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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215258 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/04/2025 |
| NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Spa Creek | | STREET ADDRESS, CITY, STATE, ZIP CODE 35 Milkshake Lane Annapolis, MD 21403 | |

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) |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation and staff interview, it was determined the facility staff failed to treat each resident in a dignified manner by standing over a resident while feeding the resident and speaking to a resident in a harsh tone. This was evident for 3 (#37, #9, #38) of 38 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>1) On 6/3/25 at 8:40 AM the surveyor walked into Resident #37 and Resident #9's room. Geriatric Nursing Assistant (GNA) #15, from a staffing agency, was standing to feed Resident #37. GNA #15 was observed quickly shoveling the food in the resident's mouth. While GNA #15 was standing to feed Resident #37, the surveyor observed the roommate, Resident #9 sleeping, curled up in a fetal position, covered with a blanket, on the bed. The over the bed tray table was next to the bed and had Resident #9's breakfast tray on the top, which was covered.</p> <p>The surveyor proceeded to walk into the resident's bathroom, which was by the exit door, to observe the contents of the bathroom. While standing in the bathroom the surveyor observed GNA #15 state in a harsh and loud voice as she walked over to Resident #9, wake up, stop sleeping. Your breakfast is here. Wake up! GNA #15 repeated stop sleeping, wake up multiple times until Resident #9 rolled on his/her back and sat up in bed.</p> <p>2) On 6/3/25 at 9:07 AM GNA #15 was observed in the second floor dining room standing to feed Resident #38 while another resident was at the same table.</p> <p>On 6/3/25 at 10:24 AM an interview was conducted with the Director of Nursing (DON). The DON was informed about the way GNA #15 spoke to Resident #9. The DON stated, she should not talk like that. The DON was also informed about GNA #15 standing to feed the roommate and he said, Oh, no, she must sit to feed. The DON was also informed about GNA #15 not sanitizing her hands between resident contact.</p> <p>On 6/3/25 at 11:39 AM the DON informed the surveyor that he addressed the issue with the GNA and did an in-service. He also said he sent the GNA back to the staffing agency so they could in-service her and he called the staffing agency to express his concerns.</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. On 6/3/25 at 8:40 AM the following environmental observations were made on 3 of the 4 hallways on the second-floor nursing unit:</p> <p>In room [ROOM NUMBER]B there were (2) areas on the night stand where the laminate was missing on the right top and the left lower corner. In the bathroom the toilet riser frame had rust in the front middle bar and on the legs.</p> <p>In room [ROOM NUMBER]A laminate was peeling off the bed's footboard approximately 6 inches on the left side and on the right corner.</p> <p>In room [ROOM NUMBER]B the vinyl on the left wheelchair armrest was cracked on the front side. The laminate on the dresser was peeling on the third drawer on the right and left side. There was no handle on the drawer.</p> <p>In room [ROOM NUMBER]A the laminate on the over the bed tray table was missing about 5 inches by 4 inches with the particle board exposed. The laminate was missing on the night stand top right corner.</p> <p>In room [ROOM NUMBER]A the laminate was peeling off all four of the dresser drawers and a 6-inch by 3-inch area on top of the nightstand.</p> <p>In room [ROOM NUMBER]A the second drawer handle was hanging sideways. The laminate on the fourth drawer on the right side was missing. The nightstand was missing laminate on the bottom right corner.</p> <p>In room [ROOM NUMBER] the laminate was missing on the first drawer approximately five inches in length.</p> <p>On 6/3/25 at 3:29 PM an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated she was aware of the issue, and they had planned a renovation, and the furniture was going to be replaced.</p> <p>Based on review of complaints, interview, and observation, it was determined the facility staff failed to provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This was evident for 12 of 70 resident rooms.