| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 215215 | A. Building<br>B. Wing | 05/01/2025 |

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| Autumn Lake Healthcare at Alice Manor | 2095 Rockrose Avenue<br>Baltimore, MD 21211 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>45131<br><br>Based on observation, record review, and interviews with residents and facility staff, it was determined that the facility failed to maintain a safe environment. This was evident for 1 of 2 soiled utility rooms observed during a tour of the environment during the recertification/complaint survey.<br><br>Findings Included:<br><br>On 05/01/25 at 10:13 AM, during a tour of the facility during the system triggered environment task, it was observed that the soiled utility room on the first floor was unlocked, this soiled utility room contained used biohazard bags, used needle/sharps containers, used oxygen equipment and trash.<br><br>On 05/01/25 at 10:47 AM, during the facility tour with the Maintenance Director (Staff #26), he was notified that the soiled utility room on the 1st floor was unlocked and was a safety concern. He attempted to lock the door, but he was unable to fix the issue, and he stated he was not sure why the door was unlocked, and they would address the issue.<br><br>On 05/01/25 at 11:28 AM, in an interview with the Director of Nursing (DON), the DON was notified that the 1st floor soiled utility closet was unlocked and there were biohazard bags and needle containers stored in the room, which was a safety concern. She verbally acknowledged the concern. |

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 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>43096<br><br>Based on medical record reviews and interviews with residents and staff, it was determined that the facility staff failed to provide adequate responses to grievances presented by the residents. This was evident for 2 (Resident #55, #64) of the 3 residents whose grievance records were reviewed during the recertification/complaint survey.<br><br>The findings include:<br><br>1) During the screening process on 4/24/25, at 2:00 PM, Resident #55 reported that a couple of weeks prior, he/she was upset with a facility staff member, Geriatric Nurse Aide #31, because the aide had caused a plant to die. The resident stated that this plant had been given to him/her by a loved one. Resident #55 stated that he/she had requested that GNA #31 not come into his/her room, as seeing the staff member reminded him/her of the situation and caused him/her distress. Resident #55 stated that even though he/she had requested that GNA #31 not enter his/her room, the GNA still entered to care for his/her roommate. Resident #55 said, I did not understand why the staff still entered my room. I did not need to see him.<br><br>On 4/28/25, at 10:20 AM, the surveyor requested and reviewed the grievance forms for Resident #55. The social worker provided seven grievance forms dating from March 2024 to January 2025, addressing issues such as wandering residents, room temperature, meal service, provider's care, and morning care. However, there was no grievance form filed regarding GNA #31 damaging his/her plant.<br><br>In an interview with GNA #31 on 4/28/25 at 1:49 PM, the staff member recalled the incident involving Resident #55's plant. GNA #31 stated that he had reported the incident to the supervisor and written a statement. He said, The supervisor told me not to go to Resident #55's room, but I was still assigned to take care of [name of Resident #55's roommate]. Resident #55 saw me, then yelled and cursed at me, using the F-word.<br><br>On 4/28/25, at 2:12 PM, the surveyor interviewed the Director of Nursing (DON) and the Nursing Home Administrator (NHA) and requested all documentation regarding the above incident.<br><br>The facility staff provided a copy of GNA #31's written statement on 4/29/25, at 11:15 AM. However, there was no additional documentation to support the facility's response, such as a grievance form, supervisor's order, and/or follow-up documentation for this incident.<br><br>On 4/30/25, at 12:47 PM, the surveyor interviewed the NHA and shared concerns. The NHA validated these concerns.<br><br>2) On 4/25/25, at 8:54 AM, Resident #64 reported the loss of multiple clothing, including pants, short-sleeved shirts, and underwear. The resident stated, Since the facility changed the laundry process - sending them out for washing - this has happened frequently. The resident indicated that the most recent instance of missing clothes occurred the previous week. Resident #64 also explained that all of their clothing had labels with their last name and room number. The resident reported that these issues had been brought to the attention of the social worker and management.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/25/25, at 10:55 AM, the surveyor interviewed Staff #4, the Environmental Services Director. Staff #4 confirmed that the facility had recently changed its laundry procedures: facility staff collected laundry every Monday and Wednesday, and a contracted company picked it up every Tuesday and Thursday to be washed in New Jersey and then delivered back to the facility. Staff #4 also stated awareness of residents' missing and/or damaged clothing. He commented, We did not have any issues when we washed them in the building. When asked how the facility addressed this recurring problem, Staff #4 stated, I contacted the company several times. They kept saying they would look into it. I reported it to the social worker, who filled out grievance forms and arranged for replacement or reimbursement.