

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	

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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304</p> <p>Based on observations, interview with facility staff, and review of the medical record, it was determined that the facility failed to ensure that a resident's documented dining preference was honored. This was evident for 3 of 15 residents (#57, #524 and #525) reviewed for dining preference during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 2/26/25 at 7:41 AM the surveyor interviewed Registered Nurse (RN #28). During the interview RN #28 stated that breakfast trays arrive to the unit around 8:15 AM.</p> <p>On 2/26/25 at 8:10 AM dietary was observed delivering breakfast cart to the unit. The surveyor noted that there was only one resident in the common/dining area.</p> <p>On 2/26/25 at 8:12 AM in an interview with RN #28 when asked why there was only one resident in the dining area during breakfast time, she stated most of the residents stay in their rooms for breakfast and get out of bed after breakfast. When asked if that was their preference, she stated she did not know if that was their preference but this is a skilled unit and so they get up anyway to go to therapy and then they can eat their lunch in the dining room.</p> <p>On 2/26/25 at 8:16 AM the surveyor interviewed all available residents (15 residents) on the unit and 3 residents (Residents # 57, # 524, and # 525) stated their preference was to eat their breakfast in the dining room.</p> <p>On 2/26/25 at 8:57AM the surveyor shared with RN #28 that the available residents on the unit were interviewed, and 3 residents stated their preference was to eat breakfast in the dining room. RN #28 stated she did not know that was their preference. When asked if nursing should be aware of and honor residents' dining preferences she stated if she asked them she would know and she could ask them. When asked if she has ever asked a resident their preferred dining location she stated again that she could have asked them. When asked if residents have the right to choose where to eat she stated, of course but denied asking their preference. When asked if dining preferences are documented in the medical record she stated she did not know.</p> <p>(continued on next page)</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/26/25 at 9:39 AM review of the 3 residents' (Residents # 57, # 524, and # 525) medical record revealed Eats in dining room was documented as their preference in the Dietary section of each of their baseline care plans.</p> <p>On 2/26/25 at 10:31 AM the Director of Nursing (DON) was interviewed. During the interview the DON was asked if residents' dining preferences for where they would like to consume their meals are assessed. She stated she was not sure. When asked if she knew where it would be documented she stated, I know it is not documented anywhere. When asked if the expectation is that a resident's nurse would know the preferences for where residents would like to eat, she stated if it was an agency nurse .however, the surveyor informed the DON that the nurse interviewed had worked in the facility for almost [AGE] years, to which the DON stated then they should know the residents' preferences.</p> <p>On 2/26/25 at 11:08 AM in an interview with the DON, the surveyor shared the 3 residents who stated their preference was to eat breakfast in the dining room had that preference documented in their medical record. During the interview, the DON acknowledged and confirmed these findings. When asked if residents have the right to choose where they eat, she stated yes and confirmed that it should be a resident's choice as to where they dine.</p>

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>49304</p> <p>Based on record review and interviews with facility staff, it was determined that the facility failed to provide residents with information to formulate an advanced directive. This was evident for 1 (Resident #81) of 3 residents reviewed for advanced directives during the recertification/complaint survey.</p> <p>The findings include:</p> <p>An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.</p> <p>On 2/18/25 at 1:33 PM in an interview with Unit Manager (UM #27) when asked where resident's advanced directives can be found, she stated if they have an advanced directive, it would be in their paper chart.</p> <p>On 2/18/25 at 1:38 PM review of Resident #81's paper chart and electronic medical record revealed no documentation related to advance directives.</p> <p>On 2/18/25 at 1:57 PM in an interview with the Director of Nursing (DON) when asked the process for new admissions regarding advanced directives, she stated the residents come in with their MOLST and advanced directive. Then, Social Services and the doctor review them. If they do not have an advanced directive, Social Services will offer the residents and/or family the information to complete one.</p> <p>On 2/19/25 at 12:17 PM in an interview with the DON she stated Social Services completes an advance directive assessment. When asked who is responsible for offering the information to a resident who enters the facility without an advanced directive, she stated it is the responsibility of Social Services.</p> <p>On 2/19/25 at 12:02 PM review of Resident #81's medical record revealed two advance directive admission assessments [AUTM Advanced Directive Admission -V2] completed by Social Services. The most recent assessment was completed on 2/12/24 and the other assessment was completed on 3/1/23. Both assessments documented that the resident did not have an advanced directive in place, that they were interested in developing an advanced directive, and that they were interested in meeting with a member of the Social Work team to discuss steps to implement an advanced directive.</p> <p>On 2/19/25 at 12:07 PM review of Resident #81's progress notes from 9/26/24 to 12/26/24 did not reveal a note(s) mentioning advance directives or any social services notes.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Social Services #2 was interviewed on 2/19/25 at 12:47 PM. When asked to explain the process for a new admission regarding advanced directives, she stated she does an initial advanced directive assessment [Social Services #2 verified and confirmed the assessment she was referring to was AUTM Advanced Directive Admission - V 2] within 72 hours of a resident's admission. During the interview, Social Services #2 stated if the resident does not have an advanced directive, she offers them the information and helps them with the process of completing the forms. Then, when the advanced directive is completed, the same assessment is completed again, showing that the resident now has an advanced directive on file. Social Services #2 further stated if there is not a second assessment then there should be a note explaining why. The surveyor shared the concern that Resident #81 has 2 completed assessments, both of which documented that the resident did not have an advanced directive, was interested in developing one, but was not provided the information to formulate an one.</p> <p>On 2/19/25 at 1:16 PM Social Services #2 stated she went and spoke to Resident #81 and asked if he was interested in formulating an advanced directives and he said no, so she would put a note in. When asked why the resident was not provided information to formulate an advance directive when it was documented twice that he wanted to meet with a member of the social work team to discuss steps to implement an Advanced Directive, she stated she could not speak about what happened in the past.</p> <p>On 2/19/25 at 1:46 PM review of the facility's policy, Residents' Rights Regarding Treatment and Advanced Directives revealed under the Policy Explanation and Compliance Guidelines section:</p> <ol style="list-style-type: none"> 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 8. Decisions regarding advance directives and treatments will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>50904</p> <p>Based on a review of health records and interviews with facility staff, it was determined that the facility failed to notify Resident #449 or appointed family members after a dietary change. This was evident for one resident (Resident #449) out of seven residents reviewed during the complaint investigation.</p> <p>The findings include:</p> <p>The Brief Interview for Mental Status (BIMS) score is a number between 0 and 15 that indicates a person's cognitive health: 13-15 points: The person's cognition is intact; 8-12 points: The person has moderate cognitive impairment; 0-7 points: The person has severe cognitive impairment.</p> <p>1) On 02/18/2025 at 10:49 AM, a review was conducted regarding complaint MD# MD00196883. The complainant stated that since 09/08/2023, Resident #449 had not been receiving the appropriate dietary foods at the nursing facility, despite being on dialysis.</p> <p>On 02/18/2025 at 11:08 AM, a review of records showed that on 08/29/2023 at 10:10 PM, Resident #449 was placed on a renal diet upon admission to the facility. The records also indicated that on 08/30/2023, the resident's BIMS score was 15. Nutritionist notes from 08/30/2023 at 02:13 PM confirmed that the resident's diet order was a renal diet of regular consistency. However, later that day, at 08:46 PM, an order summary revealed a new diet order: a regular diet with regular texture.</p> <p>On 02/18/2025 at 12:23 PM, the surveyor did not find any documentation in the electronic health record indicating that the resident or their responsible party had been notified of the diet change.</p> <p>On 02/20/2025 at 10:21 AM, the surveyor informed the Nursing Home Administrator that Resident #449 or their appointed family members had not been informed of the diet change, as there was no documentation to support such notification. The administrator acknowledged that the resident or family members should have been notified.</p> <p>On 02/27/2025 at 10:33 AM, in a follow up interview with the Director of Nursing (DON), she was asked what the facility protocol was regarding informing family members of a change in resident's care/treatment, She stated that it was the responsibility of the staff member entering the change notes in the electronic record to notify the resident or responsible party. When the surveyor informed the DON about the lack of documentation indicating that the resident or their emergency contact had been notified of the diet change, the DON stated that the nurse should have informed the resident and/or the family member and documented the notification.</p>		

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<p>F 0585</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 voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>43096</p> <p>Based on investigating complaints, record review, and interviews, it was determined that the facility failed to follow the grievance process for residents. This was evident for 2 (Resident #9 and #151) of 34 residents reviewed for the grievance process during this recertification/complaint survey.</p> <p>The findings include:</p> <p>On 2/18/25, around 9 AM, the surveyor reviewed residents' complaints. The review revealed that at least three residents expressed concerns related to their laundry services, missing clothes, stolen items, and misplacement; a) Resident #433's family member stated that they observed that the resident put on other residents' clothing, b) an anonymous complainant reported that the residents' person item stolen and misplaced, and c) Resident #445 reported that the facility's laundry machine was broken and not properly washing.</p> <p>The surveyor asked about residents' grievance process during an interview with the Nursing Home Administrator (NHA) on 2/25/25 at 9:04 AM. The NHA said, If residents filled out the forms, it is brought to my attention. I will review them, meet resident/family, and follow up with the report. If it is item-related, we should replace/ reimburse them. The NHA confirmed that he had no grievance regarding residents' clothing issues.</p> <p>In an interview with the housekeeping manager (Staff #23) on 2/25/25 around 10:30 AM, she explained how to manage residents' items. She said, If residents reported their missing items, interview with residents to get information from them, search up, report the issue to the administrator (if it is still not found), and he will replace/ refund them. Staff #23 verified that the laundry staff did not fill out the grievance form; they reported the issue to the administrator, and the staff follow-up should be done by the administrator.</p> <p>1)During an interview with Resident #9 on 2/18/25 at 10:33 AM, the resident expressed concerns that he/she had some missing items (headbands and beads). The laundry staff reported those; however, they were not replaced.</p> <p>On 2/20/25 at 10:00 AM, the surveyor asked for any grievance form related to Resident #9. The NHA stated that the facility had no documentation for the resident.</p> <p>During an interview with the NHA on 2/25/25 at 9:04 AM, the surveyor asked about Resident #9's missing items. He said, I don't know about Resident #9's missing items issue.</p> <p>In a follow-up interview with Resident #9 on 2/26/25 at 8:22 AM, the resident provided detailed information about his/her missing items. The resident said, The laundry staff threw away mine, and the staff said she would replace it. But no one followed up on this.</p> <p>During an interview with the laundry manager (Staff # 23) on 2/26/25 at 8:50 AM, she confirmed that she had not heard about it. She said, I will ask our team members.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) In an interview with Resident #151 on 2/18/25 at 11:14 AM, the surveyor observed many clothing items; there are grease-type stains on various clothing items, on the back as well, not just the front of clothing items- some have peroxide-type stains, bleach appearing, (at least two items). Resident #151 stated that it happened a few weeks ago. The resident reported that the unit manager (Staff #27) was aware of the damaged clothing issues but did not document or write them. Resident #151 said, I had lots of grievances.</p> <p>In an interview with a laundry staff member (Staff #34) on 2/24/25 at 11:03 AM, the staff explained how to wash residents' items. Staff #34 said, Usually, we do not mix linens and personal items. If we have to mix them, like if residents' clothes were small amounts, I put them together with linens and personal items. I listed residents' items on a paper to prevent messing up. That's how I learned how to wash them.</p> <p>During an interview with the NHA on 2/25/25 at 12:57 PM, he confirmed that the facility did not have any grievance regarding Resident #151's damaged clothing. He submitted a copy of the grievance report form. The form was documented as received on 2/25/25 with details such as Per surveyor [Resident #151's name] reported some of his/her clothes were bleached by the laundry staff when washing the clothes. The NHA confirmed that this process was initiated after the surveyor's intervention. The surveyor shared concerns that the facility's grievance process was not adequately applied to residents. The NHA validated it.