</p> <p>The findings include:</p> <p>1. The Surveyor began an environmental tour with the Maintenance Director on 5/29/25 at 12:10 PM. The following were observed:</p> <p>room [ROOM NUMBER] baseboard molding loose and hole in ceiling in bathroom</p> <p>room [ROOM NUMBER] tile not covering bathroom floor fully and hole in molding</p> <p>(continued on next page)</p> | | |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>room [ROOM NUMBER] dry wall exposed above heater</p> <p>room [ROOM NUMBER] dry wall exposed above heartier, baseboard molding missing by bed</p> <p>room [ROOM NUMBER] baseboard molding loose</p> <p>room [ROOM NUMBER] fan dirty, plastic pipe for bathroom sink on floor, drain broken in bathroom sink</p> <p>room [ROOM NUMBER] baseboard molding loose in bathroom</p> <p>The Maintenance Director confirmed the Surveyor's findings during the tour on 5/29/25 at 12:10 PM</p> <p>2. Interview with Resident #20 on 6/2/25 at 1:00 PM, Resident states his/her wheelchair has been in disrepair since September 2023 and he/she has advised facility staff. Observation of Resident #20's wheelchair at that time revealed the arms could be lifted up and not secured to chair. The Resident stated the corners of wheelchair seat are sharp so he/she covered with a seat pad. Observation of the wheelchair seat corners revealed sharp metal. Resident #20 also stated the curtain between the beds is dirty and has a brown spot not sure what it is from, Surveyor observation confirmed. Observation of Resident's footboard revealed the top of footboard material worn away and baseboard molding missing.</p> <p>The Surveyor shared the Resident's concerns with the Administrator on 6/2/25 at 1:07 PM.</p> <p>Interview with the Administrator on 6/2/25 at 2:30 PM, the Administrator stated Resident #20's footboard and wheelchair has been replaced.</p> <p>Interview with the Administrator on 6/3/23 at 9:50 AM states the facility staff will replace Resident #20's curtain.</p> |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on reviews of facility reported incidents and interview, it was determined the facility failed to report allegations of abuse to the regulatory agency, the Office of Health Care Quality (OHCQ) within 2 hours of the allegation. This was evident for 1 (Resident #13) of 17 residents reviewed for facility reported incidents during a complaint survey.</p> <p>The findings include:</p> <p>On 6/2/25 at 9:05 AM a review of facility reported incident MD00197617 was conducted and revealed an allegation that housekeeping staff reported on 9/27/23 at 5:45 AM they saw Resident #13 sitting at the first-floor nursing station in a wheelchair with a bed sheet that appeared to be tied around the resident's back in a knot.</p> <p>The investigation documented that there was no one to report the issue to on the first floor so the housekeeper went up to the second-floor nursing unit and reported it to a geriatric nursing assistant (GNA). The charge nurse on the second floor overheard the conversation and immediately reported it to the first-floor charge nurse.</p> <p>Review of the facility's documentation revealed the initial report was not sent to OHCQ until 9/27/23 at 2:45 PM, which was not within 2 hours of the alleged abuse.</p> <p>On 6/3/25 at 10:12 AM an interview was conducted with the Director of Nursing (DON). The case was reviewed with the DON, and he confirmed that it was not reported within 2 hours.</p> | | |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 4 (#26, #18, #22, #33) of 38 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>The MDS is part of the Resident Assessment Instrument that was Federally mandated in legislation passed in 1986. The MDS is a set of assessment screening items employed as part of a standardized, reproducible, and comprehensive assessment process that ensures each resident's individual needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident.</p> <p>1) On 5/29/25 at 7:45 AM Resident #26's medical record was reviewed. Review of the November 2024 Medication Administration Record (MAR) documented that Resident #26 received Oxycodone (Opioid) for pain on 11/1/24 and 11/4/24.</p> <p>Review of the MDS assessment, with an assessment reference date (ARD) of 11/6/24, failed to capture the use of an Opioid.</p> <p>On 6/3/25 at 1:47 PM an interview was conducted with the MDS Coordinator who confirmed the finding.</p> <p>2) On 6/2/25 at 9:50 AM Resident #18's medical record was reviewed. Review of Resident #18's October 2024 Medication Administration Record (MAR) documented Resident #18 received Lidocaine External Patch 4 % (Lidocaine) to both knees every day for chronic pain. The October 2024 MAR also documented that Resident #18 received Voltaren External Gel 1 % (Diclofenac Sodium) Topical three times a day for pain.</p> <p>Review of the 10/11/24 MDS assessment, Section J0100 Pain management, J0100A, received scheduled pain medication regimen, was coded no. The facility failed to capture the use of scheduled pain medications.</p> <p>Further review of the October 2024 MAR revealed Resident #18 received the medication Gabapentin 300 MG twice per day for osteoarthritis. Gabapentin belongs to a class of medications called anticonvulsants.</p> <p>Review of the 10/11/24 MDS, Section N, Medications, failed to capture the use of an anticonvulsant.</p> <p>On 6/3/25 at 2:34 PM an interview was conducted with the MDS Coordinator who confirmed the findings and stated it was an oversight.</p> <p>3) On 6/3/25 at 10:30 AM Resident #22's medical record was reviewed. Review of Resident #22's July 2024 MAR revealed the medication Amoxicillin 500 mg. was administered 3 times a day for a urinary tract infection. Amoxicillin belongs to a class of medications called antibiotics.