<br><br>The surveyor requested and reviewed residents' grievance forms from the Social Worker on 4/25/25, at 11:40 AM. The review revealed two grievance forms filed by Resident #64 regarding their clothing. The first, dated 2/06/25, concerned the resident's belief that the contracted laundry company's detergent had damaged their clothes. The second grievance form, completed on 2/18/25, documented Resident #64's concerns about clothes not being returned by the washing company. These items were reimbursed by the facility on 3/21/25. However, no additional grievance forms related to missing clothing week of 4/17/25 were found. After the surveyor ' s intervention, the facility created a grievance form dated 4/25/25.<br><br>During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 4/25/25, at 12:29 PM, the surveyor inquired about the laundry issues. The NHA explained that since the laundry was being washed in New Jersey, returns to residents sometimes took time. He stated that facility staff were aware of the issue and that he had contacted the contracted company to resolve it. The NHA explained that the facility had not received a response from the company but would follow up with residents who had issues with damaged and/or missing clothing.<br><br>On 4/30/25, at 2:58 PM, Resident #64 expressed significant frustration that their clothes were still missing and had not yet been received.<br><br>On 4/30/25, at 3:20 PM, the surveyor informed the NHA of Resident #64's ongoing concerns. The NHA stated that he would follow up with the resident.<br><br>In an interview with the DON on 5/01/25, around 12:45 PM, the surveyor shared concerns regarding the aforementioned issues. The DON validated these concerns. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>43096<br><br>Based on observations, record review, and interviews with facility staff, it was determined that the facility failed to keep residents free from accidents and hazards, as evidenced by; 1) the failure to lock a Geri chair while a resident was using it. This was evident in 1 (Resident #75) of the 3 residents reviewed for fall risk during the recertification/complaint survey. Also, the facility failed to 2) ensure the resident's environment was free from accident hazards by failing to keep a resident's fall mat clear of other objects. This was evident for 1 (Resident # 43) of 5 residents reviewed for accidents during the recertification/complaint survey.<br><br>The findings include:<br><br>Huntington's disease (HD) is an inherited neurological disorder that causes the breakdown of nerve cells in the brain, leading to a progressive decline in movement, cognitive function, and psychiatric health. The symptoms include uncontrolled, jerky movements (chorea), difficulty with balance, and coordination problems.<br><br>A Geri chair, also known as a geriatric chair or medical recliner, is a type of chair designed for comfort and support, particularly for individuals with mobility limitations or who need to sit for extended periods. It combines the features of a recliner and a transport wheelchair, offering adjustable backrests, footrests, armrests, and sometimes head supports, as well as wheels for easy movement. For safe use of a Geri chair, it is recommended to lock the wheels and employ safe transfer techniques, proper footrest positioning, secure positioning of the resident, and safety belts/restraints (if applicable).<br><br>[Reference : residentessentials.com]<br><br>1) Upon the recertification survey, which commenced on 4/24/25, around noon, surveyors observed that Resident #75 was lying in a Geri chair between the 2nd-floor nursing station and the activity (also used as the dining room) area. This area was noted to be busy, with 5-6 residents sitting in wheelchairs and/or passing by. Staff members were pushing meal carts or getting water from the nourishment room. Resident #75 exhibited shaking and/or jerky movements when the surveyor observed him/her.<br><br>On 4/28/25, at 12:25 PM, two surveyors observed that Resident #75 was near the entrance door of the activity room in a Geri chair with unlocked wheels. At 12:27 PM on the same day, while the surveyor observed him/her, a Licensed Practical Nurse moved the resident's Geri chair slightly closer to the wall and locked only one wheel. Resident #75 began having uncontrolled movements, and it was noted that the chair moved slightly. The LPN remained next to the resident; however, only one wheel was locked.<br><br>On 4/28/25, at 1:14 PM, a review of Resident #75's medical record revealed that the resident had a diagnosis of Huntington's disease and was at high risk for falls. Additionally, the resident had experienced a recent fall on 4/27/25, and had been transferred to the hospital for follow-up evaluation.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of Resident #75's medical record on 4/29/25, at 5:08 PM revealed that the resident had another fall on 4/29/25 around 1 AM, and was transferred to the hospital again.<br><br>On 5/01/25 at 9:16 AM, the surveyor observed Resident #75 lying in the Geri chair in front of the nurse station with unlocked wheels. As the resident began moving involuntarily, the chair shook and moved forward slightly. After this observation, the surveyor interviewed the Director of Nursing (DON). She stated that Resident #75 was at high risk of falls and had a frequent fall history. For safety purposes, the facility staff placed him/her in a Geri chair near the nursing station so they could monitor the resident closely. The surveyor pointed out that the wheels were not locked. The DON immediately locked the wheels and acknowledged the surveyor's concern.<br><br>The surveyor reviewed Resident #75's care plan on 5/01/25, at 10:00 AM. The review revealed that several care plans related to fall risk had been initiated. One intervention stated, resident to be in dining room for meals and activities only. Date initiated on 2/21/25. However, there were no care plans or interventions specifically addressing Resident #75's Geri chair use and/or placement.<br><br>On 5/01/25, at 12:27 PM, the surveyor informed the DON about the above concern. She validated it.