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>47200</p> <p>Based on interview and record review it was determined the facility failed to implement their policy for abuse, neglect and exploitation and their policy for employment background investigations. This was evident for one facility employee (Geriatric Nursing Assistant #64) during the surveyor's review of the following facility reported incidents and complaints: MD#00210602, MD#00210823, MD#00211759, and MD#00210884 during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 2/19/25 at 1:14PM the surveyor requested the complete investigation files for facility reported incidents, MD#00210823 and MD#00210602 from the facility's Administrator.</p> <p>On 2/19/25 at 8:25AM the surveyor conducted an interview with the facility's Director of Nursing who confirmed with the surveyor that GNA #64 was currently an active employee of the facility.</p> <p>On 2/19/25 at 1:46PM conducted a review of the facility's complete investigation file for MD#00210602 which revealed a copy of the background check which was performed for GNA #64 upon hire, in which their last name was observed to be contained in the first name entry box, and their last name was observed to be contained in the first name entry box with the last name additionally having been incorrectly spelled, and no previous addresses or further background information appeared to have resulted from the background check. Review of the national public sex offender check performed by the facility for GNA #64 additionally revealed a check was performed with the last name incorrectly spelled. In response to these findings, on 2/19/25 at 1:53PM the surveyor reviewed a public state information database in which GNA #64's name and other identifying information indicated a criminal background was present.</p> <p>On 2/20/25 at 11:57AM the surveyor reviewed GNA #64's credentials via the Maryland Board of Nursing website and observed their credentials were currently in suspended status.</p> <p>On 2/20/25 at 11:58AM the surveyor observed GNA #64 was listed on the employee roster provided by the facility and reviewed by the surveyor.</p> <p>On 2/20/25 at 11:59AM the surveyor requested for the DON to provide timecard records for GNA #64.</p> <p>On 2/20/25 at 12:46PM the surveyor received and reviewed GNA #64's current timecards which revealed they had last worked on 2/4/25.</p> <p>On 2/21/25 at 9:18AM the surveyor conducted an interview with Human Resources Director (HRD) #41. When the surveyor inquired as to the spelling of the name of GNA #64 and other information surrounding their background check with no resulting information, HRD #41 reported they had handwritten the correct last name on the background check's paper printed out form.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/25 at 11:50AM the surveyor conducted another interview with HRD #41 who reported (after surveyor intervention) they had called the background check company the facility utilizes and was informed they had the first and last names of GNA #64 entered in the wrong boxes on the form and additionally had learned that even if a social security number was present that the background check system still would not pull and provide the person's background check results. HRD #41 stated they did not know that the order of the first and last name mattered when they input names into the background check system, but now that they were aware that this is important, going forward they will be carefully reviewing the information that is being input into the system as well as performing an audit of existing employee background check information.</p> <p>On 2/21/25 at 1:34PM the surveyor reviewed the facility's background investigation policy dated as implemented on 2/3/2023 which stated the following information: Job reference checks, licensure verifications, and criminal conviction record checks are conducted on all personnel making application for employment with this company. The surveyor noted the policy further explained that the human resources department will conduct all applicable background investigation(s) on each individual making application for employment with the facility. Review of the facility's Abuse, Neglect, and Exploitation policy revealed the following information stated within the policy under the screening section: Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants, and the facility will maintain documentation of proof that the screening occurred. Additional review of the facility's Abuse, Neglect, and Exploitation policy stated the following information: The facility will provide ongoing oversight and supervision of staff in order to assure that it's policies are implemented as written.</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>47200</p> <p>Based on interview and record review it was determined the facility failed to ensure timely reporting of abuse allegations. This was evident for 1 out of 1 resident (Resident #151) reviewed for allegations of abuse during the surveyor's review of the following facility reported incidents and complaints: MD#00210602, MD#00210823, MD#00211759, and MD#00210884 during the recertification/complaint survey.</p> <p>The findings include:</p> <p>1.) On 2/18/25 at 9:44AM the surveyor conducted an interview with Resident #151 who reported to the surveyor that they initially reported their sexual abuse concern regarding the facility's GNA to the Kitchen Account Manager #58 in September of 2024, approximately two and a half weeks after the incident occurred, and that they had let the Director of Nursing know they needed to report it.</p> <p>On 2/19/25 at 1:14PM the surveyor requested the complete investigation files for facility reported incidents, MD#00210823 and MD#00210602 from the facility's Administrator.</p> <p>On 2/19/25 at 1:43PM the surveyor reviewed the initial self-report form submitted by the facility to the Office of Health Care Quality (MD#00210602) which revealed the facility documented the type of allegation being reported was sexual abuse, in which Resident #151 reported an allegation of sexual abuse by a Geriatric Nursing Assistant (GNA). Review of the initial self-report form submitted by the facility indicated the date and time of staff becoming aware of the incident was on 10/7/24 at 2:30PM, however, further review of the initial self-report revealed the facility documented notification to the police department occurred on 10/7/24 at 2:18PM, and notification to the ombudsman occurred on 10/7/24 at 1:40PM, and 10/7/24 at 4:30PM was documented as the time and date the report was submitted to the Office of Health Care Quality.</p> <p>On 2/19/25 at 2:10PM the facility Administrator confirmed with the surveyor that the investigative files provided were the complete investigative files, and provided a total of three grievance/concern forms to the surveyor and confirmed these were all the concerns/grievances relating to the resident. Surveyor review of a concern form dated as both received and resolved on 9/17/24 revealed the facility's prior DON documented the following oral resident complaint: Resident stated s/he preferred not to have male care providers (GNA's)</p> <p>On 2/21/25 at 1:51PM the surveyor made a request to the facility's Administrator to provide any and all documentation regarding the timing of the facility's reporting of the incident.</p> <p>On 2/24/25 at 9:13AM the surveyor conducted an interview with Kitchen Account Manager #58 who stated during the interview that Resident #151 initially expressed the allegation of sexual abuse to them and they took action by immediately informing Unit Manager, Licensed Practical Nurse #27 who they observed going to speak with the resident regarding the allegation.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/24/25 at 2:43PM the surveyor reviewed a police report dated 10/5/24 at 8:37PM which revealed documentation that Resident #151 reported the incident to police on 10/5/24, and included documentation that the resident expressed they were advised by Unit Manager, Licensed Practical Nurse #27 that it was not necessary to report the allegation.</p> <p>Review of documentation provided to the surveyor on 2/25/25 at 7:36AM by an anonymous source revealed documentation in which Resident #151 had contacted them on 9/30/24 to inform them that they had reported the incident to Kitchen Account Manager #58.</p> <p>On 2/27/25 at 10:00AM the surveyor shared concerns with the facility's Administrator who acknowledged and confirmed understanding of the concerns. No further documentation was provided to the surveyor by the facility regarding the timing of reporting.</p> <p>On 2/27/25 at 2:00PM the survey team reviewed concerns during the facility's exit conference with the Administrator and Interim Director of Nursing present.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>47200</p> <p>Based on review of a facility reported incident it was determined the facility failed to ensure the thorough investigation of an allegation of abuse. This was evident for 1 out of 1 resident (Resident #151) reviewed for allegations of abuse during the surveyor's review of the following facility reported incidents and complaints: MD#00210823, MD#00210602, MD#00211759, and MD#00210884 during the recertification/complaint survey.</p> <p>The findings include:</p> <p>1.) On 2/19/25 at 1:14PM the surveyor requested the complete investigation files for facility reported incidents, MD#00210823 and MD#00210602 from the facility's Administrator.</p> <p>On 2/19/25 at 1:43PM the surveyor reviewed the initial self-report form submitted by the facility to the Office of Health Care Quality (MD#00210823) which revealed the facility documented the type of allegation being reported was mental/verbal abuse and deprivation of goods and services by staff. The initial self-report form documented two allegations made by Resident #151, one of which involved an allegation received via text message from Resident #151 to facility staff regarding concern for retaliation in response to their previous reporting of an allegation of abuse, and secondly, an allegation made by Resident #151 regarding concern for retaliation because of arguments occurring with roommates, and additional information was provided in which an allegation was made that Resident #151 had physically assaulted Director of Nursing #65 (DON).</p> <p>On 2/19/25 at 2:10PM the facility Administrator confirmed with the surveyor that the investigative files provided were the complete investigative files. Surveyor review of the investigation file for MD#00210823 revealed the following: 1.) there was no statement in the investigative file from DON #65 regarding the allegations made, 2.) there was no documentation of any staff interviews conducted, including no documentation of interview with DON #65, 3.) there was no documentation present in the investigative file of the 10/14/24 meeting involving Resident #151 and who was in attendance at the meeting to determine all appropriate staff necessary for interviewing and collecting of statements regarding the allegation of Resident #151 assaulting DON #65 upon their exit from that meeting in which the facility's self-report referred to there being witnesses, 4.) there was no further action taken when two staff (Kitchen Account Manager #58, and Dietician #1) statements received by the facility were conflicting in nature regarding the location of where DON #65 was allegedly hit with a cane by the resident (#151), 5.) statements were present for only three staff members, 6.) there was no evidence of the text message which was documented as the information in which prompted the self-report and investigation, 7.) the facility's self-report documented the following information: Resident #151 declined interview by facility staff, however, there was no documentation present to support that an interview was attempted, or to support the resident having declined the interview, and 8.) the facility's initial self-report listed further information under the section of the form which was labeled deprivation of goods and services which documented an allegation relating to arguments with roommates, however, the investigative file did not contain any information relating to defining what goods and services were alleged to have been withheld, how this allegation came about, or any documentation/investigation regarding resident to resident arguments/issues occurring.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/25/25 at 10:30AM the surveyor conducted an interview with Resident #151 who reported to the surveyor that they believed 5 staff members were present at the meeting which was held on 10/14/24.</p> <p>On 2/26/25 at 10:45AM the surveyor conducted an interview with the facility's Administrator. When the surveyor inquired as to what further investigation was performed regarding the conflicting information in staff statements, the facility Administrator replied: Where do you see that? The surveyor showed them the conflicting areas within the two staff statements and the Administrator did not provide any response to the surveyor regarding this concern.</p> <p>On 2/26/25 at 11:33AM the surveyor conducted an interview with Dietician #1 who reported to the surveyor that five to six staff members were present at the meeting held regarding Resident #151 on 10/14/24.</p> <p>On 2/27/25 at 10:00AM the surveyor shared concerns with the facility Administrator who acknowledged and confirmed understanding of the concerns.</p> <p>On 2/27/25 at 2:00PM the survey team reviewed concerns during the facility's exit conference with the Administrator and Interim Director of Nursing present. The surveyor noted that no further information was provided prior to surveyor exit from the facility.</p> <p>2.) On 2/18/25 at 9:44AM the surveyor conducted an interview with Resident #151 who reported to the surveyor that they initially reported their sexual abuse concern regarding facility Geriatric Nursing Assistant (GNA) #64 to the Kitchen Account Manager (KAM) #58 in September of 2024, approximately two and a half weeks after the incident occurred, and that they had let the Director of Nursing (DON) #65 know they needed to report it.</p> <p>On 2/19/25 at 1:14PM the surveyor requested the complete investigation files for facility reported incidents, MD#00210823 and MD#00210602, and all grievance/concern documentation regarding the resident from the facility's Administrator.</p> <p>On 2/19/25 at 1:43PM the surveyor reviewed the initial self-report form submitted by the facility to the Office of Health Care Quality (MD#00210602) which revealed the facility documented the following information on the initial self-report made to the Office of Health Care Quality: Resident (#151) stated s/he was touched inappropriately by a male Geriatric Nursing Assistant (GNA) around 8/27/24 but did not report incident to staff.</p> <p>On 2/19/25 at 2:10PM the facility Administrator confirmed with the surveyor that the investigative files provided were the complete investigative files, and provided a total of three grievance/concern forms to the surveyor and confirmed these were all the concerns/grievances relating to the resident. Surveyor review of a concern form dated as both received and resolved on 9/17/24 revealed the facility's prior DON documented the following oral resident complaint: Resident stated s/he preferred not to have male care providers (GNA's)</p> <p>.