</p> <p>Review of the MDS assessment with an ARD of 7/27/24, Section N, Medications, coded 0 for the use of antibiotic medication. The facility failed to capture the use of antibiotics.</p> <p>(continued on next page)</p> | | |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Section M1200, Skin and Ulcer/injury treatments, H. applications of ointments/medications other than to feet was coded no.</p> <p>Review of Resident #22's July 2024 Treatment Administration Record (TAR) documented the treatment, apply Zinc Oxide to Sacrum. The order stated to apply every shift and PRN (when necessary.) The facility failed to capture the application of the Zinc Oxide cream on the MDS.</p> <p>On 6/4/25 at 10:11 AM an interview was conducted with the MDS Coordinator. The MDS Coordinator confirmed the errors and said it was an oversight.</p> <p>4) Review of Resident #33's medical record on 5/28/25 revealed the Resident was admitted to the facility in March 2025 with a diagnosis to include history of falling.</p> <p>Further review of Resident #33's medical record revealed the Resident had a fall during his/her stay on 4/2/25. The facility staff assessed the Resident on 4/2/25 quarterly MDS assessment and 4/18/25 discharge MDS assessment and coded the Resident with no falls.</p> <p>Interview with the MDS Coordinator on 5/30/25 at 12:17 PM confirmed the facility staff failed to assess the Resident correctly and capture the 4/2/25 fall.</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on review of complaint, medical record review, and staff interview, it was determined the facility failed to properly perform neuro checks after a fall for residents (Resident #33 and #34). This was evident for 2 of 22 residents reviewed during a complaint survey.</p> <p>The findings include:</p> <p>A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination.</p> <p>1. Review of Resident #33's medical record on 5/28/25 revealed the Resident was admitted to the facility in February 2025 with a diagnosis to include history of falling.</p> <p>Further review of Resident #33's medical record revealed a nurse's note from Staff #10 on 2/8/25 at 3:44 PM that stated: Resident had a fall around 1:30 PM. This writer heard a loud sound while in another resident room. As this writer walked down the hallway checking on each resident, this writer came upon resident in bathroom on the floor kneeling.</p> <p>Review of Resident #33's change in condition on 2/8/25 revealed the facility staff notified the provider on 2/8/25 at 2:25 PM and the recommendation was to monitor the Resident per facility protocol.</p> <p>During interview with the Assistant Director of Nursing (ADON) on 5/30/25 at 11:00 AM, the ADON stated the facility staff are to complete neuro checks on a resident for an unwitnessed fall and provided the Surveyor with the facility's neurological checklist schedule protocol that details at what intervals the facility staff should do neuro checks. The neuro check schedule is to obtain post neuro assessment, then every 15 minutes times 3, every 30 minutes times 2, every hour times 4, and every shift times 6.</p> <p>Further review of Resident #33's medical record for neuro checks on 2/8 and 2/9/25 revealed the facility staff completed neuro checks at the following times: 2/8/25 at 1:30 PM, 3:41 PM 4:00 PM, 4:45 PM, 5:15 PM, 6:15 PM, 7:15 PM, 8:15 PM and 2/9/25 at 3:40 PM.</p> <p>Review of Resident #33's neuro checks revealed the 2/8/25 1:30 PM neuro checks revealed the facility staff used vital signs from 12:03 PM. The facility staff did not complete neuro checks on 2/8/25 at 1:45 PM, 2:00 PM, 2:15 PM, 2:45 PM and 3:15 PM. The neuro checks on 2/8/25 at 3:41 PM used vitals signs from 2/8/25 at 12:03 PM. No neuro checks were completed from 2/8/25 8:15 PM and 2/9/25 at 3:40 PM, the facility staff did not complete the every shift vital signs on 2/8/25 night shift.</p> <p>During interview with Staff #10 on 5/30/25 at 11:19 AM, Staff #10 stated when she found Resident #33 in the bathroom on 2/8/25 no one else was in the Resident's room.</p> <p>Interview with the ADON on 5/30/25 at 12:45 PM confirmed the facility staff completed neuro checks for Resident #33 at incorrect time intervals per facility protocol and inaccurately on 2/8 and 2/9/25.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. Review of Resident #34's medical record on 5/29/25 revealed the Resident was admitted to the facility in March 2025 with a diagnosis to include weakness.</p> <p>Further review of Resident's medical record revealed a change in condition note on 3/11/25 at 12:01 AM that states, called to room and observed patient sitting between bed and wall holding onto water bottle. Range of motion to all extremities without difficulty, hoyer lift to used to assist patient back to bed. Patient denies pain and hitting head.</p> <p>Review of physician note on 3/11/25 at 12:51 AM states resident with unwitnessed fall. follow facility protocol for unwitnessed fall. Monitor with neuro checks per facility protocol.