<br><br>52359<br><br>2) During the initial tour of the facility on 04/24/25 at 08:22 AM, it was observed by the surveyors that there was an IV pole found being stored on top of Resident #43's safety fall mat.<br><br>Review of Resident #43's medical records On 04/24/25 at 09:37 AM, revealed that there was an alert note on 1/10/25 at 2:34 PM stating that the resident was found on the floor by their bed after a fall.<br><br>On 04/25/25 at 09:19 AM, an observation of Resident #43's room showed that the IV pole was still on the fall mat.<br><br>During an Interview on 04/25/25 at 11:46 AM with Staff #10, a licensed practical nurse (LPN), he stated that for residents identified as a fall risk they do hourly safety rounds. He said that in his rounds he checks for bed in low position, other fall precautions are in place, that the resident is in the bed or wheel chair, and that if they have a fall mat he would make sure that the fall mat is clear from any objects. After the brief interview, the surveyor walked with the LPN into the Resident #43's room, the LPN immediately identified the issue on his own and removed the IV pole that was on the fall mat and ensured the resident's bed was in the low position.<br><br>The Director of Nursing was also made aware of the concern on 4/29/25 and again at exit on 5/1/25. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>51128<br><br>Based on record review and interview with facility staff, it was determined that the facility failed to initiate the use of nonpharmacological methods for pain management tool on the Resident's Medication and Treatment Administration Record (MAR and TAR). This was evident in the review of 1 of 1 (Resident #49) reviewed for unnecessary medications during the recertification/complaint survey.<br><br>The findings include:<br><br>On 04/29/25 at 09:34 AM during an unnecessary medication review for Resident #49, the surveyor found a physician order dated 12/24/2024 at 14:30 for Acetaminophen Oral Tablet 325 MG (Acetaminophen), Give 650 mg by mouth every 4 hours as needed for mild pain. Pain assessment: Pain management score .0=no pain, 1-3=mild pain, 4-7=moderate pain, 8-10=severe. Regularly assess those residents who receive routine pain medication every shift.<br><br>The care plan review on 4/29/25 at 09:47 was initiated on 12/1/24 and indicated that Resident #49 had potential for alteration in comfort related to acute illness and chronic morbidities. The goal was for Resident to express level of comfort daily as evidenced by 0 pain. The interventions were for nurses to administer analgesic medication as ordered, monitor for pain daily using 0-10 pain scale and document and conduct pain assessment every shift and as needed.<br><br>On further medical record review on 4/29/25 at 09:52 AM, the surveyor noted that there was no documentation for nonpharmacological pain interventions on the care plan, MAR, and TAR. Therefore, there was no way to validate that nonpharmacological measures were documented prior to the administration of pain medication.<br><br>On 04/30/25 at approximately 09:00 AM, during an interview with the Unit Manager, Staff #18, the surveyor asked where the nonpharmacological methods were used in pain management documented on Resident # 49's chart. After Staff #18 reviewed the medical record, she/he stated that it was not there, and it should have been there.<br><br>On 04/30/25 at 10:00 AM, an interview was conducted with the Director of Nursing (DON) who stated that the nonpharmacological pain intervention was not in Resident #49's medical record and it should have been there. DON agreed that this was a concern and that she will check all the other Resident's record to ensure this was corrected. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>43096<br><br>Based on a review of complaints, observations, and interviews with residents and staff, it was determined that the facility failed to maintain sufficient staffing levels to meet the needs of its residents. This was evident in statements from 6 out of 10 interviewable residents (Resident #23, #29, #45, #54, #55, and #60 ), 1 of 11 complaints, and statements from nursing staff (2 out of 3) during the recertification/complaint survey.<br><br>The findings include:<br><br>1) Interviews with residents (Resident #23, #29, #45, #54, #55, and #60) during the screening process on 4/24/25, revealed concerns regarding staffing levels:<br><br>- On 4/24/25, at 9:12 AM, Resident #45 stated that the facility experienced the worst staffing on the evening shift (3:00 PM - 11:00 PM for Geriatric Nurse Aides).<br><br>- On 4/24/25, at 10:26 AM, Resident #23 said, The nurses bring my medication whenever they want to; sometimes I get medication at noon. They are always short-staffed. Sometimes it takes them 2 hours to answer the call lights.<br><br>- On 4/24/25, at 11:45 AM, Resident #60 stated, It takes hours to get assistance, especially at night, to get changed.<br><br>- On 4/24/25, at 12:06 PM, Resident #54 reported that staff took a long time to respond when they called.<br><br>- On 4/24/25, at 12:33 PM, Resident #29 stated that it appeared agency staff did not care about residents, adding, There are a lot of them on each shift.<br><br>Also, on 5/01/25, at 9:20 AM, Resident #55 said, Last night I put the call light on around 2:00 AM. There was no response until 3:15 AM. The resident reported feeling fear when there was no response to the call bell, stating, If I pushed the call bell, it meant I needed help. I heard the staff talking and laughing from the hallway, but there was no help for more than an hour. If it was an emergency, someone could die. I am very concerned about the response times. Resident #55 also added, I observed several times that my roommate was not fed by staff. They tried to touch her lip a couple of times to see if she was hungry, then just gave up and left. And I observed that no one gave her water.