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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, staff interviews, and facility policy review, the facility failed to ensure four of six residents reviewed for abuse (Residents (R) 22, R11, R106 and R35) out of a total sample 29 were free from resident-to-resident abuse. This failure had the potential to cause physical injury or psychosocial distress for the four residents involved. Findings include: Review of the facility's policy titled Abuse, Neglect and Exploitation dated 11/13/23 indicated, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property .'Abuse' means the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. 1. Review of R22's electronic medical record (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of Down's syndrome. Review of R22's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 10/03/23. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of three out of 15 revealed the resident was severely cognitively impaired. The assessment indicated the resident was dependent on staff, for on all activities of daily living. Review of R22's EMR titled change in condition Progress Notes located under the Prog (Progress) Note tab dated 10/14/23 indicated the resident was identified with a bruise to his left eye. Review of R22's Care Plan dated 10/17/23 located in the EMR under the Care Plan tab indicated R22 had the potential to demonstrate physical/verbal behaviors related to his diagnosis of dementia. The care plan indicated the resident had poor impulse control, would make racial comments, throw food, and would throw himself on the floor. In addition, the care plan revealed the resident would hit others. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R11's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (stroke). Review of R11's EMR titled Care Plan located under the Care Plan dated 01/16/23 indicated the resident had impaired thought processes related to his diagnosis of a stroke. In addition, the care plan was updated on 03/13/23 which indicated the resident had behavioral problems such as aggression and depression. One of the interventions was to monitor the resident's behavior episodes and attempt to determine the underlying cause. Review of a document provided by the facility titled Physical dated 10/16/23 indicated R11 was interviewed on 10/15/23, as part of the facility's investigation, and specifically questioned R11 about R22's bruise to his eye. R11 stated on 10/14/23, that R22 was yelling and making noise, and he was unable to sleep. R11 stated he told R22 to stop making noise and R22 would not, so R11 stated he got out of bed, fell , got himself up, and then went over and slapped R22 in his face. Both residents were separated. Review of R11's quarterly MDS with an ARD of 02/18/24 indicated the resident had a BIMS score of 12 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident had no behaviors directed towards others. The assessment indicated the resident used a wheelchair for locomotion. Review of the facility's investigation titled Facility Reported Incidents Initial Report Form dated 10/15/23, indicated there were no witnesses to the resident-to-resident altercation which involved R11 and R22. As part of the facility's investigation, R22's roommate R11 was interviewed and informed the facility that he had slapped R22's face on 10/14/23. 2. Review of the facility document located in the EMR titled Admission Record under the Profile tab indicated R35 was admitted to the facility on [DATE]. Review of R35's Care Plan dated 01/18/23 in the EMR under the Care Plan tab indicated R35 had severe dementia and had a wander guard due to roaming. Review of R35's quarterly MDS with an ARD of 04/18/24 in the EMR under the MDS tab indicated R35 had a BIMS score of zero out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had no behavioral issues directed to staff or to other residents. Review of a facility document titled, Facility Reported Incident Follow-Up Investigation Report Form dated 06/11/24 indicated R35 was in the dining room when R22 wheeled over to the table where R35 was sitting and smacked R35 with her open hand across R35's right eye/face. There had been no previous conflict between the two residents, and they were immediately separated. Review of R22's Admission Record located in the EMR under the Profile tab indicated R22 was admitted to the facility on [DATE]. Review of R22's quarterly MDS with an ARD of 04/04/24 indicated the resident had a BIMS score of 03 out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated the resident had Down Syndrome and dementia with behavioral disturbances, psychotic disturbance, and anxiety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R22's Care Plan dated 04/13/24 in the EMR under the Care Plan tab indicated R22 had physical/verbal behaviors due to dementia. R22 has a pillow with his mother's picture on it for anxiety and comfort. Review of a facility document titled Facility Reported Incident Follow-Up Investigation Report Form dated 06/11/24 indicated R35 was in the dining room when R22 wheeled over to the table where R35 was sitting and smacked R35 with an open hand across R35's right eye/face. There had been no previous conflict between the two residents, and they were immediately separated. R22 was taken to his room and assessed for injury. A skin assessment was completed and R35's right eye was red and swollen. R35 had no knowledge that she had been smacked in the eye. R22 had no injuries and R22 stated, My mother not here, am sorry. Interview with the Administrator on 08/14/24 at 3:42 PM revealed We tried a pillow that had R22's mother's face on it for his anxiety and it works at times. 3. Review of R106's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] with a diagnosis of cerebral infarction. Review of R106's EMR admission MDS with an ARD of 01/08/24 indicated the resident had a BIMS score of 14 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident had no behavior directed to others during this assessment period. The assessment indicated the resident used a walker for ambulation. Review of R106's Care Plan located in the EMR under the Care Plan tab dated 02/23/24 had the potential to demonstrate physical or verbal behaviors related to a diagnosis of depression and poor impulse control. The intervention revealed when the resident became agitated to intervene before agitation escalated and to guide away from source of distress and attempt to engage calmly in conversation. Review of a facility document titled, Facility Reported Incident Follow-Up Investigation Report Form dated 02/27/24 indicated R106 entered his room and pushed past his roommate R11 and told R11 to move out of his way. R106 then hit R11 and R11 then hit R106 on the left side of his face. According to the investigation, the incident was verified by R13 and R40. During an interview on 08/14/24 03:40 PM, the Administrator was asked to define abuse. The Administrator requested the facility's policy and read from the policy the definition of abuse. During an interview on 08/15/24 09:45 AM, the Administrator confirmed all of the above resident-to-resident altercations were considered abuse. 43050