</p> <p>During interview with the Assistant Director of Nursing (ADON) on 5/30/25 at 11:00 AM, the ADON stated the facility staff are to complete neuro checks on a resident for an unwitnessed fall and provided the Surveyor with the facility's neurological checklist schedule protocol that details at what intervals the facility staff should do neuro checks. The neuro check schedule is to obtain post neuro assessment, then every 15 minutes times 3, every 30 minutes times 2, every hour times 4, and every shift times 6.</p> <p>Further review of Resident #34's medical record for neuro checks on 3/11 and 3/12/25 revealed the facility staff completed neuro checks at the following times: 3/11/25 at 12:16 AM, 12:33 AM, 12:45 AM, 2:45 AM, 3:45 AM, 4:45 AM, 5:45 AM, 6:57 PM and 3/12/25 at 3:52 AM, 3:16 PM.</p> <p>Review of Resident #34's neuros checks revealed the 3/11/25 12:16 AM neuro checks revealed the facility staff used vital signs from 3/10/25 at 7:02 PM. The facility staff did not complete neuro checks on 3/11/25 at 1:15 AM and 1:45 AM. The facility staff did not complete neuro checks on 3/11/25 day shift. The neuro checks on 3/12/25 at 3:16 PM revealed the facility staff used vital signs from 3/12/25 at 2:45 AM, 12 hours prior.</p> <p>Interview with the Director of Nursing on 6/2/25 at 9:20 AM confirmed the facility staff completed neuro checks for Resident #34 at incorrect time intervals per facility protocol and inaccurately on 3/11 and 3/12/25.</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility staff failed to provide treatment/services to prevent/heal pressures ulcers. This is evident for 2 (Resident #15 and #16) of 4 residents reviewed for pressure ulcers during a complaint survey.</p> <p>The findings included:</p> <p>A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed).</p> <p>A deep tissue injury (DTI) is a unique form of pressure ulcer. The National Pressure Ulcer Advisory Panel defines a deep tissue injury as A pressure-related injury to subcutaneous tissues under intact skin. Initially, these lesions have the appearance of a deep bruise.</p> <p>The findings include:</p> <p>1. Review of Resident #15's medical record on 6/2/25 revealed the Resident was admitted to the facility in August 2023 with diagnosis to include cerebral infarction. Cerebral infarction, often referred to as a stroke, is a serious medical condition that occurs when blood flow to the brain is interrupted, leading to a lack of oxygen and nutrients to brain tissue.</p> <p>Further review of the Resident's medical record revealed the Resident was seen weekly by the Wound Nurse Practitioner (WNP). On 9/14/23 the WNP assessed Resident #15 and documented the Resident had an unstageable pressure ulcer to the sacrum. The WNP documented the Treatment Instructions for the sacral pressure ulcer were to cleanse with dakins, apply santyl with dakins wet to dry dressing every day.</p> <p>Review of Resident #15's September 2023 Medication and Treatment Administration Records revealed the facility staff failed to administer the sacral treatment of dakins and santyl on 9/16, 9/17 and 9/18/2023. The facility did document the sacral treatment was administered on 9/19/23 and the Resident was discharged to the hospital on the same day.</p> <p>Interview with the Director of Nursing on 6/2/25 at 11:30 AM confirmed there is no evidence the facility staff administered Resident #15's ordered sacral pressure ulcer treatment of dakins and santyl on 9/16, 9/17 and 9/18/2023.</p> <p>2. Review of Resident #16's medical record on 5/28/25 revealed the Resident was admitted to the facility in January 2023.</p> <p>a. Further review of Resident #16's medical record revealed the Resident was readmitted to the facility on [DATE] from the hospital.</p> <p>(continued on next page)</p> | | |

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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Resident was assessed by the WNP (Wound Nurse Practitioner) on 4/20/23 to have a Stage 3 sacral pressure ulcer.</p> <p>Review of the facility staff's weekly wound assessments revealed the facility staff failed to assess Resident #16's wounds to include measurements on 11/9/23, 11/28/23 and 3/11/24.</p> <p>Interview with the ADON (Assistant Director of Nursing) on 6/2/25 at 8:15 AM confirmed the facility staff failed to do weekly wound assessments on 11/9/23, 11/28/23 and 3/11/24 to include measurements.</p> <p>b. Further review of Resident #16's medical record revealed the Resident was readmitted to the facility on [DATE] from the hospital.</p> <p>Review of Resident's Weekly Skin Evaluation on 11/9/23 revealed the Resident was assessed to have a left heel pressure ulcer but the evaluation does not contain measurements.</p> <p>Further review of Resident #16's medical record revealed the Resident was seen by the WNP on 11/16/23 and assessed the Resident to have a left heel DTI. The WNP ordered treatment of paint with betadine daily to left heel.</p> <p>Review of Resident #16's November 2023 Treatment Administration Records revealed although the facility staff assessed the Resident to have a left heel wound on 11/9/23, treatment did not begin until 11/22/23.</p> |

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| NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Spa Creek | | STREET ADDRESS, CITY, STATE, ZIP CODE 35 Milkshake Lane Annapolis, MD 21403 | |
