| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215203 | A. Building<br>B. Wing | 06/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Riverview | 1 Eastern Boulevard<br>Essex, MD 21221 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>2. MD00204713 was reviewed on 5/30/25 at 1:15 PM for allegations of abuse to Resident #232. According to the investigation and a statement provided by staff, Environmental Staff (EVS) #18, who indicated that she overheard the resident say to GNA (#17), you are hurting me and the GNA went on to use [explicative] at the resident.<br><br>Further review of the investigation revealed that the allegation could not be verified or refuted based on the timeline of events, interviews with the resident and other residents and no one else reported hearing cursing from the resident room. There was a possibility that Staff # 18 voiced the concern as retaliation towards Staff #17 due to the staff making a complaint about Staff #18 the previous day.<br><br>An interview was conducted with the DON on 5/30/25 at 2:00 PM and she stated that according to the investigation, Staff # 18 allegedly overheard staff verbal abuse and did not report it until the next day. The DON stated that Staff #18 received a written warning for failure to report in a timely manner and that education was provided to staff.<br><br>3. MD00204531 was reviewed on 6/2/25 at 2:30PM for allegations of sexual abuse to Resident #222. According to the facility's investigation, two staff, a GNA (#26) and a Nurse (#27) overheard the resident screaming and immediately went to the resident room to see what was wrong. At that time the resident made accusations alleging seeing a black figure under the covers.<br><br>Further review of statements provided by the speech therapist (Staff # 25) on 4/9/24 indicates the resident appeared visibly upset and distressed and reported to the therapist that someone tried to rape him/her last night. The resident told the therapist that two staff came into the room the previous night after s/he screamed and told him/her that she was dreaming and that no one was in the room.<br><br>An interview was conducted with the DON on 6/3/25 at 1:30PM and she was asked to explain what the expectation of staff is when a resident report abuse allegations and she said that staff are to report any allegations of abuse immediately. The DON was then asked if Staff # 26 and # 27 were to report the resident allegations and she stated, yes. The staff should have reported this to administration, and they did not. The abuse allegations was unsubstantiated.<br><br>All concerns were discussed with the Administration team on 6/3/25 at 6:15 PM at the exit conference.<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on review of administration documentation and interviews with facility staff it was determined the facility failed to report an injury of unknown origin and allegations of abuse to the State Agency in a timely manner. This was found to be evident for 3 (Resident #11, #232, #222) of 18 residents reviewed for abuse allegations during the survey.<br><br>Findings include<br><br>1. On 5/30/2024 at 7:53 AM, a review of Resident #11's electronic medical record revealed a nursing note dated 6/23/2024 at 5:13 PM which state, Resident c/o left leg pain from the knee down while nurse and resident's daughter was in the room. X-ray of left leg was ordered awaiting for it to be done. Further review revealed imaging results for the left tibia and fibula, and left ankle exam completed on 6/23/2024 at 3:30PM and the report at 9:59 PM revealed that the resident sustained a left tibial fracture.<br><br>An additional review of the resident's electronic medical record revealed a nursing note dated 6/23/2024 at 10:58 PM which stated, Resident transferred to [hospital] for acute nondisplaced mid tibial fracture. Further review failed to reveal documentation to verify if the source of the injury was observed by any person nor if the source of the injury could be explained by the resident.<br><br>On 6/2/2025 at 11:40AM during an interview conducted with the Nursing Home Administrator (NHA), the Surveyor expressed the concern that Resident #11 sustained an injury of unknown origin on 6/23/2024, which x-ray confirmed a fracture of the left tibia. The Surveyor informed the NHA and the Director of Nursing (DON) that there was no documentation within the resident's medical record to indicate how and when the fracture occurred and if the facility investigated the injury. An injury of unknown origin, unobserved/unexplained fracture, is an incident that should be reported to the Office of Health Care Quality within 2 hours of their knowledge. The NHA nor the DON were able to provide documentation of an investigation in which the staff and resident were able to explain how the resident sustained the injury. There was no record of a facility reported incident from the facility. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>2. Food temperatures above 41 degrees Fahrenheit (for cold foods) and below 135 degrees Farhenheit (for hot foods) allow the rapid growth of pathogenic microorganisms that can cause foodborne illness.<br><br>On 06.01.25 at 12:30 PM the surveyor observed the kitchenette/galley serving station in the Seagull activity room/dining room. There was no dietary aide present in the galley preparation area. The surveyor observed a bin of small containers/cups of apricots and applesauce that were not refrigerated on the second shelf next to the hot water/steam serving table. The outside of the containers were warm to touch. The surveyor observed the 40 residents in the Seagull dining room waiting to be served their lunch meal. Six geriatric nursing assistants (GNAs) were present in the dining room.<br><br>On 06.01.25 at 1:07 PM the surveyor observed the dietary staff # 11 enter the galley area and unloaded the food items to the steam table. The surveyor during the interview informed dietary staff #11 of the presence of the cups of apricots and applesauce that were unrefrigerated. Staff #11 stated that he/she had prepared the fruit cups in the kitchen earlier that morning and could place these items in the refrigerator now to chill. The surveyor requested that dietary staff #11 perform a temperature test on the cups of fruit and the results were:<br><br>1. Applesauce temperature: 70.2 degrees Fahrenheit<br><br>2. Apricot slices: 50 degrees Fahrenheit<br><br>Since the temperatures for the applesauce and apricot slices should have tested at 41 degrees Farhenheit or lower, after the temperature testing of the fruit and applesauce cups staff #11 stated that he/she would dispose of the food items in the kitchen after the noon meal was served to the residents.<br><br>These potential deficiencies were discussed with the administrator, and the director of nursing on 06.01.25 prior to the surveyors leaving the facility at 2:30 PM.<br><br>Based on observations and interviews with facility staff it was determined the facility failed to ensure staff wore appropriate hair restraints while in food preparation areas and failed to store and/or refrigerate food items at a safe temperature. This was found to be evident during initial tour of the kitchen and during observations made during dining experiences during the survey.<br><br>The findings include:<br><br>1. On 05/27/25 at 7:45 AM, during the initial kitchen observation and tour, the surveyor observed Staff #33 walking towards the exit of the kitchen from the area where food was prepared without wearing a hairnet. A clearly posted sign at the kitchen entrance stated, Hairnets Required Beyond This Point.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | This concern was brought to the attention of the Director of Nursing and the Nursing Home Administrator (NHA) during the end-of-day conference on 05/27/25. The NHA stated at this time that hairnets were to be worn in the kitchen areas which is in accordance with professional standards for food service safety. |