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/24/25 at 9:13AM the surveyor conducted an interview with KAM #58 who stated during the interview that Resident #151 initially expressed the allegation of sexual abuse to them and they took action by immediately informing Unit Manager, Licensed Practical Nurse (UM,LPN) #27 who they observed going to speak with the resident regarding the allegation. The surveyor noted that the investigative file did not contain an interview or statement from KAM #58 and Resident #151's statement was obtained by UM,LPN #27 which did not include or document any information regarding the resident not reporting the incident to staff as was mentioned in the facility's initial self-report.</p> <p>On 2/24/25 at 2:43PM the surveyor reviewed a police report dated 10/5/24 at 8:37PM which revealed documentation that Resident #151 reported the incident to police on 10/5/24, and included documentation that the resident expressed they were advised by UM, LPN #27 that it was not necessary to report the allegation. The surveyor noted there was no evidence of an interview conducted or a statement obtained from UM, LPN #27 or the DON #65 in the facility's investigative file.</p> <p>Review of documentation provided to the surveyor on 2/25/25 at 7:36AM by an anonymous source revealed documentation in which Resident #151 had contacted them on 9/30/24 to inform them that they had reported the incident to Kitchen Account Manager #58. The surveyor noted at this time, that the investigation into the allegation was not conducted by the facility until 10/7/24 when the initial self report was made by the facility, and the GNA in question was not suspended pending outcome of investigation until 10/7/24.</p> <p>On 2/27/25 at 10:00AM the surveyor shared concerns with the facility Administrator who acknowledged and confirmed understanding of the concerns.</p> <p>On 2/27/25 at 2:00PM the survey team reviewed concerns during the facility's exit conference with the Administrator and Interim Director of Nursing present. The surveyor noted that no further information was provided prior to surveyor exit from the facility.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409</p> <p>Based on medical record review and staff interviews, it was determined that the facility failed to notify the Resident/Resident representative in writing about the bed hold policy when the Resident was transferred/discharged from the facility to an acute care facility. This was evident for one (Resident #64) of two residents reviewed who were transferred to an acute care facility during the recertification/complaint survey.</p> <p>The findings include:</p> <p>Review of the medical record for Resident #64 on 02/24/25 at 08: 40 AM revealed that Resident #64 was admitted to the facility on [DATE] and was sent to an acute care facility on 02/19/25 at 02:35 PM for a change in his/her medical condition. Further review of the medical record failed to produce written evidence that the Resident and /or the Resident representative were given written notice of the bed hold policy. The facility's documentation on the change in condition transfer form reveals that the bed hold policy was not given to the Resident and /or Resident representative.</p> <p>On 02/24/25 at 09:10 AM, in an interview, Licensed Practical Nurse (LPN) staff #39 stated that the Resident was sent to the hospital on 02/19/25 at 11:35 PM; he/ she does not remember completing the bed hold policy or giving it to the Resident or Resident representative.</p> <p>An interview with LPN staff # 40 revealed that the Bed hold policy is signed by the Nurse in charge, and sent it off to the hospital after notifying the family.</p> <p>On 02/27/25 at 2:30 PM, during the review with the Director of Nursing (DON), a copy of the bed hold policy was provided; however, he/she could not produce written evidence that the Resident # 64 or Resident representative was given, written notice of the bed hold policy.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49409</p> <p>Based on the surveyor's observation, medical record review, and staff interviews, it was determined that the facility failed to have an accurate MDS (minimum data set) assessment regarding the status of dental issues for 1 (Resident # 38) of 80 Residents reviewed during the recertification/complaint survey.</p> <p>The findings include:</p> <p>The facility must comprehensively and accurately assess each Resident's functional capacity. Comprehensive assessment of a Resident's needs, strengths, and goals using the Resident assessment instrument (RAI) specified by the Centers for Medicare and Medicaid Services (CMS). The assessment must also include Dental and nutritional status. The information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need.</p> <p>On 02/18/25 at 10 AM, the surveyor observed Resident # 38 missing teeth (both upper and lower jaws) and four front loose teeth (incisors) of the lower jaw.</p> <p>On 02/18/25 at 01:18 PM, a medical record review revealed that Resident #38 had a Doctor's order dated 07/12/24; dental consult 6-11 bridge failing. Recommendation EXT of the bridge by outside office: 1/10/25 Dietician and Nurses progress notes reveal that dental procedure was pending.</p> <p>Further review of the medical record of resident #38 revealed that the annual MDS assessment was completed on 10/02/24. Documentation of section L in MDS revealed that there were no oral/Dental issues like broken or loosely fitting dentures and loose teeth for Resident #38.</p> <p>On 02/25/25 at 12:09 PM, an interview with LPN Nurse staff # 44 revealed that Resident # 38 had issues with his implants and confirmed that the treatment was not initiated.</p> <p>On 02/25/25 at 12:14 PM, an Interview with Nurse Manager Staff #40 confirmed that Resident #38 dental consults were delayed, but upcoming appointments were set.</p> <p>An Interview with MDS staff #43 on 02/25/25 at 02:14 PM confirmed that the annual MDS dated [DATE], section L status of oral/ Dental coding, does not reflect an active dental issue.</p> <p>On 02/27/25 at 10:38 AM, Reviewed the MDS discrepancy with the Director of Nursing (DON), and the DON acknowledged it.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>49409</p> <p>Based on medical record review and staff interviews, it was determined that the facility failed to ensure that the Level II Preadmission screening and Resident review (PASARR) screen was completed by Adult Evaluation and Review Services (AERS) before the resident's admission. This was evident for 1 (Resident #82) of 60 residents reviewed for PASARR compliance.</p> <p>The findings include:</p> <p>Preadmission Screening and Resident Review is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. Everyone who applies for admission to a nursing facility must be screened for evidence of serious mental illness (MI) and/or intellectual disabilities (ID), developmental disabilities (DD), or related conditions, who would then require PASARR Level II evaluation and determination before admission to the facility. The state mental health or intellectual disability authority must conduct a Level II Resident review within 40 calendar days of admission.</p> <p>1) On 02/18/25 at 12:59 PM, the medical record review of Resident #82 revealed that a scanned copy of PASARR level one dated 01/11/2023 was available from electronic medical records. PASARR form page 2 indicated that the resident must be referred to AERS for level two Evaluation.</p> <p>Further record review revealed that the PASARR dated 01/11/23 for resident #82 was not referred to AERS for level two evaluation.</p> <p>On 02/18/25 at 2 PM, an interview with Social Services designee staff #2 Confirmed understanding the process of positive Residents for PASARR level one would be sent to AERS for level two evaluation.</p> <p>On 02/25/25 at 1:30 PM, reviewed with The Director of Nursing (D.O.N), and the DON acknowledged the findings.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304</p> <p>Based on interviews with residents, review of medical records, and interview with facility staff, it was determined that the facility failed to ensure that residents and/or residents' representatives were provided with summaries of their baseline care plans including a list of their medications and failed to timely complete a baseline care plan. This was evident for 3 (#5, #57, and #145) of 34 residents reviewed for baseline care plans during the recertification/complaint survey.</p> <p>The findings include:</p> <p>A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and medication list must be given to each resident and/or his/her representative. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission.</p> <p>1) Resident #57 was interviewed on 2/18/25 at 10:46 AM. During the interview, the resident stated that s/he did not think s/he had been provided with a summary of their baseline care plan or medication list.</p> <p>On 2/18/25 at 10:57 AM Resident #57's medical record was reviewed. The review included an admitted [DATE] and a Baseline Care Plan dated 1/12/25. In the BLCP Section 7- BCP Summary and Signatures Part B: was a filed that documented Signature of Resident and Representative. This field was blank. There was no signature in either the resident and/or representative field. The review failed to reveal any evidence that Resident #57 had been provided with a summary of their baseline care plan and medication list.</p> <p>On 2/20/25 at 9:37 AM the Director of Nursing (DON) was interviewed. During the interview she stated the BLCP must be completed within 48 hours of admission. Furthermore, she stated that after the BLCP is completed, it along with a list of medications should be presented, reviewed, and discussed with the resident/family and that there should be documentation in the medical record that the BLCP was completed, presented and given to the resident/family with a list of their medications.</p> <p>On 2/20/25 at 11:35 AM the DON stated and confirmed there is no documentation that Resident #57 was provided with a written summary of their BLCP including medication list within 48 hours.</p> <p>51789</p> <p>2) On 2/20/2025 at 9:37 AM, an interview was conducted with the Director of Nursing (DON), and she was asked: Who initiates and completes the Baseline Care Plan? What is the timeframe for completion? The DON answered that the admitting nurse initiates the baseline care plan, and then the team completes it (Social Services, Registered Dietician, Rehabilitation Department, and Nursing). The baseline care plan must be completed within 48 hours of admission.</p> <p>(continued on next page)</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/2025 at 11:44 AM, an electronic medical record review was conducted for Resident # 145 and revealed that his/her baseline care plan was initiated on 3/31/2024 and 4/29/2024, and both care plans were locked on 5/7/2024.</p> <p>On 2/26/2025 at 9:20 AM, an interview with the Director of Nursing (DON) was conducted. DON confirmed that the baseline care plans for Resident # 145 dated 3/31/2024 and 4/29/2024 were completed late.</p> <p>51213</p> <p>3) On 02/25/25 at 12:15 PM medical record review revealed that resident #5's baseline care plan was completed in Point Click Care (PCC), but no documentation verified that staff presented and reviewed the baseline care plan within 48 hours of admission, to the resident/resident representative.</p> <p>On 02/25/25 12:32 PM the Director of Nursing (DON) was interviewed and asked if they could provide documentation that the resident #5 received her baseline care plan within 48 hours of admission and that it was reviewed with the resident/resident representative? The DON checked and reported, I do not have any documentation to verify that the resident or the resident representative was given the 48-hour base line care plan or that it was reviewed with them.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304</p> <p>Based on observations, record review, and interviews of the residents and facility staff, it was determined that the facility failed to initiate and develop a comprehensive person-centered care plan that includes measurable objectives, interventions, and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs. This was evident for 3 (Resident #38, #57, and #145) of 34 residents reviewed during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>A care plan is an individualized guide that addresses the unique needs of each resident including both medical and non-medical concerns. It describes residents' needs and the interventions to address them and should be updated as changes in the residents' conditions occur. It is used to plan, assess, and evaluate the effectiveness of the resident's care they receive in a facility.</p> <p>Oxygen therapy is a treatment that provides you with supplemental, or extra, oxygen. It is only available through a prescription from your health care provider. Supplemental oxygen therapy helps people with breathing problems get enough oxygen to function and stay well. Low blood oxygen levels (hypoxemia) can damage organs and be life-threatening.</p> <p>1) On 2/18/25 at 11:08 AM review of Resident #57's medical record revealed a physician order for oxygen at 2 L/min (liters per minute) via nasal cannula continuously. A nasal cannula is a device that delivers oxygen directly to a person's nostrils via a flexible plastic tube. Further review of the medical record revealed Resident #57's diagnoses included acute respiratory failure with hypercapnia, hypertensive heart disease with heart failure, and unspecified combined systolic (congestive) and diastolic (congestive) heart failure, which can affect a person's breathing and the respiratory care, services, and interventions needed. However, review of Resident #57's care plan failed to reveal that a respiratory care plan was developed for oxygen therapy with measurable goals and nursing interventions/evaluations.</p> <p>On 2/20/25 at 11:42 AM the Director of Nursing (DON) was interviewed. During the interview, the DON stated that residents on oxygen should have an oxygen care plan with goals and interventions. The surveyor reviewed Resident #57's care plan with the DON. The DON confirmed that there was no focus, goals, or interventions on the care plan for the use of supplemental oxygen for Resident #57.</p> <p>49409</p> <p>2) On 02/18/25 at 10 AM, the surveyor observed Resident # 38 missing teeth (both upper and lower jaws) and four front loose teeth (incisors) of the lower jaw.</p> <p>On 02/18/25 at 01:18 PM, a medical record review revealed that Resident #38 had a Doctor's order dated 07/12/24; dental consult 6-11 bridge failing. Recommendation EXT of the bridge by outside office: 1/10/25 Dietician and Nurses progress notes reveal that dental procedure was pending.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the care plan does not reflect Resident # 38's 1). Dental issues and possible interventions, 2) Resident's level of care changed to Palliative care on 09/19/24.</p> <p>Care conference notes dated 10/3/2024 at 15:49 do not reflect the documentation of dental issues and related dental appointments.</p> <p>An interview with the social work designee, staff # 2, on 02/24/25 at 10:33 AM revealed that the care plan meetings are scheduled and communicated with resident/ Resident families by the social work designee. The care plan meeting summary was documented by social work staff # 2, however, each department was responsible for updating the care plans. An interview with a Licensed Practical Nurse (LPN) staff, #44, on 02/24/25 at 11:15 AM revealed that the unit managers initiate and update the care plans in the nursing department.</p> <p>An Interview with the Activities Director, staff #25, on 02/24/25 at 11:33 AM revealed that each department is responsible for initiating and updating the care plans.