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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a complaint, record review, and interview, it was determined the facility failed to provide timely medication to meet the needs of the residents. This was evident for 1 (#17) of 22 residents reviewed for complaints during a complaint survey.</p> <p>The findings include:</p> <p>On 5/30/25 at 8:11 AM a review of complaint MD00199890 alleged that the facility failed to have prescribed medications available for Resident #17 after the resident was admitted .</p> <p>Review of Resident #17's medical record revealed the resident was admitted to the facility on [DATE] around 2:00 PM from an acute care hospital. Resident #17 was treated at the hospital for a fall off a roof which resulted in a displaced fracture of the left humerus, a closed fracture of the ribs, and a fractured pelvis.</p> <p>Review of the hospital discharge summary documented the order for Hydromorphone 2 mg. every 4 hours PRN (when necessary) for moderate pain or 2 tablets every 4 hours PRN severe pain, Alprazolam (Xanax) 2 mg. for anxiety, Lorazepam (Ativan) 2 mg. for anxiety, and pregabalin (Lyrica) 100 mg. for nerve pain/seizures. All of the medications were considered controlled substance prescriptions.</p> <p>Review of Resident #17's November 2023 Medication Administration Record (MAR) did not have evidence that the hydromorphone, alprazolam, lorazepam, or pregabalin were administered on 11/24/23.</p> <p>Review of the complaint alleged after 2 hours from admission, Resident #17 was in pain and the family asked for pain medication for the resident but was told the resident would have to wait for the order to be cleared by the physician since it was a controlled medication. The complaint alleged that after 6 hours of being in pain and not having any of the prescribed medications, the spouse signed the patient out AMA (against medical advice) and was taking the resident to the hospital for medication.</p> <p>Review of Resident #17's medical record revealed a 11/24/23 at 16:30 (4:30 PM) nurse's note that documented the process for getting pain medication was explained to the resident and spouse. The note documented that the resident did not voice any complaints of pain.</p> <p>A 11/24/23 at 19:00 (7:00 PM) nurse's note documented that Resident #17 wanted to leave the facility and go home and have the physician on call to phone in the pain medication order. The note documented that the resident was informed that his/her medications were called in STAT (immediate) and pending delivery. The note documented the resident was assessed for pain and offered alternatives such as Acetaminophen 500 mg and Ibuprofen 800 mg, however the resident refused. The note did not document the level of pain.</p> <p>On 5/28/25 at 8:30 AM an interview was conducted with LPN #8 as he was the admitting nurse on 11/24/23. LPN #8 stated Resident #17 was assessed and did not complain of pain. LPN #8 stated the resident was medicated prior to arrival and that he had started on the medication paperwork right away so he could get the medication ordered and delivered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 5/30/25 at 10:24 AM the ADON was interviewed and stated that the process was when the resident gets to the facility the nurse will go over the medications from the hospital discharge summary and review them with the physician. The ADON stated that the physician has to fill out a C2 form (for controlled substances) and then it gets faxed to the pharmacy. She stated, if it is a narcotic we ask for it STAT. The ADON stated that they had narcotics in the Omnicell, but they have to get an authorization code from the pharmacy before it is pulled from the Omnicell. The ADON stated, I would expect 4 to get the medication within 4 hours with pharmacy delivery and if we get a code we should be able to get it right away. The ADON stated, I would expect within 4 hours that the medications would be here. If I was the nurse, especially with the resident coming with a fracture, if the pain med was not here I would call the physician. The resident should have gotten the medications. That was an isolated incident.</p> <p>On 5/30/25 at 11:20 AM a review of the list of medications that the facility had available in the Omnicell (medication system for when medications are needed but had not been sent to the facility) was given to the surveyor from the ADON. On the list of available medications was alprazolam 0.25 mg and 0.5 mg., hydromorphone 2 mg., lorazepam 0.5 mg., and pregabalin 25 mg. and 50 mg. capsules.</p> <p>On 6/4/25 at 9:20 AM an interview was conducted with the Director of Nursing (DON). The DON showed the surveyor a grievance form the spouse had submitted to the facility on [DATE]. The DON did an investigation and confirmed that the medications were not available. The findings were, medications/orders should have been entered into the system within 4 hours of admission. If Omnicell is not available, medications should be ordered STAT from pharmacy without delay or waiting for resident/wife to determine if they were staying or leaving against medical advice.</p> | | |