<br><br>2) During a review of complaints on 4/30/25, at 10:00 AM, one anonymous complainant reported that the facility was significantly understaffed on a weekend in March 2025, and that was not an isolated incident. The complainant stated that they were responsible for over 30 patients without assistance from a supervisor or other nursing staff.<br><br>During an interview with Staff #29 (Staffing Coordinator) on 4/30/25, at 10:23 AM, she outlined the facility's staffing goals per unit:<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Unit One: 3 GNAs on day shift (7:00 AM - 3:00 PM), 3 GNAs on evening shift (3:00 PM - 11:00 PM), and 2 GNAs on night shift (11:00 PM - 7:00 AM). Two nurses for day shift (7:00 AM - 7:00 PM), and two nurses for night shift (7:00 PM - 7:00 AM).<br><br>- Unit Two: 5-6 GNAs on day shift, 5 GNAs on evening shift, and 4 GNAs on night shift. Two nurses for day shift, two nurses for night shift, and one CMA (Certified Medical Assistant).<br><br>On 4/30/25, at 12:54 PM, the surveyor received the facility's actual staffing records along with the resident census. This review revealed that:<br><br>- On 2/08/25 (Saturday), Unit 1 had a census of 34 residents. The night shift was staffed with 2 nurses and one GNA (Geriatric Nursing Aide).<br><br>- On 3/01/25 (Saturday), Unit 1 had a census of 37 residents. The night shift was staffed with 2 nurses and one GNA.<br><br>- On 3/02/25 (Sunday), Unit 1 had a census of 37 residents, and Unit 2 had a census of 62 residents. The night shift on both units was staffed with 2 nurses and 1 GNA each.<br><br>- On 3/16/25 (Sunday), Unit 1 had a census of 39 residents. The night shift was staffed with 2 nurses and one GNA.<br><br>- On 3/30/25 (Sunday), Unit 1 had a census of 34 residents, and Unit 2 had a census of 63 residents. The night shift on both units was staffed with 2 nurses and 1 GNA each.<br><br>- On 4/26/25 (Saturday), Unit 1 had a census of 29 residents. The night shift was staffed with 2 nurses and one GNA.<br><br>3) During an interview with Geriatric Nursing Aide (GNA #21) on 5/01/25, at 7:01 AM, they stated that the facility was sometimes understaffed, which caused GNA #21 to stay longer to finish their work. When asked about the resident-to-staff ratio, they said, The worst ratio was like yesterday. I was the only GNA on this floor. I needed to take care of more than 30 residents.<br><br>In an interview with GNA #22 on 5/01/25, at 9:33 AM, the surveyor inquired about any staffing-related concerns. The GNA stated that there had been many call-outs, which made their workload heavier. GNA #22 said, Sometimes I was not able to complete work in a timely manner. Sometimes the night shift has only one GNA covering the entire 2nd floor, and they were not able to complete their tasks like changing pads and repositioning residents.<br><br>During an interview with the Director of Nursing (DON) on 5/01/25, at 12:27 PM, the surveyor shared concerns about the staffing issues raised by residents and staff interviews, as well as the complaint. She validated these concerns. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>14894<br><br>Based on staff interview and an investigation of intake #MD00217176 it was determined that the facility staff failed to ensure all nursing staff were educated on the location of the facility's Automated External Defibrillator (AED). This was evident for 3 staff (Staff #23, 24, 25) out of 11 who were interviewed during the recertification/complaint survey.<br><br>The findings are:<br><br>An AED is a portable, user-friendly medical device designed to analyze a person's heart rhythm and deliver an electric shock, if necessary, to restore a normal heart rhythm.<br><br>An investigation of intake #MD00217176 for Resident #94 was conducted on 4/30/25 and 5/1/25. On 4/30/25 from 2:00 PM to 3:00 PM and on 5/1/25 at 7:01 AM survey member conducted interviews with nursing staff related to the AED and their locations. Eleven members of the nursing staff were interviewed and three of them did not know where the AED's were located. Staffing of those interviewed were: 3 Licensed Practical Nurses (all agency), 1 Certified Medication Aide (CMA)(staff), and 7 Geriatric Nursing Assistants (GNA) (6 agency and 1 staff) were interviewed. Two GNA's and the CMA did not give the correct answer for the AED location.<br><br>On 4/30/25 at 2:10 PM, GNA (Staff #25) was interviewed, and they said, the AED was on the medication cart.<br><br>On 4/30/25 at 2:15 PM, CMA (Staff #24) was interviewed, and they said, the AED is in the medication room, I can show you. She entered the medication room behind the nursing station. Then asked one of the nurses about the AED, then said oh my bad, it is located on the wall, not the med room one in use.<br><br>On 4/30/25 at 2:30 PM, GNA (Staff #23) was interviewed, and they said they never showed me the AED location. The GNA started to look around and added oh, it's there near the nursing station wall.<br><br>The Welcome Training packet for nursing staff was reviewed on 5/1/25 at 12:59 PM. The packet did not include any evidence of teaching new facility staff and/or agency staff where the AED's are located. |