</p> <p>On 02/25/25 at 1:30 PM, reviewed resident# 38's care plan with Unit manager staff # 44 and the The Director of Nursing (D.O.N) and the DON acknowledged the findings.</p> <p>51789</p> <p>3) On 2/21/2025 at 11:44 AM, an electronic medical record review was conducted. Resident # 145 has a history diagnosis of PTSD (post-traumatic stress disorder). He/she was initially admitted to the facility on [DATE], discharged on [DATE], and returned to the facility on [DATE]. He/she was hospitalized on [DATE] due to a medical condition and was readmitted on [DATE]. The Minimum Data Set (MDS) comprehensive assessment reviewed dated 1/11/2024 and 3/7/ 2024, respectively, both confirmed the diagnosis of post-traumatic stress disorder. Section D of both assessments reflected the presence of depression in various degrees. The Care Area Assessment (CAA) was triggered for mood and psychosocial well-being.</p> <p>Further review of the electronic medical record revealed a care plan for the history of trauma initiated on 1/24/2024 and canceled on 2/25/2024. No additional care plan for trauma-informed care was found.</p> <p>A care plan for depression related to grief was initiated on 2/3/2025. Resident # 145 has been exhibiting depression based on the assessments since his/her initial admission on 1/5/2024. In addition, Resident # 145 was seen by psychiatry on 8/20/2024 due to anxiety and agitation and was prescribed Lexapro (antidepressant) 5 mg once a day for anxiety and agitation. There was no care plan for mood and behavior, including the use and side effects of psychotropic medication.</p> <p>On 2/24/2025 at 1:59 PM, Staff # 2 (Social Services designee) was interviewed. The surveyor asked: What is your process for a resident with PTSD (post-traumatic stress disorder)? Staff # 2 stated: We immediately refer to psychiatric services and ensure he/she is being followed up. I do not have any assessment used for PTSD (post-traumatic stress disorder); Social Services oversees the care plan. Staff # 2 added that Resident # 145 did not trigger during the social services assessment for trauma, and therefore, no care plan was required.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/24/25 at 02:40 PM, Staff # 2 provided a copy of the care plan for PTSD (post-traumatic stress disorder) and stated, This was all we have. The care plan was canceled on 2/5/2024.</p> <p>On 2/26/2025 at 9:20 AM, the identified concern was reviewed with the Director of Nursing, related to post-traumatic stress disorder.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>51128</p> <p>Based on interviews and medical record reviews, it was determined that the facility failed to 1) use an interdisciplinary team to revise care plans in order to meet the residents' need and 2) ensure that a resident's representative was offered an opportunity to participate in a quarterly care plan review assessment. This was evident for 5 (#23, #2, #64, #73 and #119) of 34 residents reviewed during the recertification/complaint survey.</p> <p>The findings include:</p> <p>Care plans are developed for residents to guide the care that residents receive in the facility. They are required to be developed within 7 days of completion of a resident's admission comprehensive Minimum Data Set (MDS) assessment and revised at least every quarter (or more often as needed). The facility is required to have care plans developed and revised by an interdisciplinary team including: the attending physician, a registered nurse, a nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable).</p> <p>1) An interview was conducted on 02/18/25 at 11:59 AM with Resident #23, who stated that he/she has a circulation problem and issues with wound healing.</p> <p>On 02/21/25 at 02:45 PM, the surveyor observed a bandage on Resident #23's left heel. Resident #23 stated, The podiatrist was in today and said I have an issue with my heel.</p> <p>During an interview with RN #7 on 02/21/25 at 02:53 PM, RN#7 stated that the podiatrist suggested that the resident may be transferred to the hospital for a wound infection to the Left heel and left great toe, but Resident #23 refused to be transferred.</p> <p>A Record review conducted on 2/21/2025 at 1:51 PM noted documentation of a change in condition written by LPN #15, Pressure wound on left heel and great toe with no drainage on the heel. There is some drainage on the great toe. Left heel measuring 5 by 5 and left great toe measuring 3 by 2.</p> <p>Further record review on 02/24/25 at 0930 AM documents a care plan for a skin condition initiated on 12/23/2024 and revised on 2/6/2025. The care plan did not have a revision or update for the change in the condition of the left heel and left great toe</p> <p>On 02/24/25 11:58 AM During an interview with the DON, the surveyor asked the DON who updated the care plan, and the DON stated that the nurse and the unit manager would update the care plan based on the change in condition. When asked if the care plan would be updated following a new skin infection, DON said yes, and agreed that the care plan should have been updated.</p> <p>2) During the screening portion of the survey on 02/18/25 at 09:24 AM, a surveyor observed Resident # 2 reaching for a cup of water with a straw in it.</p> <p>On 2/25/2025 at 09:00 AM, a record review noted a diet order for a CCD diet with chopped texture, thin liquids consistency, no straws, and aspiration precautions.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>02/26/25 08:35 AM, in an interview with the dietician (staff #1), the surveyor asked how the communication of special diets, no straw use, and aspiration precautions got to staff caring for the residents. Staff #1 could not explain how that information is passed on to staff. When the surveyor asked if the order should have been initiated on the care plan, staff #1 said, yes.</p> <p>02/26/25 08:44 AM An interview was conducted with the nurse (staff #60), who stated that since the resident was taking pills, she was not on aspiration precautions.</p> <p>02/26/25 01:20 PM A follow-up interview with the unit manager (staff #27) revealed that an order for aspiration precautions and no straws should be initiated on the care plan, which will populate on a Kardex that staff would follow to care for the residents. Staff # 27 agreed that the order was missed and thus not care-planned.</p> <p>02/26/25 02:14 PM An additional interview was conducted with the DON, who stated that the order for aspiration precaution and no straw was not initiated on the care plan, so the staff was unaware of the order. DON acknowledged that this was a concern.</p> <p>45131</p> <p>3) On 2/18/25 at 2:10 PM, in an telephone interview with Resident #119's healthcare representative, it was revealed that the resident was admitted to the facility in August 2024; however, the facility failed to complete the care plan meeting as required.</p> <p>On 02/26/25 at 11:01 AM, a review of the MDS assessment dates revealed that the assessments were completed on 8/9/2024 (admission), 11/9/2024 (quarterly), and 1/16/2025 (quarterly); however, there was no documented evidence to support that the care plan was developed with an interdisciplinary team to ensure that all of the resident care and needs were addressed in a timely manner.</p> <p>The review of the care conference note written on 10/31/24 revealed that the care plan meetings would be rescheduled. Review of the care conference note on 12/28/24 revealed that a meeting was held with nursing, therapy and activities; however, there was no documentation to suggest that the care plan meeting included the resident/resident representative(s). A review of a social service note on 1/14/25 revealed attempts were made by the facility to schedule a care plan meeting with the resident representative(s); however, there was no documentation to suggest that the care plan meeting was conducted.</p> <p>On 2/26/25 at 11:18 AM, in an interview with the Director of nursing (DON), the DON stated that one of the care plan meetings was scheduled to take place but then the resident was sent to the hospital. The DON was asked the expectation for care plan meeting occurrence, and she stated that care plan meetings are to be done quarterly. The surveyor notified the DON that the care plan meeting for this resident was not found in the resident's electronic health record, and the DON was asked to provide documentation if the care plan meeting was completed since the august 2024 admission. The documentation received on 02/27/25 revealed that a care plan meeting with the interdisciplinary team and resident/representative(s) was held on 02/22/25 during the survey process.</p> <p>49409</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4) A medical record review on 2/20/2025 at 3:43 PM revealed that the care plans and care conference progress notes were not updated with any of Resident #64's changes. Further review of the medical record revealed that care conferences were not held for 17 months (from 08/18/2022 to 02/20/2024).</p> <p>An interview with the Unit manager, staff # 40 on 02/24/25 at 09:52 AM revealed that the care plan process includes the review of care plans and document updates. The Nursing team updates care plans for any significant changes in Resident health status. Primarily, the Unit Manager is Responsible for keeping Nursing care plans current. Each department updates its care plans, and social services document the care conference notes.</p> <p>An interview with social services, staff #2 on 02/24/25 at 10:33 AM revealed that Social services schedule care plan meetings and communicate with families. After the care conference, Social services document the summary of care conference. All departments are responsible for documenting their care plan updates and documentation. Staff # 2 added that there was a staff transition in the social services department during the period between 08/18/2022 and 02/20/2024.</p> <p>On 02/25/25 at 1:30 PM, reviewed resident # 64's care plan with Unit manager staff # 44 and the The Director of Nursing (D.O.N) acknowledged the findings.</p> <p>43096</p> <p>5) On 2/22/25 at 8:51 AM, the surveyor reviewed the resident's medical records. The review revealed that Resident #73 was admitted to this facility in July 2024.</p> <p>Further review of Resident #73's medical records revealed that the resident's MDS (Minimum Data Set: a standardized assessment tool used to comprehensively evaluate the health and functional capabilities of each resident in a Medicare or Medicaid-certified nursing home, allowing staff to identify potential health problems and create personalized care plans) was assessed on 7/10/24 for admission assessment, 10/10/24 and 1/10/25 for quarterly assessments. However, there was no documentation for care plan meetings for care plans of July 2024 and January 2025.</p> <p>During an interview with the social worker (Staff # 2) on 2/24/25 at 7:49 AM, she confirmed that each care plan meeting should be documented in a progress note under the electronic medical records system.</p> <p>On 2/24/25 at 3:08 PM, the surveyor reviewed Resident #73's progress note with the Director of Nursing (DON). The DON verified that there was no documentation for the care plan meeting regarding July 2024 and January 2025. The surveyor shared the concern, and the DON validated it.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>42507</p> <p>Based on medical record review and resident and staff interviews it was determined the facility staff failed to ensure that dependent resident's personal hygiene needs were adequately met by offering and providing showers as scheduled. This was evident for 1 (#4) of 2 residents reviewed for Activities of Daily Living (ADL) care during a recertification/complaint survey.</p> <p>The findings include:</p> <p>In an interview with Resident #4 on 2/18/2025 at 9:30 AM, Resident #4 stated s/he had not been getting showers in the past 2 years and would like to have one. S/he added that they don't understand that taking showers help the body heal. Resident #4 also stated that the staff gave her/him bed baths and s/he would prefer that ADL care be provided after breakfast and not after lunch as was the current practice.</p> <p>On 2/19/2025 at 12:54 PM a review of Resident #4's quarterly MDS (Minimum Data Set) completed on 12/22/2024 revealed that the resident was totally dependent on staff for shower/bathe self, personal hygiene and dressing. The Brief Interview for Mental Status (BIMS) revealed a score of 13 indicating adequate cognitive ability.</p> <p>The MDS is a federally-mandated assessment tool that helps nursing home staff gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need.</p> <p>On 2/19/25 at 1:13 PM Review of physician orders did not reveal any active orders for showers. However further review revealed a shower order on 8/17/2023 that was discontinued on 1/23/2024: Showers on Monday and Thursday 3-11, every evening shift every Mon, Thu for Shower days.</p> <p>On 2/20/2025 at 2:05 PM, the surveyor reviewed Resident #4's care plan. The review revealed that Resident #4 had a care plan initiated on 2/22/2021 stating, Resident #4 has an Activities of Daily Living self-care performance deficit related to hospitalization and deconditioning. One of the interventions listed was, Shower per schedule and as needed.</p> <p>On 2/21/2025 at 7:55 AM a review of Resident #4's shower sheets revealed the resident was scheduled for showers every Monday and Thursday. Further review revealed that for the entire month of January, the resident got showers twice (Thursday 1/2/2025 and Thursday 1/30/2025) and as of 2/21/2025, the resident got a shower once (Monday 2/3/2025). However, in January 2025, NA (Not applicable, Not attempted due to medical condition or safety concerns) was documented on Monday 1/6/2025 and Monday 1/20/2025; RR (Resident refused) documented on Thursday 1/9/2025 and Monday 1/27/2025. N (No) documented on Monday 1/13/2025 and Thursday 1/16/2025. In February 2025, N noted on Thursday 2/6/2025; NA noted on Monday 2/10/2025, Thursday 2/13/2025, and Monday 2/17/2025; RR noted on Thursday 2/20/2025.</p> <p>On 2/21/2025 at 8:33 AM, a follow up interview was conducted with Resident #4 in their room. Resident #4 re-affirmed that s/he has not taken any showers this year and staff had not given her/him showers for the past 2 years. S/he stated that they give me bed baths but I would like to have showers too.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/21/2025 at 8:48 AM An interview was conducted with Geriatric Nursing Assistant (GNA #24) who has worked in the facility for a little over a year. GNA #24 stated that Resident #4 was currently on her assignment. Regarding showers, GNA #24 stated she has never given Resident #4 showers. GNA #24 stated she did not know the resident's scheduled shower days but could look up the information if the surveyor wanted her to.</p> <p>On 2/21/25 at 9:09 AM, the surveyor interviewed Resident #4's nurse, Registered Nurse (RN # 17), who has worked in the facility for almost 5 years. During the interview RN #17 described how to identify the residents that were scheduled for a shower that day: She stated that there was a shower sheet with the shower schedules located at the nurses' station on the unit. RN #17 got the shower schedule and showed the surveyor that Resident #4's shower days were Mondays and Thursdays. She further stated that residents were scheduled for two showers a week and would get baths on the days they were not on the schedule for a shower. When asked if she has assisted in giving the resident showers, RN #17 stated that she has never given and/or assisted in giving the resident showers. She added that the GNAs provided showers, but she (RN #17) sometimes supervises. RN #17 further stated that she has not seen Resident #4 taken to the shower room by any GNA.