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| <p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined that the facility staff failed to obtain outside services for residents in a timely manner. This was evident for 2 (Resident #15 and #16) of 22 residents reviewed for complaints during a complaint survey.</p> <p>The findings include:</p> <p>1. The facility staff failed to schedule a follow up neurologist appointment for Resident #15. A neurologist is a medical doctor specializing in diagnosing and treating diseases of the brain, spinal cord, and nerves.</p> <p>Review of Resident #15's medical record on 6/2/25 revealed the Resident was admitted to the facility in August 2023 with diagnosis to include cerebral infarction. Cerebral infarction, often referred to as a stroke, is a serious medical condition that occurs when blood flow to the brain is interrupted, leading to a lack of oxygen and nutrients to brain tissue.</p> <p>Review of Resident #15's hospital Discharge summary dated [DATE] revealed a discharge instruction to follow up with neurology and call for an appointment with neurologist.</p> <p>Further review of Resident #15's medical record revealed no order was placed or neurologist appointment scheduled from admission to the Resident's discharge on [DATE].</p> <p>Interview with the Director of Nursing on 6/3/25 at 11:39 AM confirmed the facility staff did not schedule a neurologist appointment for Resident #15.</p> <p>2. The facility staff failed to schedule follow up appointments with urology, pulmonology and orthopedic for Resident #16 in a timely manner.</p> <p>Review of Resident #16's medical record on 5/28/25 revealed the Resident was admitted to the facility in January 2023 with diagnosis to include bladder neck obstruction, solitary pulmonary nodule and low back pain. Review of the Resident's hospital Discharge summary dated [DATE] revealed the Resident is to have follow up outpatient appointment scheduled with urology, pulmonology and orthopedic.</p> <p>a. Further review of Resident #16's medical record revealed the Resident urology appointment was not ordered until 4/6/23 and the Resident saw the urologist on 4/10/23.</p> <p>b. Further review of Resident #16's medical record revealed the Resident's pulmonology appointment was not ordered until 5/3/23 and there is no evidence the Resident was seen by the pulmonologist.</p> <p>c. Further review of Resident #16's medical record revealed the Resident's orthopedic appointment was not ordered until 5/3/23 and there is no evidence the Resident was seen by the orthopedic surgeon.</p> <p>(continued on next page)</p> | | |

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| <p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview with the Administrator on 5/30/25 confirmed the Resident's appointments for urology, pulmonology and orthopedics were not ordered timely and there is no evidence the Resident was seen by the pulmonologist or orthopedics.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (Resident #16) of 22 residents reviewed for complaints during a complaint survey.</p> <p>The findings include.</p> <p>A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.</p> <p>Review of Resident #16's medical record on 5/29/25 revealed the Resident was admitted to the facility in January 2023 with a diagnosis to include bladder neck obstruction.</p> <p>Further review of the Resident's medical record revealed an order for a cystoscopy on 10/23/23. Review of the electronic and paper medical record did not reveal the results of the cystoscopy.</p> <p>Interview with the Administrator on 5/30/25 at 9:00 AM confirmed Resident #16's medical record did not contain the results of cystoscopy on 10/23/23.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility staff failed to follow infection control practices and guidelines to prevent the development and transmission of disease. This was evident on 1 of 2 nursing units observed during a complaint survey.</p> <p>The findings include:</p> <p>1) On 6/3/25 at 8:40 AM GNA #15 was observed feeding Resident #37. GNA #15 finished feeding Resident #37 and proceeded to walk to the next bed and set up Resident #9's breakfast tray. GNA #15 then walked back to Resident #37. She did not sanitize her hands in between patient contact.</p> <p>2) On 6/3/25 at 9:07 AM GNA #15 was observed in the second-floor dining room standing to feed Resident #38. GNA #15 wiped Resident #38's mouth and cleaned up the breakfast tray, put it on a rack and retrieved another soiled tray to place on the food tray rack. GNA #15 then walked down the center hallway and walked into room [ROOM NUMBER]. GNA #15 did not sanitize her hands after contact with Resident #38 and the soiled breakfast trays.</p> <p>3) On 6/3/25 at 8:40 AM a tour was conducted on the second-floor nursing unit and the following was observed in resident bathrooms:</p> <p>In room [ROOM NUMBER] there was a gray round basin sitting on a white laundry container. The basin was not in plastic. There was also a round gray basin sitting on a trash can with used paper towels in the basin.