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| F 0728<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43096<br><br>Based on record reviews and interviews, it was determined that the facility failed to ensure that a Certified Nursing Assistant (CNA) received the required training to become a Geriatric Nursing Assistant (GNA) within the 4-month timeframe, and that all nursing staff maintained active licenses. This was evident in 1 (Staff #20) of the 3 CNA/GNA employee records reviewed during the recertification/complaint survey.<br><br>The findings include:<br><br>On [DATE], at 6:00 PM, the surveyor reviewed a randomly selected sample of 3 CNA/GNA employee files. The review revealed that Staff #20, who was hired in [DATE] as a CNA, did not possess an active license. The Maryland Board of Nursing license verification website showed that Staff #20's CNA license had expired on [DATE], and the status for the entry date of [DATE], was listed as pending. Furthermore, the staff member's training records contained no documentation to support that she had received the necessary training and/or testing to become a GNA.<br><br>During an interview with the Director of Nursing (DON) on [DATE], at 7:42 AM, the DON stated that the facility hires both CNAs and GNAs. CNAs are required to complete their training and pass the test to become GNAs. The DON also stated that the Human Resources team is responsible for maintaining staff licenses.<br><br>In an interview with the Assistant Director of Nursing (ADON), who also serves as the educator, on [DATE], at 8:34 AM, she stated that she did not provide any specific training for aides to become GNAs. She commented, HR may know.<br><br>On [DATE], at 8:34 AM, the surveyor interviewed the HR Director (Staff #28). She confirmed that the facility hires CNAs and GNAs. She stated, [Staff #20's name] is the only CNA currently working in this building. The facility does not have any special training course for CNAs to become GNAs. We just recognized this issue, as well as her license status, and we have now removed her from the schedule.<br><br>The above concern was reviewed with the DON on [DATE], at 12:27 PM. She validated it. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>52359<br><br>Based on observation, review of records, and interview with staff, it was determined that the facility failed to ensure narcotics removed from the resident's supply were administered to the resident, as evidenced by staff documenting the removal of narcotics without documentation of the need for the narcotic or documentation that the narcotic was administered to the resident. This was evident for 2 (#38 and #69) of 2 residents reviewed for controlled drug administration and medication administration records reviewed during the recertification/complaint survey.<br><br>The findings include:<br><br>On 04/29/25 at 01:00 PM, the surveyor conducted a review of the facility's controlled drug administration records for medication cart 1 on floor 1 and medication cart 1 floor 2.<br><br>1) In medication cart 1 on floor 1, Resident #69's controlled drug administration record was reviewed for an order, Oxycodone 5mg 1 capsule by mouth every 12 hours as needed. During the review of the controlled drug record the resident's Medication Administration Record (MAR) was also being reviewed in order to compare and check for accuracy of documentation. The reviews showed that dates and times that were documented on the controlled drug record were missing in the resident's MAR. There were 5 dates and times that were not in the MAR but that were documented as signed out of the medication cart:<br><br>- 4/22/25 at 12:20 PM<br><br>- 4/23/25 at 09:00 AM<br><br>- 4/24/25 at 09:00 AM<br><br>- 4/25/25 at 11:00 AM<br><br>- 4/27/25 (No time documented)<br><br>The findings were reviewed with LPN #16 at this time. She confirmed they did not match.<br><br>2) In medication cart 1 on floor 2, Resident #38's controlled drug administration record was reviewed for an order, Tramadol half tab 25mg PO every 6 hours as needed for pain. The reviews showed that there are dates but no times documented on the controlled drug record for when the medication was removed. These findings were reviewed with LPN #8 at this time. She confirmed that the times were not documented on the controlled drug record.<br><br>On 05/01/25 at 12:34 PM, the Director of Nursing was interviewed. She stated that her expectations for the narcotic tracking is that the controlled drug administration records are to match exactly with the MAR. At this time she was made aware of the findings. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14894<br><br>Based on clinical record review and staff interview it was determined that the facility staff failed to implement behavior monitoring for residents receiving antipsychotics medications and to ensure a resident received medications as ordered. This was evident for 3 (#34, #44 and #49) out of 5 reviewed for unnecessary medications during the recertification/complaint survey.<br><br>The findings are:<br><br>1) A review of Resident #34's clinical record on 4/29/24 at 8:37 AM revealed the resident was being administered Seroquel 25 mg at bedtime for bipolar disorder. The physician ordered that the resident's behavior be monitored. The resident had a care plan to address: The resident has a behavior problem related to threatening, vandalism, using profanity on staff. The goal of this care plan was for the reduction of the behaviors. A behavior monitoring log would allow staff to determine if there is a decrease. A review of the resident's Medication Administration Records (MAR) revealed there was no behavior monitoring.<br><br>The survey team interviewed the Unit Manager (Staff #18) on 4/30/25 at 10:00AM. The surveyor asked what was the expectation for monitoring when a resident is taking an antipsychotic or an anti-anxiety medication. The Unit Manager replied there should be a behavior management tool listed in Point Click Care (PCC - the name of the electronic health record system).<br><br>A survey team member interviewed the Director of Nursing (DON) on 4/30/25 at 12:01 PM. The DON stated that the expectation was that residents prescribed an anti-psychotic and/or anti-anxiety medication should have a behavior monitoring tool. The DON stated that some residents did not have the behavior monitoring in their PCC record and that she is going through all the residents records who are prescribed anti-psychotics and/or anti-anxiety medications to ensure that they have it. DON was made aware that this was a concern.