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604 43050 Based on record review, interview, and facility policy review, the facility failed to ensure two of two residents (Resident (R) 23 and R55) reviewed for hospital transfers in the sample of 29 was given a written copy of a bed hold notice prior to or within 24-hours of emergency transfer to the hospital. This failure created the potential for the residents and/or responsible parties to not have the information needed to safeguard their return to the facility. Findings include: Review of the facility's policy titled, Bed Hold Notice Upon Transfer, dated 12/27/22, revealed At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed .Information will specify the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; The reserve bed payment policy in the state plan policy; The facility policy regarding bed-hold periods to include allowing a resident to return to the next available bed . Documentation that the bed-hold notice was provided will be maintained in the medical record. 1. Review of R23's undated Admission Record located in the electronic medical record (EMR) under the Profile tab revealed R23 was admitted to the facility on [DATE]. Review of the EMR Progress Notes located under the Progress Notes tab, revealed R23 was hospitalized on [DATE] to 09/04/23 for an intertrochanteric fracture of the right hip; hospitalized on [DATE] to 10/18/23 for a left stump infection; hospitalized on [DATE] to 10/24/23 for chronic infection to left stump and acute osteomyelitis; hospitalized on [DATE] to 11/21/23 for a urinary tract infection and positive stool culture for Clostridioides difficile (C.diff.); hospitalized on [DATE] for right shoulder pain; hospitalized from 11/27/23 to 12/22/23 in Intensive Care (ICU) for Septic Shock; and hospitalized from 02/03/24 to 03/12/24 in the ICU for Septic and Cardiogenic shock. 2. Review of R55's undated Admission Record,'' located in the EMR under the ''Profile'' tab, revealed R55 was admitted to the facility on [DATE]. Review of R55's Progress Note, dated 05/17/24, located in the EMR under the ''Progress Note'' tab, revealed that R55 was sent to the hospital's emergency room (ER) due to an episode of agitation and aggressiveness towards staff. Interview with the Administrator on 08/15/24 at 9:45 AM, when asked if the facility had documentation of the Bed Hold Notifications for each transfer to the hospital, the Administrator stated, probably not.

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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** 28604 Based on observation, interview, record review, document review, and manufacturer's instruction review, the facility failed to provide education for one of one Licensed Practical Nurse (LPN1) to possess the competencies and skill set necessary to ensure proper technique was used to administer insulin for one of two residents (Resident (R)52) that received insulin during medication administration. This failure had the potential to result in the resident receiving the wrong dose of insulin. Findings include: Review of R52's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R52 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus (DM) with hyperglycemia. Review of R52's Physician Orders, dated 05/31/24, located in the EMR under the Orders tab, revealed an order for Insulin Lispro (1 [one] unit dial) subcutaneous solution pen-injector [short acting insulin] 100 Unit/Milliliter (ML). During an observation on 08/13/24 at 12:06 PM, LPN1 retrieved R52's insulin pen (a pen contains the vial of insulin inside the pen and has a mechanism where the dose to be administered is set on a dial at the top of the pen, and only that amount can then be injected) from the medication cart, wiped the top with an alcohol wipe, attached a needle to the pen then dialed the dose to one unit and pushed the plunger. LPN1 carried the pen to R52's room. LPN1 washed her hands, applied gloves, observed R52's left arm, cleansed the back of the arm with an alcohol wipe, gently inserted the pen needle into the flesh, injected the dose, then removed the needle after five seconds. LPN1 carried the pen to the medication cart, disposed of the needle, and performed hand hygiene. During an interview on 08/13/24 at 12:17 PM, LPN1 confirmed she did not prime the pen with two units to ensure the needle was working instead she primed it with one unit to get the air out of the pen. LPN1 stated she received orientation with a nurse about seven months ago but didn't recall if she was trained on use of the insulin pen and did not recall receiving an in-service on insulin pen administration. During an interview on 08/13/24 at 12:45 PM, the Assistant Director of Nursing (ADON) acknowledged LPN1 should have been trained on insulin administration during orientation and he performed random medication administration observations, but they did not include insulin pen administration. During an interview on 08/13/24 at 1:14 PM, the Director of Nursing (DON) verified she completed LPN1's charge nurse competency but it did not include insulin pen administration. The DON stated the medication administration observation form needed to be revised to include insulin pen administration. The DON stated she expected the nursing staff to administer insulin via the manufacturer's directions and the insulin pen should be primed with two units after attaching the needle to ensure it worked. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated facility-provided document titled Instructions for Use LYUMJEV Kwik pen (insulin lispro) injection, for subcutaneous use 3 [three] ML [milliliters] single-patient-use pen 100 units/ML revealed, . Priming your Pen Prime before each injection. Priming your Pen means removing the air from the needle and cartridge that may collect during normal use and ensures that your Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Step 6: To prime your Pen, turn the dose knob to select 2 [two] units. Step 7: Hold your Pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your Pen with the needle pointing up. Push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to 5 [five] slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 [six] to 8 [eight], but not more than 4 [four] times. If you still do not see insulin, change the needle, and repeat priming steps 6 to 8. Small air bubbles are normal and will not affect your dose Review of the facility-provided undated document titled, Medication Pass Observation, dated 07/03/24, revealed LPN1 was observed administering medications satisfactorily; however, insulin pen administration was not included on the form. Review of the facility-provided document titled, Facility Assessment Tool, dated 08/01/24, revealed, . Staff training/education and competencies . Licensed Nurses Valid Nursing License (Registered Nurse (RN) or LPN) All Staff Training Role Licensed Nurse Competency . [the facility] provides the training on topics and competencies that include, but are not limited to: . medication administration . Review of the facility-provided job description titled, Charge Nurse/Staff Nurse, revealed . Drug Administration Functions: Prepare and administer medications as ordered by the physician .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 12679 Based on policy review, interviews, and review of Centers for Disease Control (CDC) and American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) guidelines, the facility's water management program was incomplete in that it was not consistent with current ASHRAE guideline, which specifically called for the design to evaluate the potential exposure of Legionnaire's disease (a serious pneumonia infection) within a healthcare facility. This failure created a potential for the 43 facility residents, who were over the age of 65, to be infected by Legionella Findings include: Review of the CDC website titled Legionella. Prevention and Control, dated 03/25/21, indicated, The key to preventing Legionnaires' disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella.Key Elements.Seven key elements of a Legionella water management program are to. Establish a water management program team. Describe the building water systems using text and flow diagrams. Identify areas where Legionella could grow and spread. Decide where control measures should be applied and how to monitor them. Establish ways to intervene when control limits are not met. Make sure the program is running as designed (verification) and is effective (validation). Review of ASHRAE website titled Risk Management For Legionellosis dated 10/2015 indicated, The design engineer first needs to evaluate which requirements of the standard apply to their project. This evaluation determines if the project contains any of the following building risk factors.Health-care facility with patient stays over 24 hours.Facilities designated for housing occupants over age 65.The risk of disease or illness from exposure to Legionella bacteria is not as simple as the bacteria being present in a water system. Other factors that contribute to the risk are environmental conditions that promote the growth and amplification of the bacteria in the system, a means of transmitting this bacteria (via water aerosols generated by the system), and the ultimate exposure of susceptible persons to the colonized water that is inhaled or aspirated by the host providing a pathway to the lungs. The bacteria are not transmitted person-to-person, or from normal ingestion of water. Susceptible persons at high risk for legionellosis include, among others, the elderly, dialysis patients, persons who smoke, and persons with medical conditions that weaken the immune system. Review of a facility policy titled Water Management Program dated 12/04/22 indicated .It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens.in the facility's water system based on nationally accepted standards.Data to be used for completing the risk assessment may include, but are not limited to.Water system schematic/description. Based on the risk assessment, control points will be identified. During an interview on 08/14/24 at 1:00 PM, the Maintenance Director stated there have been no Legionnaires outbreaks and stated that the water enters from the county water supply. During this interview, he presented a hand drawing of the facility's water system, and he verified that he completed it on this date. During this interview, the Maintenance Director provided a document titled Furnace Location undated which provided a description of the locations of each hot water furnace and how to turn off during an emergency. The document failed to contain information on how water enters into the facility and potential areas for water pathogens to develop.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to offer one of six residents (Resident (R) 37) and/or their representatives reviewed for immunizations, the opportunity for the resident to be vaccinated in accordance with nationally recognized standards out of a current facility census of 54. This practice had the potential to increase the risk for the residents to contract pneumonia. Findings include: Review of the facility's policy titled Pneumococcal Vaccines dated 12/18/22 indicated .It is our policy to offer our residents . immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations.For adults [AGE] years' or older who have not previously received any pneumococcal vaccine.Give 1 dose of PCV15 or PCV20.If PCV15 is used, this should be followed by a dose of PPSV23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebral fluid leak.if PVC20 is used, a dose of PPSV23 is not indicated.For adults [AGE] years' or older who have only received a PPSV23.Give 1 dose PCV15 or PCV20.The PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. Review of the CDC website titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, effective 01/28/22, indicated . CDC recommends pneumococcal vaccination for all adults [AGE] years or older . for older who have only received PCV13, CDC recommends you . Give PPSV23 as previously recommended . For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. Review of R37's electronic medical record (EMR) titled Immunization located under the Immun (Immunization) tab indicated the resident received the PCV13 on 02/03/16. Review of R37's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. The resident was over the age of 65 upon admission. During an interview on 08/13/24 4:01 PM, the Infection Preventionist (IP) confirmed R37 had the PCV13, and she had administered the PCV20 this morning. During an interview on 08/15/24 at 8:58 AM, the IP stated that she completed a recent audit for the PCV20, and just missed R37.