</p> <p>On 2/21/2025 at 9:16 AM, An interview was completed with the Unit Manager (UM #27), who has worked in the facility for 3 years. UM #27 looked at the shower schedule on the wall in her office and confirmed that Resident # 4's shower days were Mondays and Thursdays. Regarding resident not getting showers, UM #27 stated that staff do offer to give the resident showers but most days the resident prefers to have a bed bath instead of going to the shower room. Surveyor reviewed Resident #4's shower sheets with UM #27. UM #27 verified that per staff documentation, the resident got showers on 1/2/2025 and 1/30/2025 (two days for the entire month of January), and on 2/3/2025 (once as of February 21, 2025).</p> <p>Regarding staff documentation of NA and N on the shower sheets as mentioned above, UM #27 stated that according to the notations it could be deduced that the staff did not offer to give the resident showers on those days. UM #27 added that the GNAs were expected to document if a resident refuses a shower and notify the nurse who will document the refusals in their progress notes. When asked if she has seen the GNAs take Resident #4 to the shower room, UM #27 stated that she has not specifically seen the resident go in and/or out of the shower room.</p> <p>On 2/24/2025 at 8:01 AM Review of nurses' progress notes for January and February 2025 did not reveal any documentation of resident refusals of showers on 1/9/2025, 1/27/2025, and 2/20/2025 as documented in the shower sheets. There was no nurse's notes for the dates that staff marked N and NA in the shower sheets.</p> <p>On 2/26/2025 at 8:21 AM, the surveyor reviewed the shower sheet documentation for the months of January and February of 2025 with the Director of Nursing (DON). DON verified that according to staff documentation, the resident was given showers 2 times (1/2/2025 and 1/30/2025) for the whole month of January and one time (2/3/2025) as of 2/21/2025. She acknowledged that the resident was not being offered/given showers twice a week as per her shower schedule. During this interview the DON stated she was unsure why N and/or NA was documented for showers. However, no additional documentation was provided to indicate that Resident #4 refused to take showers on the dates that were marked N and/or NA in the shower sheets.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45131</p> <p>Based on record reviews, observation, and interviews, it was determined that the facility failed to have documented evidence to support that the facility provided an ongoing program to support residents in their choice of activities. This is evident for 1(Resident #119) of 3 residents reviewed for activities services during the recertification/complaint survey.</p> <p>Findings Include:</p> <p>On 2/18/25 at 2:20 PM, in an interview with Resident #119's healthcare representatives, they revealed concerns that the facility failed to provide any activities to the resident. The healthcare representative stated that the resident was bedbound, alert but non-verbal and the facility never tried to get the resident out of bed to engage in any activities.</p> <p>On 2/25/25 at 10:44 AM, an observation revealed the resident resting in bed, awake, alert, but non-verbal, the TV on was on in the resident's room; however, no other activities observed.</p> <p>On 02/25/25 at 10:50 AM in an interview with licensed Practical Nurse (LPN #16), she stated that the activity personnel came in to see the resident but she was unsure about what kind of services/activities were provided and how often it was provided. She was asked if the resident got out of bed for activities and she admitted that the plan to start getting the resident out of bed to the chair was implemented at the start of the week.</p> <p>On 02/25/25 at 12:35 PM, a review of the admission assessment for activity preferences revealed various activity selection including to do things with groups of people and religious services or practices, all identified as very important.</p> <p>On 02/25/25 at 02:28 PM, in an interview with Staff #25 (activity director), she stated that each resident receives the facility's daily chronicle (reading, puzzle and the activity schedule). The surveyor asked how the facility accommodate bedbound and non-verbal resident, and Staff #25 stated that for activities needs we reach out to the families, to see what adoptable services can be provided. For Resident #119, Staff #25 stated that one-to-one activities were provided twice a week which would include activities such as playing music and reading to the resident.</p> <p>On 02/25/25 at approximately 3:25 PM, a review of Resident #119's one-to-one participation log revealed that the visit were done twice per week; however, the resident received no activities between [DATE] to [DATE] because according to Staff #25 the resident was placed on isolation precaution and the staff did not feel safe going into the resident's room to provide activities.</p> <p>On 02/26/25 at 11:18 AM, in an interview with the Director of Nursing (DON), she was asked about the expectations for the activities staff members when the resident is placed on isolation precaution. The DON confirmed that the staff was still expected to provide any services as scheduled. The DON was made aware that the activities department staff failed to provide services due to the resident isolation status. The Surveyor also reviewed the activities policies with the DON, and she agreed that activities should be provided on an ongoing basis.</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>43096</p> <p>Based on a review of the resident medical records and interviews with facility staff, it was determined that the facility failed to 1) ensure that a resident followed up with a GI (gastrointestinal) specialist and 2) ensure that a physician's order for an anticoagulant lab draw was carried out. This was evident for 2 (Resident #11, and # 437) of 71 residents medical records reviewed during this recertification/complaint survey process.</p> <p>The findings include:</p> <p>Crohn's disease is an inflammatory bowel disease (IBD) that causes the digestive tract to become swollen and irritated. The symptoms are abdominal pain, diarrhea, weight loss, and rectal bleeding. This is a lifelong condition that can't be cured. However, treatments typically help manage your symptoms and allow you to live an active life.</p> <p>1) During a complaint review on 2/21/25 at 9:24 AM, the surveyor reviewed Resident #437's medical record. The review revealed that the progress note written by the facility's staff on 7/24/24 stated, Resident returned from GI Consult, next follow-up scheduled in 2 months, MD/RP notified.</p> <p>The surveyor requested a copy of the consultation note. On 2/26/25 at 10:20 AM, the Director of Nursing (DON) provided a copy of the handwritten consultation note dated 7/24/24 from the GI specialist (staff #54). Since the note was not readable, the surveyor requested to figure out its details.</p> <p>On 2/27/25, around 8 AM, the DON stated that she contacted Staff #54's office and verified with the doctor. The office confirmed that Resident #437 was seen by Staff #54 on 7/24/24, ordered as-needed medication, and recommended follow-up in 3 months. The surveyor asked the DON whether Resident #437 had any further follow-up with the GI doctor after 7/24/24. The DON confirmed that the resident had no further appointments with Staff #54.</p> <p>During an interview with the DON on 2/27/25 at 8:20 AM, she stated that due to Resident #437's diagnosis, the GI specialist should regularly follow him/her. The surveyor shared concerns about Resident #437's GI follow-up not being conducted.</p> <p>51128</p> <p>2) Anticoagulants are medicines that prevent blood from clotting. They decrease the blood's ability to clot, which helps prevent harmful blood clots from forming and blocking blood vessels. This includes a PT, PTT, INR, and sometimes a CBC.</p> <p>On 02/24/25 at 07:45 AM, during a record review of unnecessary medication review, it was noted that the resident had a physician's order for an anticoagulant, Apixaban Oral Tablet 5 MG (Apixaban), one tablet to be taken by mouth twice daily.</p> <p>On 02/24/25 at 10:46 AM, the care plan review noted that Resident #11 is on anticoagulant therapy initiated on 10/21/2024 and revised on 10/21/2024. One of the interventions was to draw labs as ordered and report abnormal lab results to the MD.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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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>A review of Lab orders on 2/24/25 at 11:07 AM noted an anticoagulant lab draw order dated 1/14/25, which was confirmed by the unit manager (staff #32).</p> <p>On 02/24/25 at 10:50 AM, an interview was conducted with staff #32. The surveyor asked how lab orders were placed in the Electronic Health Record (EHR). Staff #32 stated that the physician or the unit manager entered labs into the facility EHR. One print-out copy was given to the nurse, who placed the order into the Diamond Lab system, and one copy was placed in the lab binder.</p> <p>On 02/24/25 at 10:50 AM, during a further interview with Staff#32 concerning the anticoagulant lab order for resident #11, staff #32 stated that the labs were entered incompletely on 1/14/25 in the EHR and were not entered into the Diamond lab system, resulting in no anticoagulant lab drawn.</p> <p>In an interview with the Director of Nursing (DON) on 2/24/25 at 11:05 AM, the surveyor shared concern about Resident #11's anticoagulant labs not being entered completely and not drawn. The DON validated the concern.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304</p> <p>Based on record review and interview with facility staff, it was determined that the facility failed to monitor a resident's weight who was assessed as underweight and at risk of malnutrition. This was evident for 1 resident (Resident #29) of 5 residents reviewed for nutrition during the recertification/complaint survey.</p> <p>The findings include:</p> <p>Current standards of practice recommend weighing a resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document weight trends.</p> <p>A review was conducted of Resident #29's medical record on 2/21/25 at 8:21 AM and revealed a Nutrition Evaluation dated 12/11/2024. In the Nutrition Assessment section it stated, .Has potential for malnutrition d/t (due to) alcohol abuse, low BW (body weight) and fair appetite. In the Nutrition Goals section it stated, Weight without significant changes and Yes was checked for Proceed to Care Plan.</p> <p>Resident #29's care plan was reviewed on 2/21/25 at 8:34 AM. The review revealed a care plan for nutritional problem/potential nutritional problem with an intervention to weigh the resident at the same time of day and record: weekly.</p> <p>The Registered Dietician (RD #1) was interviewed on 2/21/25 at 8:43 AM. During the interview she stated, when a resident is admitted , nursing gets their initial height and weight. Then she completes a baseline care plan within 24 hours and looks at diet, BMI [body mass index], any issues that might put them at risk for weight loss, and from there she monitors weights each week. Once a resident has had 4 weeks of weights and they are stable, they go to monthly weights. She stated she runs a report of weights 1-2 times a week and it is submitted to the Director of Nursing (DON) and Unit Managers (UM's).</p> <p>On 2/21/25 at 9:55 AM in an interview with the DON, she stated the facility's policy and expectation regarding weight was to weigh a resident on admission, then once a week for 4 weeks, and then once a month. If there was a concern such as a significant weight loss, then the resident would go back to weekly weights. When asked if there needed to be an order, she stated no, it is the standard of practice in the facility.</p> <p>Review of the facility's policy, Weight Monitoring, revealed, A weight monitoring schedule will be developed upon admission for all residents: weights should be recorded at the time obtained and newly admitted residents- monitor weight weekly for 4 weeks.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #29's medical record on 2/18/25 at 12:36 PM revealed the resident was readmitted on [DATE]. Further review of the medical record revealed only 2 weights for the resident's current admission: 12/20/2024 at 8:08 PM 105.0 lbs [pounds] mechanical lift and 2/5/2025 at 7:44 PM 107.6 lbs wheelchair. The admission weight was documented on 12/20/24. However, the resident was not weighed weekly for 4 consecutive weeks thereafter and was not reweighed until almost a month and a half after his/her admission.</p> <p>On 2/21/25 at 12:33 PM in an interview with RD #1 she stated Resident #29's initial weight on 12/6/24 was 111.6 lbs, the next day they did a weight, and it was the same, on the 13th, she was 112 lbs, then s/he ended up in the hospital and when s/he was readmitted on [DATE] she was 105 lbs. During the interview RD #1 stated there were no more weights after that and that she did not get another weight until February 5th. When asked why, she stated because nursing did not get them.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49304</p> <p>Based on surveyor observations, review of the medical record, and interview with facility staff, it was determined the facility staff failed to provide residents with respiratory care consistent with professional standards by failing to 1) administer oxygen as prescribed, 2) label oxygen administration equipment, and 3) develop and implement a care plan that includes appropriate interventions for respiratory/tracheostomy care. This was evident for 2 (#57, and #115) of 4 residents reviewed for respiratory care during a recertification/complaint survey.</p> <p>The findings include:</p> <p>Oxygen flow meters are a relatively simple device that consists of a tube through which gas passes and a small, free-moving indicator such as a ball. When valves are open, the gas moves through the flow meter and causes the ball to float. A numbered scale on the tube along with the indicator allows the healthcare provider to determine the flow rate of oxygen. To ensure the most accurate reading of the flow rate, the flow meter is read at a close distance, straight in front of the meter, with the indicator ball centered over the line on the numbered scale, and at eye level with the indicator.</p> <p>1) On 2/18/25 at 11:00 AM Resident #57 was observed receiving oxygen via nasal cannula at a flow rate of 1.5 liters per minute (L/min). A nasal cannula is a device that delivers oxygen directly to a person's nostrils via a flexible plastic tube.</p> <p>Unit Manager (UM #10) was interviewed on 2/18/25 at 11:05 AM. During the interview she stated the expectation was that a resident's oxygen tubing was labeled with the date and initials of the nurse who changed the tubing. The surveyor stated she did not see a label on Resident #57's oxygen tubing which UM #10 verified.</p> <p>On 2/18/25 at 11:08 AM review of Resident #57's physician orders revealed the resident was ordered oxygen at 2 L/min via nasal canula continuously.