<br><br>2) A review of Resident #44's clinical record on 4/30/25 at 1:04 PM revealed the resident's primary physician ordered that the resident receive Tylenol as needed for pain. A review of the Medication Administration Records (MAR) revealed the order instructed staff to administer 2 500mg tablets every 8 hours for pain of 1-5. Nursing staff document numbers from 0-10 which indicated the pain scale being used was 0-10.<br><br>The resident received Tylenol for pain even when staff documented there was no pain on 3/1/25 all three shifts, midnight of 3/2/25, midnight of 3/5 and 3/6, all three shifts on 3/7; 8 AM and 4 PM on 3/8, midnight and 4 PM on 3/9, midnight on 3/10, midnight on 3/11, midnight on 3/13, midnight on 3/14, 8 AM on 3/16, midnight on 3/17, midnight on 3/18, midnight and 8 AM on 3/19, midnight on 3/20, midnight and 8 AM on 3/21, midnight on 3/22, midnight and 8 AM on 3/23, every shift on 3/24, midnight on 3/25, and every shift for every day till the end of the month.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The resident received Tylenol for pain even when staff documented there was no pain on midnight of 4/1/25, all shift of 4/2, midnight of 4/3, 4 PM on 4/4, all shift 4/5, midnight and 4 PM on 4/6, midnight and 8 AM on 4/7, midnight on 4/8, 8 AM and 4 PM on 4/9, midnight on 4/10, all shifts for 4/11 to 4/13, midnight of 4/14, midnight of 4/15, midnight of 4/16, all shift of 4/17, midnight and 4 PM of 4/18, midnight of 4/19, midnight on 4/20, all shift on 4/21, midnight of 4/22, and midnight of each day from 4/24 through 4/28.<br><br>This surveyor interviewed the Assistant Director of Nursing on 5/1/25 at 10:27 AM. She was shown the Medication Administration Records which showed staff using a pain scale of 0-10 but only interventions for 1-5. She said it probably occurred when the resident started to receive oxycodone. Acknowledged that there no interventions for pain levels of 6-10. I then showed where the resident was administered medication even though the resident had pain levels of 0.<br><br>51128<br><br>3) During the Unnecessary Medication Review of Psychotropic Medication on 04/29/25 at 10:35 AM, indicated that Resident #49 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, paranoid schizophrenia, anxiety, and schizoaffective disorder. Medications ordered included:<br><br>-Olanzapine Oral Tablet 7.5 MG by mouth one time a day for Bipolar<br><br>-Olanzapine Oral Tablet 10 MG by mouth at bedtime for Bipolar<br><br>-Divalproex Sodium Oral Tablet Delayed Release 125 MG, Give 375 mg by mouth two times a day for mixed bipolar affective disorder. Take 3 tablets by mouth every morning and evening<br><br>- Lorazepam Oral Tablet 0.5 MG 1 tablet by mouth one time a day for Catatonia and Give 2 tablet by mouth at bedtime for Catatonia<br><br>On 4/29/25 at 10:42, review of care plan initiated on 4/12/24 revealed that Resident #49 has a potential for mood disturbance related to schizophrenia, paranoid type and Bipolar disorder. The goal for Resident #49 was to remain free of signs and symptoms of distress, symptoms of depression anxiety or sad mood. The Interventions for nursing staff included monitor and record mood to determine if problems seem to be related to external causes and to observe for signs and symptoms of mania or hypomania racing thoughts or euphoria; increased irritability; frequent mood changes; pressured speech; flight of ideas; marked change in need for sleep; agitation or hyperactivity.<br><br>Further review of records on 4/29/25 at 11:05 revealed that there was no initiation of a behavioral monitoring tool or documentation of behavior monitoring on the Medication or Treatment Administration Record (MAR or TAR) that are associated with antipsychotics and antianxiety medication.<br><br>On 04/30/25 at approximately 09:00 AM, during an interview with the Unit Manager, Staff #18, the surveyor asked where the behavioral monitoring were documented on Resident # 49's chart. After Staff #18 reviewed the medical record, she/he stated that the behavioral monitoring tool was not in the Resident's record, and it should have been there.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/30/25 at 10:00 AM, an interview was conducted with the Director of Nursing (DON) who stated that the behavioral monitoring tool was not initiated in Resident #49's medical record and it should have been there. DON agreed that this was a concern. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>43096<br><br>Based on interviews and a review of medical records, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary and recommended dental services in a timely manner. This was evident for 2 (#55, #60) of 4 residents reviewed for dental services during the recertification/complaint survey.<br><br>The findings include:<br><br>1) During an interview on 4/24/25, at 2:13 PM, Resident #55 reported that he/she requested dental services but never received them. The resident stated, The facility said my insurance is not covering that service. Resident #55 further indicated that the facility never followed-up on this request.<br><br>A review of Resident #55's medical records on 4/28/25, at 10:44 AM revealed that there was no dental consultation documentation since the resident's admission in February 2024.<br><br>In an interview with the Director of Nursing (DON) on 4/28/25, at 11:10 AM, the DON explained that the facility had a contracted dental services team that visited monthly for resident dental care. The team followed residents on their list, and facility staff also scheduled outside dental services as needed. The DON confirmed that all dental service documentation would be filed in residents' medical records. When asked who received dental services, the DON stated, everybody can receive the services. The surveyor then informed the DON of the lack of dental service documentation in Resident #55's medical record.<br><br>On 4/28/25, at 2:17 PM, the DON verified that no dental services had been provided to Resident #55.