</p> <p>In room [ROOM NUMBER] bathroom there were round, gray basins that were not covered, sitting on a white container.</p> <p>In room [ROOM NUMBER] there were 2 gray round basins sitting on top of the laundry basket inside each other and not covered. There was a soiled fork in the top shelf of the wire rack on the wall next to the sink.</p> <p>In room [ROOM NUMBER] under the sink were 2 white containers with dirty lids and handles. There were 2 gray basins sitting on top of the dirty containers and they were not covered. There was a soiled white washcloth on the floor behind the toilet.</p> <p>In room [ROOM NUMBER] there was 1 pink and 1 gray basin sitting inside each other on laundry container and not in plastic.</p> <p>In room [ROOM NUMBER] there was 1 square gray basin on the floor with 2 paper towels in it and 1 pink round basin in 1 gray round basin in the seat of a wheelchair in the bathroom.</p> <p>In room [ROOM NUMBER] in the bathroom were 2 square gray basins and 1 round basin on top of the laundry basket not labeled or covered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>In room [ROOM NUMBER] there were 2 urinals that were not labeled that were hanging on the grab bar behind the toilet. It was noted that 2 females occupied the room. There was a gray basin sitting in a w/c not covered.</p> <p>In room [ROOM NUMBER] there was 1 gray basin on a laundry basket not covered and 1 pink in 2 gray basins sitting on the second laundry basket not labeled or covered.</p> <p>On 6/3/25 at 9:50 AM an interview was conducted with the Infection Control Nurse (ICP). The ICP was informed of the findings and stated, each resident's basin is supposed to be cleaned after use, put in a bag and kept in the bathroom. Some residents prefer it to be kept in their closet. Ideally it should be cleaned, dried and stored in the bathroom in a bag. They should be labeled with the resident's name.</p> <p>On 6/3/25 at 12:47 PM the ICP came back to the surveyor and stated she went up into all the rooms that the surveyor had told her about and saw that they do have a problem. She validated each finding and said it would be ongoing training. She said the only policy she could find was the Bed Bath policy #22 which said to, empty, rinse and dry the bath basin, returning it to its storage location. The ICP stated that the basins should be stored in plastic.</p> |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's and vendor's pest control logs, observations and interviews, it was determined that the facility failed to maintain an effective pest control program. This was evident for kitchen, nurses stations, pantries, and 26 of 70 resident rooms during a complaint survey.</p> <p>The findings include:</p> <p>During investigation of multiple complaints from residents and families regarding pest control, the Surveyor reviewed the pest control logs maintained at the front lobby of the facility from January 2025 through May 2025 and vendor pest control reports from January 2025 through May 2025</p> <p>1. Review of the facility's pest control logs revealed the following:</p> <ul style="list-style-type: none"> a) 2/3/25 roaches room [ROOM NUMBER] b) 2/10/25 roaches elevator c) 2/16/25 roaches pantry 1st floor d) 2/16/25 roaches 2nd floor employee lounge e) 2/16/25 ants room [ROOM NUMBER] f) 2/16/25 roaches guest services g) 2/17/25 roaches room [ROOM NUMBER] h) 2/24/25 ants room [ROOM NUMBER] i) 2/24/25 roaches room [ROOM NUMBER] j) 3/10/25 roaches room [ROOM NUMBER] k) 3/26/25 ants room [ROOM NUMBER] l) 3/29/25 roaches 1st floor pantry m) 3/29/25 roaches 2nd floor pantry n) 3/30/25 roaches guest services o) 5/13/25 ants and roaches room [ROOM NUMBER] p) 5/13/25 ants and roaches room [ROOM NUMBER] q) 5/23/25 ants vending sink room <p>(continued on next page)</p> |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>r) 5/23/25 roach rehab gym</p> <p>2. Review of vendor's pest control logs revealed the following:</p> <p>a) 1/8/25 reported roach activity in rooms [ROOM NUMBERS], inspected and treated room [ROOM NUMBER] and 223, activity seen during service. Inspected and treated 2nd floor pantry for reported roach activity. Activity seen on monitors.</p> <p>b) 1/9/25 Inspected and treated room [ROOM NUMBER] for roach activity. Heavy activity seen during service.</p> <p>c) 1/15/25 Inspected and treated nurses station 1 and 2 and kitchen and dishwasher room for occasional invaders. Inspected and treated rooms 222, 223 and 224 for prior roach activity. Minor activity seen on monitors in room [ROOM NUMBER] during service.</p> <p>d) 1/22/25 Reports of roach activity in room [ROOM NUMBER], no activity seen during service, placed monitors and gel baited as needed. Inspected and treated kitchen area and dishwasher room, nurses stations 1 and 2 for occasional invaders.</p> <p>e) 1/27/25 Complainant of roaches in room [ROOM NUMBER]. Staff verbally also stated the 1st floor pantry had roach activity. Inspected kitchen dish room since this was a hot spot for roaches during previous visits. Observed moderate activity on glue board. Observed poor sanitation and tins of standing water which is attracting pest to area.