</p> <p>Registered Nurse (RN #13) was interviewed on 2/18/25 at 11:10am. During the interview she stated oxygen tubing should be labeled with the date and initials of the nurse who last changed the tubing. When asked if Resident #57's oxygen tubing was labeled and how many liters the resident was receiving, RN #13 walked over to Resident #57 accompanied by the surveyor and stated Resident #57 was on 1.5 L and verified the tubing was not labeled. RN #13 stated that when she did her rounds this morning, she must have missed it. When asked how many liters of oxygen Resident #57 was ordered, RN #13 and the surveyor walked over to RN #13's computer and the nurse pulled up the resident's orders. While looking at Resident #57 's orders she stated and confirmed the resident was supposed to be receiving 2L.</p> <p>42507</p> <p>2) Tracheostomy is a surgical procedure that creates an opening in the trachea (windpipe) to allow air to enter the lungs. A person with a tracheostomy (trach) breathes through a tracheostomy tube inserted in the opening.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from your health care provider.</p> <p>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.</p> <p>On 2/18/2025 at 11:24 AM, during initial pool screen by a surveyor, Resident #115 was observed with a Tracheostomy present and using oxygen via a trach collar (a soft plastic mask that fits over a tracheostomy tube to deliver oxygen or humidified air).</p> <p>Review of Resident #115's clinical records on 2/25/2025 at 7:57 AM revealed the resident was readmitted to the facility in January 2025 with medical diagnoses that included but not limited to encounter for surgical aftercare following surgery on the respiratory system, encounter for attention to Tracheostomy, cancer of lower lobe, left bronchus or lung, cancer of larynx (voice box), chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), chronic obstructive pulmonary disease.</p> <p>Review of physician orders on 2/25/2025 at 8:17 AM revealed the following orders:</p> <ul style="list-style-type: none"> - Oxygen at 5 L/min via Trach every shift, order date 2/22/2025, - Suction tracheostomy tube as needed to clear airway. Document results in PN (progress note) as needed, order date 1/24/2025, - Tracheostomy site dressing change every shift and PRN as needed, order date 1/24/2025, and - Change Oxygen and/or Nebulizer equipment tubing and/or mask. label, date and initial. Change humidifier bottle, label, date and initial, every night shift every Wed for Trach Care, order date 1/24/2025 <p>Review of Resident #115's care plan on 2/25/2025 at 10:17 AM was completed: There was no care plan focus with goals and interventions for Respiratory and/or Tracheostomy care even though the resident had a trach and was on oxygen therapy. Thus, the care plan was not comprehensive and resident centered.</p> <p>Review of progress notes on 2/25/2025 at 2:54 PM revealed the following documentation by nursing on 1/23/2025 at 19:41 (7:41 PM): . patient admitted from [hospital name] into Autm Lake Glen [NAME] via stretcher alert oriented and verbally responsive under the services of MD . with diagnosis of Hypoxia, Trach, and lung adenocarcinoma. Patient on 5% oxygen via trach .</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Director of Nursing (DON) on 2/26/2025 at 8:32 AM, she stated that baseline care plans were done on admission by the staff nurse and completed by the IDT (Interdisciplinary Team). Regarding the development of a comprehensive care plan, DON stated that any member of the IDT will open a comprehensive care plan. Surveyor reviewed the resident's care plan with DON. DON verified that the care plan failed to address the resident's tracheostomy and/or oxygen therapy. She added that the expectation was to see on the care plan a focus on Trach and Oxygen with goals and interventions. Thus, acknowledging that Resident #115's care plan was not comprehensive and resident centered.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>42507</p> <p>Based on medical record reviews, resident, a complaint review #MD00208110 and interviews, it was determined the facility staff failed to 1) ensure that a resident was given pain medication consistent with professional standards of practice and 2) assess the resident's pain level. This was evident for 3 (#38, #115, #431) of residents reviewed for pain management during a recertification/ complaint survey process.</p> <p>The findings include:</p> <p>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.</p> <p>1) During an initial pool screen of Resident #115 on 2/18/2025 at 11:14 AM by a surveyor, the resident complaint of pain around the trachea (windpipe) area and rated the pain at 7/10 (severe pain). The surveyor notified the resident's nurse, Registered Nurse, RN #28.</p> <p>On 2/25/2025 at 8:17 AM, a review of physician orders for Resident #115 revealed the following PRN (as needed) pain medication orders:</p> <ul style="list-style-type: none"> - Oxycodone HCl Oral Tablet 5MG (Oxycodone HCl) <p>Give 5 mg by mouth every 4 hours as needed for Moderate pain (or if patient requests it for severe pain, start date 1/23/2025,</p> <ul style="list-style-type: none"> - Acetaminophen Oral Tablet 325 MG (Acetaminophen) <p>Give 2 tablets by mouth every 4 hours as needed for Mild to Moderate pain, start date 1/23/2025.</p> <ul style="list-style-type: none"> - Observation: Pain - Observe every shift. If pain present, complete pain flow sheet and treat trying non-pharmacological interventions prior to medicating if appropriate. Document in the PNs (progress notes) every shift, and - Non-Pharmacological Interventions attempted prior to administering any prn pain med. <p>every 24 hours as needed Document the number that corresponds to the Non-Pharmacological Interventions attempted: 1. Warm beverage offered 2. Repositioned 3. Soft music played 4. Lights dimmed 5. Other (document in a progress note) 6. Resident refused NPI, start date 1/23/2023.</p> <p>A review on 2/25/2025 at 8:57 AM of Resident #115's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for February 2025, revealed that the resident was given PRN Acetaminophen (2 tabs 325 mg) on 2/20/2025 at 8:28 AM for a pain score of 4. PRN Oxycodone 5 mg was given at 11:52 AM on 2/18/2025 (no pain score indicated). However, there was no documentation that non-pharmacological (use of non-chemical methods to reduce pain without medications) interventions were attempted prior to administering PRN pain meds as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of MAR and TAR for January 2025 revealed Resident #115 was given Acetaminophen 650 mg on 1/6/2025 at 2216 (10:16 PM) for a pain score of 6. The order was to give 650 mg for Mild pain (or if requested by patient for Moderate or Severe pain). However, there was no staff documentation that the Acetaminophen was given per Resident #115's request for a pain score of 6 (moderate pain). Further review revealed that there was an order for Oxycodone 5 mg for moderate or severe pain that was not administered. Moreso, staff did not document any non-pharmacological interventions attempted prior to administering a PRN pain medication as per physician orders.</p> <p>Review of Resident #115's care plan on 2/25/2025 at 10:17 AM revealed a care plan focus for pain with a canceled goal and no interventions, initiated on 12/31/2024 with revision on 2/24/2025. This care plan was not comprehensive and resident centered.</p> <p>During an interview with Registered Nurse (RN #28) on 2/25/2025 at 11:40 AM, she stated that the following parameters were used when assessing a resident's pain: pain scale of 0-3 mild, 4-6 moderate, and 7-10 severe pain. She added that the expectation was to assess a resident's pain level and review the pain medication parameters prior to administering any PRN pain medication. During the interview, surveyor reviewed Resident #115's MAR and TAR for February 2025: RN #28 verified and confirmed that she administered the resident PRN Oxycodone on 2/18/2025 at 11:52 AM and PRN Acetaminophen on 2/20/2025 at 8:28 AM. Surveyor further reviewed the Non-pharmacological interventions that were listed and RN #28 verified that there was no documentation on the days/times when she gave Resident #115 PRN pain medications that any non-pharmacological intervention was attempted. Thus, validating that non-pharmacological interventions were not attempted prior to administering PRN pain meds as per physician orders. Regarding Care Plans, RN #28 stated that care plans were done by MDS (Minimum Data Set) Coordinator, Unit Managers, and the DON (Director of Nursing).</p> <p>In an interview with the Director of Nursing (DON) on 2/26/2025 at 8:26 AM, surveyor reviewed Resident #115's MAR and TAR for January and February 2025: DON verified that staff did not document that they were attempting non-pharmacological interventions prior to administering PRN pain medications as ordered by the physician.</p> <p>Surveyor reviewed Resident #115's care plan with the DON: DON verified that the care plan Focus: The resident has (Specify: acute/chronic) pain r/t (blank space) Date initiated 12/31/2024 with Revision on 2/24/2025 did not have any goals and/or interventions and was incomplete. However, DON stated that a care plan was developed for pain and showed the surveyor a care plan with Focus: [Resident's name] has Potential for alteration in comfort r/t acute illness/Chronic Morbidities initiated on 1/24/2025 and revised on 1/24/2025. The Goal was: [Resident name] will express level of comfort daily AEB (as evidenced by) 0 score on pain scale x 90 days initiated and revised on 1/24/2025. The Interventions initiated and revised on 1/24/2025 were: Administer analgesic medication as ordered and Pain assessment Q shift and PRN.</p> <p>However, the above interventions were not comprehensive and resident centered. They failed to address attempting non-pharmacological interventions as per physician orders and/or indicate what to do if the pain meds given were not effective (such as notifying the doctor/provider). There was no indication of monitoring for side effects of the pain meds (e.g. sedation, constipation) and what to do/prevent the side effects.</p> <p>44441</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) On 2/20/25 at 8:40 AM, review of MD00208110 had that Resident #431 was not getting their pain medication as ordered, causing resident to be in a significant amount of pain.</p> <p>Review of the Physician's order on 2/20/25 at 8:50 AM revealed an order for pain medication Oxycodone dated 6/2/24: Oxycodone HCl ER Oral Tablet ER 12 Hour Abuse Determent 10mg (Oxycodone HCl) Give 1 tablet by mouth two times a day for chronic pain.</p> <p>On 2/21/25 at 9:00 AM review of July 2024 Medication administration audit records revealed that the Oxycodone pain medication scheduled to be given at 8:00 AM and 8:00 PM daily, was given more than 2 hours late on 7 different occasions by the morning shift as follows:</p> <p>On 6/9/24 medication was given at 15:38, 6/10/24- Given at 11:01, 6/11/24- given at 11:16, 6/17/24-given at 10:48, 6/19/24-given at 11.14, 6/26/24- given at 12:10, 6/30/24-given at 10:53.</p> <p>On 2/21/25 at 9:34 AM in an interview with the Director of Nursing (DON). She was asked about the medication administration policy and time ranges for scheduled medications. She stated that medications are to be given an hour before and an hour after, for all scheduled medications. She was made aware that Resident #431 got their pain medications more than 2 hours late past their scheduled administration times on 7 different occasions in the month of June 2024. She said she will double check it. She came back to confirm that the medications were given late on those dates and stated she would follow up.</p> <p>49409</p> <p>3) On 02/25/25 at 04:46 PM, a record review of Resident #38 revealed that, on 07/12/24, the physician ordered a dental consult due to the dental bridge being loose and the implants needed to be removed. While the resident was waiting for the dental appointment, the facility failed to do a pain assessment. Progress notes regarding dental pain were not documented.</p> <p>Further record review revealed that the Resident (#38) received Acetaminophen Oral Tablet 500 MG, one tablet by mouth every 8 hours as needed for Pain. The Resident received Tylenol in July 2024, on 7th at 6:24, 13th at 5:59, 22nd at 1:53 and 31st at 5:31pm. No documentation of pain assessment and whether the Tylenol administration was effective or not.</p> <p>On 02/25/25 at 12:09 PM, an interview with Licensed Practical Nurse (LPN) staff #44 revealed that Resident # 38 had issues with his/her dental implants and was in pain for some time. The Resident was not able to see the Dentist timely. Staff #44 added that, due to dental pain, the facility had to downgrade the consistency of the Resident's diet.</p> <p>On 02/25/25 at 2:10 PM reviewed with the Director of Nursing (DON), and the DON acknowledged.</p>

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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 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51789</p> <p>Based on record review, observation, and resident and staff interviews, it was determined the facility failed to provide culturally competent, trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization for a resident with Post-Traumatic Stress Disorder (PTSD). This was evident for 1 (#145) of 2 residents reviewed for Behavioral-Emotional care during the recertification/complaint survey.</p> <p>The findings include:</p> <p>Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization.</p> <p>On 2/18/2025 at 11:11 AM, resident #145 was interviewed. He/she stated, I have nothing to do here; I want to be out here.</p> <p>On 2/21/2025 at 11:44 AM, an electronic medical record review was conducted. Resident # 145 has a history diagnosis of PTSD (post-traumatic stress disorder). He/she was initially admitted to the facility on [DATE], discharged on [DATE], and returned to the facility on [DATE]. He/she was hospitalized on [DATE] due to a medical condition and was readmitted on [DATE].</p> <p>Further review revealed that he/she was receiving psychiatric and psychological services. The psychiatric evaluation dated 3/26/2024 noted the resident's mood seemed anxious, with mild sleep disruption. The provider's recommendation was to monitor the mood and behavior changes, provide supportive care, and encourage activity participation and socialization. On 8/20/2024, he/she was seen by the psychiatrist due to anxiety and agitation. It was documented that the resident attempted to elope and has been increasingly restless and agitated. The resident has a history of PTSD (post-traumatic stress disorder) but was not taking any psychoactive medication. The plan was to start with Lexapro 5 mg once a day for anxiety and agitation, monitor mood and behavior changes, and provide supportive care. No documentation found for mood and behavior monitoring. On 2/4/2025 and 2/25/2025, respectively, he/she attempted to be seen by the psychiatric provider due to grieving, and the resident was noted to be anxious and irritable. He/she expressed that he /she wanted to get out of there and preferred to be seen by the psychiatrist from the Veterans Administration. Both visits were documented to monitor mood and behavior changes and provide supportive care. No documentation was found for mood and behavior monitoring and the effectiveness of the psychoactive medication.