<br><br>51128<br><br>2) On 04/24/25 at 10:13 AM, Resident #60 stated that she/he has a chipped tooth and is waiting for a dental appointment. The Resident showed the Surveyor chip tooth on the right upper side of the mouth.<br><br>Record Review on 04/28/25 at 10:51 AM revealed a referral dated 10/22/24 with National Preventive Solutions (NPS) and examination note dated 10/22/24 by Staff # 30. The Note specified the following on dental exam: nurse requested an exam of Resident, who has a broken/ decayed tooth #7 and root tip #20 that should be evaluated off-site for treatment. The Resident would like to save #7 if possible so full X-ray evaluation is necessary. The Resident travels in wheelchair and may be able to sit in dental chair if she has assistance.<br><br>On 4/28/25 at 11:05 AM, during an interview with the Director of Nursing (DON) about dental procedures, the DON stated that NPS provided a list of residents to be seen on their visit and if someone is not on the list, the facility will send face sheet so that they can add that Resident to be seen. If NPS suggest that Resident need to be referred out of the facility to get Xray or extractions, that will be set up by unit secretary. Surveyor asked if there is a log book to see if Resident #60 was scheduled to be evaluated for off-site treatment.<br><br>(continued on next page) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/29/25 at 11:37 the DON provided the surveyor with 2 emails. The 1st email was sent to pphealthplan on 4/28/25 at 12:05 PM requesting a dental appointment for Resident #60. The 2nd email was from pphealthplan that Resident #60 is scheduled for a dental consultation and evaluation on 5/27/25.<br><br>On 04/29/25 at approximately 12:00 PM. The DON was made aware that this was a concern since the appointment was made after the surveyor intervened. DON agreed with the concern. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52359<br><br>Based on observation and staff interviews, it was determined that the facility failed to ensure proper labeling of food and that food items were not expired, as evidenced by multiple food items unlabeled and expired in the refrigerator, freezer, and pantry. This was evident during the initial tour of the kitchen during the recertification/complaint survey.<br><br>The findings include:<br><br>On [DATE] at 07:20 AM, the initial tour of the kitchen with staff #27 revealed:<br><br>In the walk-in refrigerator there were 12 total expired 12-packs of hamburger buns. 3 bags expired on [DATE], 4 bags expired on [DATE], and 5 bags expired on [DATE].<br><br>In the walk-in freezer there was a bin labeled for discard which had 4 packs of 8 pieces of frozen waffle without an expiration date, there was an unlabeled and opened blue bag of green beans, there was a bag labeled slices of meat for sandwiches, [DATE], there was a box of french toast and a box of frozen chopped carrots both were open to air and did not have an expiration date, there were two bins full of 16 total frozen chunks of unlabeled meats.<br><br>In the produce refrigerator there were 11 potatoes in a plastic bin without a label or dates, 1 box of celery opened to air without a label, and there were 9 green peppers some of which had a grey color appearance to them that were placed in a plastic bin without a label.<br><br>In the dry storage the surveyor found an opened 5 pound bag of corn bread mix that was partially opened to air and had a date of [DATE] on it.<br><br>There was a stack of newly delivered bread of all types sitting on the floor outside of the walk in refrigerator. On the top were 24 bags of 12-pack hot dog buns without expiration dates written on any of them.<br><br>On [DATE] during the initial tour of the kitchen and at the time of the findings staff #27 was interviewed. She confirmed that the hamburger buns that were found were expired. She was unaware how long items in the freezer were able to stay until they needed to be discarded. And she confirmed that all items without a label should have been labeled when being stored.<br><br>On [DATE] at 08:28 AM, during an interview with staff #3, the food service director/ Certified Dietary Manager, she stated that she agreed it was a concern that staff #27 was not aware how long items can be kept for before having to be discarded. She also verified that the new shipment of hotdog buns did not have an expiration date on them. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>52359<br><br>Based on observation and interviews with staff, it was determined that the facility failed to: 1) ensure staff wore appropriate personal protective equipment (PPE) for enhanced barrier precautions while administering medications, and 2) ensure nursing staff use appropriate infection control practices during medication administration. This was evident for 2 (LPN #12 and LPN #16) out of 3 staff members observed during medication administration. It was also determined that the facility failed to 3) maintain isolation precautions as ordered. This was evident for 1 (Resident #16) of 24 residents records reviewed during the recertification/complaint survey process.<br><br>The findings include:<br><br>Enhanced Barrier Precautions (EBP) are infection control measures, particularly in nursing homes, that expand the use of personal protective equipment (PPE) like gowns and gloves beyond the standard precautions for anticipated blood and body fluid exposures. This focused approach aims to reduce the transmission of multidrug-resistant organisms (MDROs).<br><br>A midline (also called a midline catheter) is an indwelling medical device that is inserted into a large vein in the upper arm. It is used to safely administer medication into the bloodstream.<br><br>1) On 04/28/25 at 09:12 AM, Licence Practical Nurse (LPN) #12 was being observed by the surveyor administering medications to Resident #16. There was an enhanced barrier precaution sign hanging outside of the residents room. LPN #12 walked in the room and provided midline care and hung Intravenous antibiotics without putting on an isolation gown.