</p> <p>f) 1/29/25 Reports of roach activity in 1st floor pantry. Inspected and treated kitchen, dish area, nurses stations 1 and 2 for occasional invaders. Inspected and treated 1st and 2nd floor pantry rooms, no activity seen during service.</p> <p>g) 2/5/25 Reports of room [ROOM NUMBER] for roach activity.</p> <p>h) 2/12/25 Reports of roach activity in elevator, no activity seen during service. Inspected and treated 1st floor pantry room for reported roach activity, minor activity seen in cabinet during service. Inspected and treated nurses stations 1 and 2 for occasional invaders. Inspected and treated room [ROOM NUMBER] for reported roach activity, no activity seen.</p> <p>i) 2/19/25 Inspected and treated room [ROOM NUMBER] for reported ant activity. Inspected and treated room [ROOM NUMBER] and guest services for reported roach activity. Inspected and treated nurses stations 1 and 2 for occasional invaders. Inspected and treated kitchen area and dishwasher room for occasional invaders, roach activity seen on monitors during service, recommend better sanitation.</p> <p>j) 2/27/25 Treated room [ROOM NUMBER] for reports of roach sighting in bathroom, no activity observed. Treated for ants in rooms 206, 105, 106 and 107 minimal activity observed. Observed heavy roach activity on monitors in kitchen, recommend roach cleanout. Observed standing water in dish room, recommend removal due to being a positive condition for roaches.</p> <p>k) 3/12/25 Reports of roach activity in rooms [ROOM NUMBERS], activity seen on monitors during service, inspected and treated. Inspected and treated kitchen area, dishwasher room, nurses station 1 and 2 for occasional invaders.</p> <p>(continued on next page)</p> | | |

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| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>l) 3/19/25 Inspected and treated room [ROOM NUMBER] for reported ant activity. Inspected and treated rooms [ROOM NUMBERS] for reported roach activity. Minor activity seen in room [ROOM NUMBER]. Inspected and treated kitchen area, dishwasher room, nurses station 1 and 2 for occasional invaders. Inspected room [ROOM NUMBER] that technician treated for roaches. Observed roach droppings on nightstand of bed b, found live and dead activity.</p> <p>m) 3/26/25 Inspected and treated kitchen area, dishwasher room, nurses station 1 and 2 for occasional invaders. Inspected and treated room [ROOM NUMBER] and 205 for reported ant activity.</p> <p>n) 4/2/25 Inspected and treated room [ROOM NUMBER], guest services, 1st and 2nd floor pantry rooms for reported roach activity. Inspected and treated kitchen area, dishwasher room, nurses station 1 and 2 for occasional invaders.</p> <p>o) 4/23/25 Inspected and treated kitchen area, dishwasher room, nurses station 1 and 2 for occasional invaders. Inspected and treated room [ROOM NUMBER] for reported ant activity. Inspected and treated room [ROOM NUMBER] for reported roach activity.</p> <p>p) 5/7/25 Inspected and treated kitchen area, dishwasher room, storage room, nurses station 1 and 2 for occasional invaders.</p> <p>q) 5/21/25 Inspected and treated kitchen area, dishwasher room, nurses station 1 and 2 for occasional invaders. Inspected and treated 1st floor pantry room for reported ant activity.</p> <p>Observation with Maintenance Director on 5/29/25 at 12:10 PM revealed the following:</p> <p>a) room [ROOM NUMBER]-ants</p> <p>b) room [ROOM NUMBER]-ants</p> <p>c) room [ROOM NUMBER]-ants</p> <p>d) room [ROOM NUMBER]-ants</p> <p>e) room [ROOM NUMBER]-ants and roach in bathroom</p> <p>Observation with Staff #10 on 6/2/25 at 10:42 AM roach in 1st floor pantry.</p> <p>Observation on 6/4/25 at 10:32 AM ants in vending machine room sink.</p> <p>Observation on 6/4/25 at 10:34 AM roach in 1st floor pantry.</p> <p>5/29/25 at 12:00 PM During interview with resident in room [ROOM NUMBER], the resident stated he/she thought he/she saw a bed bug a few days ago and told the staff but no one has followed up.</p> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215258 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/04/2025 |
| NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Spa Creek | | STREET ADDRESS, CITY, STATE, ZIP CODE 35 Milkshake Lane Annapolis, MD 21403 | |
| 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) | | |
| <p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During interview with the Administrator on 6/2/25 at 2:00 PM, the Administrator stated after the Surveyor's concerns were shared with the facility staff on 5/29/25 the facility had the pest control company in for service on 6/1/25. The Administrator also stated the facility staff followed up on the resident in room [ROOM NUMBER]'s concerns and found no evidence of bed bugs. On 6/4/25 at 8:15 AM the Administrator provided the Surveyor the list of the resident rooms the pest control treated: 105, 109, 110, 112, 124, 125, 126, 201, 204, 206, 211, 213, 214, 217, 218, 221, 224, 226, 228, 231, 232, 234, 235, 236, 238, 239 and 240.</p> | | |