA #2 and GNA #3 made no attempt to answer the call light. At 1:38 PM, AA #1 went to answer the resident's call light. She came out of the room and went to the nurses' station and addressed GNA #2 and GNA #3. The surveyor was unable to hear what AA #1 stated to them, but overheard GNA #3 state she had to complete documentation. AA #1 went back to the resident's room and went in, turned off the call light and came back out. An interview was conducted with AA #1 on 8/12/24 at 1:40 PM revealed the resident had been requested incontinence care. She reported that she cannot provide the care, so she went to the nurses' station and made GNA #2 (was not able to provide incontinence care due to gender) and GNA #3 aware of the resident's needs and was told the resident needed to wait for his/her assigned GNA to return from break. When asked if she was told to turn the resident's light off before their needs were met, she stated she had not been told to do that, however, she did not go back in and turn the light back on. She returned to her duties in the common area. The surveyor continued their observation and on 8/12/24 at 2:04 PM the assigned GNA returned to the unit and GNA #2 made her aware that Resident #14 needed to see her. During the 26 minutes that the resident had waited GNA #3 was observed in the nurses' station working on the computer and on her cell phone. At no point did GNA #2 or GNA #3 go to a nurse on the unit to let them know the resident needed care. During an interview on 8/12/24 at 2:05 PM with GNA #3, she confirmed that AA #1 had come to her and told her the needs of Resident #14. She reported that Resident #14 had requested that she not provide care to her. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A medical record review on 08/12/2024 11:47 AM revealed a care plan for the resident which documented the resident required extensive assistance for incontinence care. An interview with Resident #14 on 8/13/24 at 12:34 PM revealed she had recently had care provided by GNA #3 and that she had never asked not to have her as an aide. On 8/15/24 at 7:47 AM during a review of the grievances reported to the facility regarding Resident #14's care concerns in the past 2 years. It was noted on one report date 8/17/23 taken by the previous Social Service Director (SSD) #2, that the resident reported s/he had put on the call light for assistant on 8/17/23 at 6:45 AM. SSD #2 noted under the same section that this was also the same time that breakfast was being initiated. According to the documentation it was investigated by the former Director of Nursing (DON) #2. DON #2 documented under the results that several staff were interviewed and determined that they made the resident aware that his/her light would be answered when they were finished with breakfast trays. The corrective action read that staff were reeducated to reassure the resident that a staff member was on their way to provide care. However, she failed to conduct a full investigation to determine what the resident was requesting at that time, how urgent the need was, and how long the resident waited to have their call light answered to determine a resolution for the resident's concern. On 8/13/24 at 10:40 AM it was confirmed with the Administrator that there was no other documentation related to this grievance. She reported that everything was documented on the grievance form provided. An interview with Licensed Practical Nurse (LPN) #3 on 8/15/24 at 10:47 AM revealed Resident #14 was particular about his/her care and required additional time. An interview with the Administrator and DON on 8/15/24 at 1:43 PM revealed that GNA #3 was unable to provide Resident #14's care as requested by the Resident. However, the DON reported that both (GNA #2 and GNA #3) should have alerted the resident's assigned nurse or a supervisor that the resident needed care instead of making the resident wait for their assigned GNA to come back. They both confirmed that 26 minutes was not an acceptable wait time. The Administrator reported that regarding the grievance on 8/17/24 that she was unaware of the resident's need or the length of time the resident waited for the need to be provided. She stated that the resident has a behavior of requesting care during mealtimes, however confirmed that this was not on the care plan. Confirmed that the resident was particular about care and would intimidate staff and staff were reluctant to care for the resident. However, she reported that staff had not been educated regarding the resident's care needs related to the resident's diagnosis and how to provide the care based on the resident's preferences. In addition, staff had not been educated on the proper way to excuse themselves when the resident was taking extended time. Therefore, the lack of investigation into the grievance for 8/17/23 resulted in the facility not fully addressing the concern to find a resolution that worked for the resident and staff.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40927 Based on record review and staff interview it was determined facility staff failed to ensure that a resident who relied on staff for care needs had the care provided. This was evident for 2 (#14 and 902) of 8 residents reviewed for complaints. The finding include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1) A review of a compliant in 3/2023 for Resident #14 on 8/12/24 at 9:30 AM revealed a concern that the resident was not assigned an aide on night shift for 9/16/23 as care had not been provided. Review of a complaint in 10/23 revealed a concern with the resident receiving showers. On 8/12/24 at 11:47 AM a medical record Resident #14 revealed a care plan that was initiated on 12/16/21 that documented the resident required assistance with activities of daily living, such as bathing, personal hygiene, dressing, and etc. The care plan kardex noted that the resident's shower days are on day shift on Wednesdays and Fridays. On 8/14/24 at 10:43 AM a review of the schedules for 9/15/23 11-7 am shift revealed geriatric nursing assistant (GNA) #6 was assigned to the resident. A record review for the GNA documentation for 9/15/23 11-7 am shift on 8/14/24 at 1:22 PM revealed that staff had not documented care given to Resident #14 on 9/15/23 and 9/16/23 on the 11 PM - 7 AM shift. A review of the GNA documentation for 10/23 revealed in the section for bathing documentation that the resident was given a shower on 2 (10/18/23 and 10/25/23) of the 8 days s/he was assigned. On 10/11/23 and 10/13/23 staff marked it was not applicable, causing the resident to go a full week with no shower. On 8/15/24 at 11:35 AM Human Resource Director reported that GNA #6 had not clocked in that day. She stated she found that another GNA had clocked in, however, she was not on the assignment sheet and based on the lack of documentation it was uncertain she was aware she was assigned to Resident #14. The Administrator and Director of Nursing were made aware of the findings on 8/15/24 at 2:03 PM. 37586 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) A medical record review on 8/19/24 at 10:00 AM for Resident #902 was conducted. According to the MDS dated [DATE] Resident # 902 needed extensive assistance with toileting. Resident was alert to person, place and time. On 8/14/24 at 9:05 AM a review of the facility investigation file for the incident that occurred on 1/19/22 was conducted. Resident was admitted to the facility in January 2022 and discharged on [DATE]. The resident came to the facility for surgical aftercare following surgery on the digestive system. On 1/19/22 at 5: 00 PM the resident reported that he/she was left soiled after calling for help multiple times. On the morning of 1/19/22, before change of shift, resident # 902 put on the call bell. A GNA responded to the call bell and stated she would find help and turned off the bell. No one came and resident turned on the call bell again. Another GNA responded to the call bell and the resident stated again, 'I need be changed'. GNA stated 'I have someone in the shower, I will get you help'. Again, no one arrived. After putting his/her call bell on a third time, a GNA responded, 'Let me get my supplies and returned to the room to change the resident. Resident was soiled and asked for assistance on 1/19/22, around change of shift, and it was 11 AM when 3rd GNA answered the call bell and changed the resident. Although the facility was unable to substantiate exactly how much time had passed during this incident, as the resident was unable to visualize the clock from his/her location, due to his/her request to keep his/her curtain drawn and therefore could not definitively tell what time it was when s/he used the call bell. The facility administrator was interviewed on 8/15/24 at 11AM stated 'We are able to substantiate that resident was soiled for longer than reasonable'.