<br><br>On 4/28/25 at 09:15 AM LPN #12 was interviewed by the surveyor. The LPN stated that Resident #16 was on enhanced barrier precautions and that she did not wear a gown for that resident's care because there were not any gowns in the isolation cart outside of the room. She stated that she knew enhanced barrier precaution rooms require isolation gowns to be worn.<br><br>Review of Resident #16's medical records on 4/28/25 at 09:30 AM revealed that the Resident had a care plan for a Midline Catheter initiated on 4/15/25. The care plan states that the resident requires enhanced barrier precautions (EBP) for the midline and that all staff providing direct care follow EBP protocols on donning and doffing isolation garb.<br><br>On 5/1/25 at 08:39 AM the facility policy titled Enhanced Barrier Precautions (EBP) was reviewed. In the policy, under definitions, it stated EBP refers to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a Multidrug-Resistant Organism (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Also in the policy, under section 2b it said, an order for enhanced barrier precautions will be obtained for residents with any of the following: .Indwelling medical devices.In section 4 of the policy it defined high-contact resident care activities and device care or use, which included indwelling medical devices. And in section 7 of the EBP policy it said enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until . indwelling medical device is removed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Director of Nursing (DON) was made aware of these concerns on 4/29/25 and again at exit on 5/1/25.<br><br>2) On 04/29/25 at 09:15 AM, the surveyor observed Licensed Practical Nurse (LPN) #16 administering medications to Resident #394. The medication that LPN #16 prepared was in capsule form. Resident #394 has a gastric feeding tube and all medications needed to be crushed up or in powder form and then administered with water into the feeding tube. Capsules are not able to be crushed because of the shell that is on the outside of the powder medication. In order to get the medication out of the capsule LPN #16 used her barehands to break it open and then poured the contents into a cup.<br><br>On 4/29/25 at 09:15 AM, an interview with LPN #16 revealed that she did not use gloves to break open the medication because she was told that she was not allowed to use gloves in the hallway.<br><br>On 4/29/25 at 11:37 AM an Interview with DON was conducted. She said that her expectation was that the Registered Nurses (RN), LPNs, and Certified Medication Aides (CMA) prepare medications and do their medication checks outside of the room and then go into the room to administer the medications. The DON said she does not want them to wear gloves and has told them not to wear gloves in the hallways. She said that LPNs and CMAs are not to touch the meds with their bare hands. If they need to break open a capsule they are to take it into the room and put gloves on and then break the capsule.<br><br>45131<br><br>3) On 04/24/25 at 02:43 PM, a record review revealed that Resident #16 had a left arm midline and was receiving multiple antibiotics.<br><br>On 04/24/25 at approximately 02:50 PM, a review of the Medication Administration Record (MAR) revealed Contact/droplet precautions every shift for respiratory precautions, and there was also an order for Enhanced Barrier Precautions (EBP) to be maintained at all times every shift for 10 Days. As of 4/24/25 both isolation orders were signed off by staff on the MAR; however, there were no isolation precaution signs, or isolation cart in place in or near the resident's room.<br><br>On 4/24/25 at approximately 02:54 PM, an observation of Resident #16's room and door revealed that there were no isolation signs on the door and no isolation cart near the resident's room to ensure proper isolation precautions were in place during resident care.<br><br>On 04/25/25 at 09:26 AM, a second observation was made that there were no isolation precautions in place for Resident #16.<br><br>In an interview with the resident's nurse, License Practical Nurse (LPN #10), he confirmed that Resident #16 had a midline and was receiving intravenous antibiotics. He was asked about isolation precaution for Resident #16 and after reviewing the resident's chart he confirmed that the resident has an order for enhanced barrier precaution. The surveyor notified LPN #10 that there was no isolation precaution signs or cart by the resident's door. He stated he will look into the issue and provide an update.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215215 | A. Building<br>B. Wing | 05/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Lake Healthcare at Alice Manor | 2095 Rockrose Avenue<br>Baltimore, MD 21211 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/25/25 at approximately 12:32 PM, in an interview with LPN #10, he stated that the resident's mid-line was removed yesterday, and the isolation signage was removed from the door. He stated that the midline was later replaced, but maybe they forgot to replace the enhance barrier precaution sign on the door. He stated that the issue has been addressed.<br><br>On 04/25/25 at approximately 03:00 PM, the surveyor observed EBP sign on the door and an isolation cart by the room door.<br><br>On 05/01/25 12:27 PM, in interview with the Director of Nursing (DON), the DON was notified of all the above-mentioned findings. She was also notified that the staff continued to sign on the MAR that the resident was on contact and droplet isolation precaution even though the order was not in place. She acknowledged the findings mentioned after reviewing the documents presented. She stated that the resident was no longer on contact/droplet precaution. |