</p> <p>In addition, psychological services were provided. He/she was seen on 1/8/2024, 6/24/2024, and 2/14/2025 consecutively, all confirmed for the resident to have depression in various degrees.</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49409</p> <p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>Based on observation, medical record review, and interview with staff, it was determined that the facility failed to promptly ensure that the Resident received the recommended dental services. This was evident for one Resident # 38 out of five Residents reviewed for dental services during the recertification/complaint survey.</p> <p>The findings include:</p> <p>On 02/18/25 at 10 AM, the surveyor observed Resident # 38 missing teeth (both upper and lower jaws) and four front loose teeth (incisors) of the lower jaw. The Resident's initial admission was on 04/07/2022, and he/she remained at the facility as a long-term care Resident.</p> <p>On 02/18/25 at 01:18 PM, a medical record review revealed that Resident #38 had a Doctor's order dated 07/12/24; dental consult 6-11 bridge failing. Recommendation EXT of the bridge by outside office: 1/10/25 Dietician and Nurses progress notes reveal that the dental procedure was pending.</p> <p>On 02/25/25 at 08:45 AM further medical record review revealed that the nurse's progress notes From 8/6/2024 at 12:43 PM stated the Resident was back to unit from a dentist appointment, Resident not seen due to insurance clarification RP made aware. The nurse's progress notes on 10/31/25 stated that Resident #38 returned from Dentist with no additional documentation noted. A Consult from Aspen Dental dated 11/20/24 and 12/06/24 reveals that the Resident had a tooth extraction. The 12/06/24 consult recommended a follow-up visit on 01/15/2025 at 2:15 PM; the facility rescheduled the appointment.</p> <p>On 02/25/25 at 12:09 PM, an interview with Licensed Practical Nurse (LPN) # 44 revealed that Resident # 38 had issues with dental implants and was in pain for some time. The Resident has VA insurance, resulting in delays in getting treatment. Diet consistency was downgraded as the resident was in pain. The Resident may have another appointment coming up.</p> <p>On 02/25/25 at 12:14 PM, Reviewed with the unit manager, staff # 40, and the Unit manager validated the order for a dental consult from 07/12/24 and other appointment delays, including the dates.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51128</p> <p>Based on observation, interviews, and medical record review, it was determined that the facility failed to ensure that residents who require dental services on a routine or emergent basis receive necessary or recommended dental services in a timely manner. This was evident for 2 (#11, #23) of 5 residents reviewed for dental services during the recertification/complaint survey.</p> <p>1) On 02/18/25 at 11:35 AM, Resident #11 stated that she/he could not get a dental appointment for his/her top and bottom teeth. The surveyor observed missing teeth and side teeth with visual cavities.</p> <p>On 02/19/2025 at 1:52 PM, a record review revealed that Resident #11's MDS, dated [DATE] and 2/22/25 under Dental/Oral Evaluation, indicated that the resident has obvious or likely cavities or broken natural teeth. The care plan initiated date of 10/21/2024, with a revision date of 02/05/2025, noted that the resident had oral/dental health problems, such as missing and broken teeth. The care plan initiated on 02/06/2025 further indicated that dental care and transportation arrangements should be coordinated as needed and as ordered.</p> <p>During the interview on 02/19/25 at 2:03 PM, with the Director of Nursing (DON), when asked how dental services are provided to the residents, the DON stated that a company called National Preventive Solutions (NPS) provided a list of the residents via email of who they will service when they come to the facility. When asked how the residents get on the list, the DON stated that the unit secretary (Staff # 6) sends the names to NPS based on consultation orders.</p> <p>On 02/19/25 at 2:45 PM, an interview was conducted with Staff #6, who stated that the provider put in the consultation order, and she/he called NPS and provided the names for the dental consultation. Those names will be placed in the dental appointment book at the nurse's station. The surveyor could not locate Resident #11's name in the appointment book for the past three months.</p> <p>On 02/20/25 at 08:22 AM, the DON provided the surveyor with an NPS email dated 2/19/25 at 4:03 PM stating that Resident #11 would be added for the next dental visit. The surveyor discussed with the DON that Resident #11 was not on the list before 2/19/25, which was a concern, and the DON agreed.</p> <p>2) During an interview on 02/18/25 at 11:55 AM, Resident #23 stated that he had not seen a dentist in two years and that he/she would like to get an appointment to be seen.</p> <p>On 02/20/25 at 12:35 PM, a record review revealed an order for dental consult annually and as necessary, dated 2/10/25 and signed off by the physician on 2/20/25.</p> <p>On 02/20/25 at 01:55 PM, an interview was conducted with the DON, who stated that dental consultations should be put in on admission, and the dental consultation order dated 2/10/25 was after a re-admission. The surveyor informed DON that the resident had been at the facility since 2/16/2023. Furthermore, there were past dental consultations ordered on 09/08/2024 and 12/01/2024.</p> <p>(continued on next page)</p>		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/2025 at 0745AM, the DON stated that NPS informed her/him that they had never seen Resident #23 for any dental consultations. The DON also stated that the scheduler would inform NPS to add the resident's name to the upcoming schedule list to be seen by the dentist. The DON acknowledged that Resident #23 should have been seen by the dentist annually.		

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<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>49304</p> <p>Based on observations, interviews with facility staff, and review of the facility's documentation, it was determined that the facility failed to accurately provide a meal based on the facility's established menu and respect residents' right to make choices about their diet. This was evident for 10 of 64 residents (Resident #147, #169, #524, #523, #149, #525, #450, #451, #452, #453) reviewed for accuracy of meals during a recertification/complaint survey.</p> <p>The findings include:</p> <p>The Certified Dietary Manager (CDM #62) was interviewed during an observation in the kitchen on 2/24/25 at 12:07PM. When asked how residents choose meals, he stated they have a menu with the 4 week cycle of meals and a copy of the menu is also provided by the activities staff. Residents can call or put in a ticket during certain times if they want to make any changes and so a resident will receive the listed menu items [referred to as the Regular meal] unless they request something different. The Regular meal being served for lunch was Dijon Pork Loin, Capri Vegetable Blend, and [NAME] Pilaf as observed by the surveyor on the menu hanging inside the kitchen.</p> <p>On 2/24/25 at 12:30 PM the District Manager (DM #61) was observed crossing off and writing on a meal ticket. When asked why, DM #61 stated it was the resident's preference not to have pork and the chicken they requested was not available, so they are getting the alternative meal, a hamburger.</p> <p>On 2/24/25 at 1:13 PM the surveyor found the meal ticket on the unit that DM #61 had crossed out which had listed the Regular meal. The Dijon Pork Loin was crossed out and Hamburger was handwritten underneath. The resident, Resident #523, who received that ticket and meal was interviewed. During the interview, Resident #523 stated she did not want the hamburger and did not request it.</p> <p>On 2/24/25 at 1:29PM DM #61 was interviewed. When asked what happened during the lunch service and the resident who received the alternative meal, she stated there was not enough pork. Dietary [NAME] #59 ran out of 7-8 portions of the pork loin because he was over portioning the plates. During the interview, DM #61 stated there were about 7-8 plates that did not get the pork loin because we ran out and so those residents got the alternative.</p> <p>On 2/25/25 at 10:34 AM the Director of Nursing (DON) provided a list of 10 residents (Residents #147, #169, #524, #523, #149, #525, #450, #451, #452, #453) who did not receive the pork loin but had chosen it for their lunch on 2/24/25.</p> <p>On 2/25/25 at 10:49 AM CDM #62 was interviewed. When asked if the residents who received the alternative [hamburger] yesterday were given a choice or made aware prior to the receiving the alternative, he stated no, but there were no complaints.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47200</p> <p>Based on observation and interview it was determined the facility failed to: 1.) ensure the plate warming device was in operating condition, 2.) ensure foods were labeled, 3.) ensure accuracy of food discard dates, 4.) ensure food was not adulterated, 5.) ensure stored food was covered/protected, 6.) ensure kitchen surfaces were free from dust/debris, 7.) ensure food preparation surfaces were free from personal belongings, 8.) ensure the ceiling was free from chipping paint, and 9.) ensure kitchen equipment was clean and in good repair. This was evident during the surveyor's initial tour of the facility's kitchens during the facility's recertification/complaint survey.</p> <p>The findings include:</p> <p>During the surveyor's initial tour of the facility's main kitchen on 2/18/25 at 7:59AM the surveyor observed the exterior metal surface of the dishwasher and noted areas of peeling plastic were present and black debris was present.</p> <p>On 2/18/25 at 8:01AM the surveyor observed orange colored splattering on the wall and flooring next to the juice/drink machine in the main kitchen.</p> <p>On 2/18/25 at 8:01AM the surveyor observed liquid stains which were white in color present on the exterior of the lid on the ice machine, and brown matter was observed on the control button pad for the ice machine in the main kitchen.</p> <p>On 2/18/25 at 8:01AM the surveyor observed there were no paper towels present at the hand washing sink in the main kitchen.</p> <p>On 2/18/25 at 8:03AM the surveyor observed several areas of spilled white powder on the floor in the main kitchen.</p> <p>On 2/18/25 at 8:06AM the surveyor observed an unlabeled bag of wedge cut food in the freezer in the main kitchen.</p> <p>On 2/18/25 at 8:09AM the surveyor observed a package of hard boiled eggs with no labeling present in the walk in refrigerator within the main kitchen.</p> <p>On 2/18/25 at 8:09AM the surveyor observed two pans of orange jello type dessert present in the walk in refrigerator with scooped areas present and no covering present within the main kitchen.</p> <p>On 2/18/25 at 8:09AM the surveyor shared concerns and conducted a dual observation with Dietary [NAME] #59 who confirmed and acknowledged understanding of the concerns.</p> <p>On 2/18/25 at 8:23AM the surveyor conducted an initial tour of the facility's additional (second) kitchen.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/18/25 at 8:23AM the surveyor observed a food preparation table in the second kitchen with the following items present on it: an ice scoop sitting directly on the food preparation table surface next to a staff members half full bottle of soda and purse and keychains which were sitting directly on the food preparation table surface, with one broken dish crate holding side item bowls observed to have dried, crusted, brown food debris present on them, and holding a side item bowl with side item food present in it with a lid on it, and the crate containing milk cartons.</p> <p>On 2/18/25 at 8:24AM the surveyor observed the hand held device utilized to fill/pour containers of lemonade and fruit punch resting on the floor of the second kitchen.</p> <p>On 2/18/25 at 8:24AM the surveyor observed areas of peeling and missing paint throughout various areas of the kitchen's ceiling and surrounding the fluorescent light fixtures, and was noted to be present within the cooking area, food preparation area, and over the food serving line while food was being plated in the second kitchen.</p> <p>On 2/18/25 at 8:25AM the surveyor observed a layer of brown and black matter present on a cream colored pipe extending above the serving line where food was being plated in the second kitchen.</p> <p>On 2/18/25 at 8:27AM the surveyor observed the following in the reach in refrigerator of the second kitchen: two white containers with cream colored liquid in them with blank labels, two white containers of spilled yellow colored liquid which were covered with saran wrap with blank labels, prepared gluten free pancake batter dated as made on 2/12/25 and dated for expiration on 2/26/25, a partially uncovered side of cut up celery pieces with brown and white areas present on them with no labeling, and a side of tossed salad in which the contents had areas which were brown in color with no date present.</p> <p>On 2/18/25 at 8:32AM the surveyor conducted an interview and conducted a dual observation of the concerns with Kitchen Account Manager (KAM) #58. Regarding the pancake batter, KAM #58 stated to the surveyor: It keeps for 7 days, I'm not sure why it is labeled for 16 days. The surveyor shared all concerns and KAM #58 acknowledged and confirmed understanding of the concerns. The surveyor observed KAM #58 instruct kitchen staff as to having reminded them before about personal items not being allowed on the food prep surfaces.</p> <p>On 2/18/25 at 8:33AM the surveyor observed two wells present on the plate warming system, and observed that the well which was not holding any plates had a button with a red indicator light which was on, and the remaining well which held plates which were currently being used for the breakfast meal service had a button with a red indicator light which was not on. The surveyor felt for warmth over and on the system and the plates, and the plates and system were found to be cold to the touch.</p> <p>On 2/18/25 at 8:34AM the surveyor observed a sanitizer bucket below the serving line which contained cloudy liquid with a film and white particles present on the top of the liquid.</p> <p>On 2/18/25 at 8:34AM the surveyor observed that 4 out of 6 indicator lights were missing from the steam table where food was being held during service.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/18/25 at 8:34AM the surveyor conducted an interview with KAM #58 regarding the plate warming system. When the surveyor inquired as to how long the system had not been working they stated: It works. The surveyor observed them attempt to depress the button for the well which contained the plates being used for service and KAM #58 was unable to get the button to depress and the indicator light did not turn on, and the system and plates were again felt to be cold.</p> <p>On 2/18/25 at 8:38AM the surveyor shared their concerns with KAM #58 who acknowledged and confirmed understanding of the concerns.</p>		

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>45131</p> <p>Based on record reviews and interviews, it was determined that the facility failed to accurately assess and update the Facility Assessment as required. This deficient practice has the potential to affect all residents in the facility.</p> <p>Findings Include:</p> <p>The Facility Assessment evaluates its resident population and identifies the resources needed to provide the necessary care and services that the residents require.</p> <p>On 02/26/25 at 02:59 PM, a review of the facility assessment revealed that the assessment failed to accurately identify all available resources within the facility. The following resources were inaccurately assessed and documented on the Facility Assessment form: 1) a special care unit within the facility, 2) the social worker and 3) the infection preventionist (IP).</p> <p>1) On 02/27/25 at 11: 21 AM, in an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON), they were asked about the facility assessment completion date, and they provided documentation of 01/17/25 completion date.</p> <p>The review of the facility capacity and physical characteristic description section of the assessment revealed, Specialty Units (dementia, Life enrichment, etc) and the facility response was 1. The NHA was asked about a specialty unit identified on the 01/17/25 facility assessment, the NHA said, it is a secure unit, not specialty care, the assessment form should have said zero</p> <p>2) On 02/26/25 at 02:59 PM, a review of the Facility Assessment revealed that on page 39 the assessment identified one full-time social worker.</p> <p>On 02/27/25 at approximately 11:21 AM, the Nursing Home Administrator (NHA) stated that they did not have a full-time licensed social worker; however, they have a contract social worker that visits once per month and 2 PRN (as needed) social workers.</p> <p>3) On 2/27/25 at 10:00 AM, a review of the Facility assessment revealed that the IP was not listed.</p> <p>In an interview with the NHA, he stated that LPN #27 and the DON covered the IP's role. However, the Facility Assessment failed to identify the IP's role.</p> <p>On 2/27/25 at approximately 11:00 AM, the surveyor informed the NHA and the DON that a facility with a bed capacity of 120 beds or more is required to have a full-time qualified social worker and that the infection preventionist was not identified in the facility assessment as required. They both acknowledge the above-mentioned concern.</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>43096</p> <p>Based on review of the medical record and staff interview, it was determined that the facility failed to ensure accurately documented resident's health condition. This was found to be evident for 1 (Resident #73) out of 3 residents reviewed for pressure ulcers during this annual survey.</p> <p>The findings include:</p> <p>On 2/22/25 at 8:50 AM, the surveyor reviewed Resident #73's medical records. The review revealed that the resident had sacrum, Right heel, and Left heel wounds upon his/her admission in July 2024.</p> <p>Further review of Resident #73's wound status by weekly skin assessment and wound consultation notes revealed that the Left heel pressure ulcer was resolved on 7/24/24 and re-started on 8/28/24 with worsening status.</p> <p>However, the Treatment Administration Records (TAR) of July and August 2024 documented the order of Left heel: Betadine and leave it open to air. everyday shift for wound treatment from Resident #73's admission till 12/17/24.</p> <p>During a phone interview with a wound consultation doctor (Staff #57) on 2/24/25 at 2:02 PM, he explained that betadine would be used for dried wounds. However, Staff #57 confirmed that betadine should not be used for healed skin (wound). Also, Staff #57 added that the order should be revised based on their wound condition.</p> <p>In an interview with the Director of Nursing (DON) on 2/24/25 at 2:40 PM, the surveyor reviewed Resident #73's TAR with the DON. She stated that the order should be discontinued that day if the left heel pressure wound resolved on 7/24/24. The DON validated the surveyor's concerns about inaccurate documentation.</p>

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>45131</p> <p>Based on interviews and an administrative record review, it was determined that the facility failed to have a full-time qualified social worker for the number of licensed beds exceeded 120 in the facility. This facility was licensed for 190 certified beds. This was evident during the recertification/complaint survey and had the potential to affect all residents, as a result an extended survey was conducted.</p> <p>Findings Includes:</p> <p>On 02/19/25 at 12:15 PM, in an interview with the Nursing Home Administrator (NHA) and the Director of Nursing (DON) it was revealed that the facility's licensed social worker comes in once a month. The NHA stated that they have 3 licensed social workers who work on a part-time/as needed basis, and there was full-time social services designee who did not have a qualifying bachelor's degree.</p> <p>On 02/21/25 at 10:17 AM in an interview with the facility social service designee (Staff #2), she revealed that she was not a licensed social worker. She has been working since August 2022 as full-time social service designee . She has a supervisor who is a licensed social worker and her supervisor emails a couple of times a week and checks in periodically.</p> <p>On 02/25/25 01:56 PM, in an interview with the NHA and DON, they were made aware of the concern that there was no qualified full-time social worker in the facility. The surveyor requested that the facility provide the documentation to support that they have a qualified social worker with a related degree or license.</p> <p>On 02/25/25 02:50 PM, the NHA provided the surveyor with a copy of the licensure documentation obtained for the following social workers: Staff #5, Staff #29 and Staff #30; however, there was no documentation to suggest that the facility social worker designee (Staff #2) had any qualifying documentation.</p> <p>On 02/27/2025 at approximately 11:00 AM, in an interview with the NHA and the DON, the surveyor asked how long the facility has been without a qualified full-time licensed social worker and the stated January 2025, the documented evidence provided also suggested that the previous social worker was employed until 01/17/2025. They were made aware that the above-mentioned finding was a concern.</p> <p>On 02/27/2025 at approximately 2:00 PM, during the exit conference the NHA and the DON were made aware that the lack of a full time social worker resulted in an extended survey and they both acknowledged the findings.</p>

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>49304</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of facility records and interviews with facility staff, it was determined the facility staff failed to ensure the required committee members consistently attended monthly Quality Assurance (QAPI) meetings.</p> <p>The findings include:</p> <p>On 2/27/25 at 9:42 AM review of the facility's Quality Assurance and Performance Improvement (QAPI) Plan policy revealed, The QAPI Committee members consist at minimum of: Administrator, Director of Nursing (DON), Quality Assurance (QA) Coordinator, Infection Preventionist (IP), Staff Development, Department Heads, Vendors (including pharmacy), and a GNA (Geriatric Nursing Assistant).</p> <p>Review of the facility's QAPI monthly attendance records for 1/2024 to 12/2024 revealed the following:</p> <ol style="list-style-type: none"> 1. A Geriatric Nursing Assistant failed to attend 4 of 12 meetings (February 2024, October 2024, November 2024, December 2024). 2. The Medical Director failed to attend 1 of 12 meetings (February 2024). 3. The Director of Nursing failed to attend 1 of 12 meetings (April 2024). <p>On 2/27/25 at 10:52 AM in an interview with the DON and Administrator attendance sheets for the QAPI committee were reviewed and they confirmed the surveyor's findings.</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** 49409</p> <p>Based on the surveyor's observation, medical record review, and staff interviews, the facility failed to implement an effective infection control program by 1) failed to change oxygen tubing as per the facility protocol. This was evident for one Resident (Resident #38) out of 34 Residents reviewed for infection control, and 2) ensure that they implemented and maintained an effective infection control program related to transmission-based precaution and enhanced barrier precaution protocols: including isolation precaution posted signs on rooms. This was evident by 3 (Resident # 73, # 100 and #119) of 34 residents and 3 residents' rooms reviewed during the recertification/complaint survey.</p> <p>The findings included:</p> <p>1) On 02/18/25 at 01:23 PM, the surveyor observed Resident #38 receiving continuous oxygen via nasal cannula, and oxygen tubing was labeled with a date of 02/02/25.</p> <p>On 02/18/25 at 2 PM, an Interview with a Licensed Practical Nurse (LPN) validated that the date on the tubing was 16 days old and clarified that the facility changes oxygen tubing weekly.</p> <p>On 02/25/25 at 04:06 PM, record review revealed that there was no order to change the oxygen tubing; the facility immediately added a new order to change the oxygen tubing weekly.</p> <p>2) On 02/18/25 at 09:40 AM, the surveyor noted a poster on the doors of rooms #227, #230, and # 239 which had the following instructions: Special Droplet / Contact precautions; Clean hands when entering and leaving the room, Wear Mask, Wear eye protection, Gown and glove at the door, Keep doors closed, Use patient dedicated or disposable equipment, clean and disinfect shared equipment, and contact infection control prior to discontinuing precautions.</p> <p>An interview with Geriatric Nursing Assistant (GNA) staff # 63 on 02/18/25 at 10:45 AM, revealed that the Resident in room [ROOM NUMBER] has repeated urinary tract infections (UTIs) and has something in the Resident's urine. GNA added that staff working with the Resident in room # 230 must wear gowns for protection.</p> <p>Interview with Licensed Practical Nurse (LPN) staff # 44 stated that the facility had a Covid 19 outbreak and closed the outbreak two weeks back. He/she added that the posters should have been removed two weeks back. Staff # 44 immediately removed posters from the doors of rooms # 227, #230, and #239.</p> <p>On 02/27/25 at 10:36 AM, a medical record review of the residents from rooms # 227, #230, and #239 confirmed that the Residents who were in the three rooms with posters on their doors did not have any active health conditions requiring isolation precautions.</p> <p>On 02/27/25 at 10:38 AM, Reviewed the oxygen tubing change for Resident #38 and the infection control precaution posters on residents' doors, with the Director of Nursing (DON) and the DON acknowledged.</p> <p>51789</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>3) On 2/25/2025 at 12:46 PM, an interview with Staff # 27 was conducted. The surveyor asked if there was any transmission-based precaution case presently. Staff # 27 responded No, we do not have any case. A further question was asked by the surveyor: How would you identify any resident who was on antibiotics? Staff # 27 responded, we reviewed daily from the electronic medical records and data from the order listing report and identified who was on antibiotics, we checked the laboratory results, verified the diagnosis and notified the provider.</p> <p>On 2/26/2025 at 12:57 PM, it was observed that Resident # 73 had signage for contact precaution on the door and an isolation cart in front of his/her room.</p> <p>On 2/27/2025 at 11:06 AM, an electronic medical review was conducted. Resident # 73 has a Tube feeding and a pressure ulcer Stage 4. An order for the Enhanced Barrier Precaution (EBP) was initiated on 7/9/2024 and was discontinued on 8/4/2024. Further record review revealed that on 2/24/2025, Resident # 73 had a change in condition due to a positive laboratory result for Clostridium difficile. On 2/25/2025, a physician order was made for Fidaxomicin (an antibiotic) 200 mg oral tablet twice a day for 10 days. A care plan for Clostridium difficile infection was initiated on 2/25/2025. No order for contact isolation precaution was found in his/her record.</p> <p>On 2/27/2025 at 11:46 AM, the Staff # 53 (Geriatric Nursing Assistant) was interviewed. Staff stated he was aware of the contact precaution for Resident # 73, and that made me take care of him/her the last among my assigned residents. The surveyor asked what was the reason for the contact isolation precaution for resident # 73? and the staff responded because of his/her Gastrostomy tube. Staff # 53 added that he would wear his gloves and was pointing to the yellow material inside the isolation cart in front of the room. The staff was not able to verbalize the name of the yellow material in the cart. The surveyor asked: Where do you put the personal protective equipment after doffing? The staff answered: I put it in the regular trash. It was observed that there was no trash bin available in the resident's room accessible to dispose of used personal protective equipment.</p> <p>The concerns were discussed with the Director of Nursing (DON) on 2/27/2025 at 12:20 PM. The DON had no response to the findings.</p> <p>4) On 2/20/2025 at 07:57 AM, A Record review was conducted. Resident # 100 has a Diagnosis of Dysphagia following Cerebral Infarction and gastrostomy. He/She had a physician order for the Enhanced Barrier Precaution (EBP). No care plan for the enhanced barrier precaution was found.</p> <p>On 02/20/25 at 08:05 AM, Staff # 12 (Licensed Practical Nurse) was observed providing tube feeding care to Resident # 100 without wearing the required personal protective equipment.</p> <p>On 2/20/2025 at 8:07 AM, an interview with Staff # 12 (Licensed Practical Nurse) was consulted. The surveyor asked if Resident # 100 was on the Enhanced Barrier Precaution. Staff #12 responded yes because he/she has the feeding tube. A follow-up question was asked: What was your process for tube feeding care? I usually wash my hands and wear gloves; I do not need to wear the gown because there was no direct contact and this resident has no wounds. I had to hang the tube feeding formula and provide the medications through the gastrostomy tube. I had to remove my gloves and perform handwashing.</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>On 2/21/2025 at 1:23 PM, Staff # 14 (Licensed Practical Nurse) was interviewed. The surveyor asked, what was your process for tube feeding care for a Resident # 100? I washed my hands and wore gloves, masks, and a gown for infection control. For the medication administration through the gastrostomy tube, I crushed the pills separately, administered them through the tube, added the flushes, and repeated them for each medication.</p> <p>On 2/21/2025 at 1:29 PM, a family member was interviewed and stated, she observed that the staff were not wearing gowns; staff were only wearing gloves and masks when providing tube feeding administration and care.</p> <p>On 2/26/2025 at 9:01 AM, the Director of Nursing (DON) was interviewed. The surveyor asked what the criteria were for the Enhanced Barrier Precaution (EBP). DON stated that any resident with enteral tubes, chronic wounds, indwelling catheters, tracheostomy, and central lines required the use of EBP. DON agreed that staff should wear gowns and gloves during tube feeding care, including medication administration and accessing the enteral tube.</p> <p>5) On 2/18/2025 at 3:02 PM, the surveyor observed Resident # 119, who has tube feeding, to have no sign posted on his/her door for the Enhanced Barrier Precaution (EBP).</p> <p>On 2/25/2025 at 10:46 AM, the surveyor observed that Resident # 119 had no sign posted on his/her door for the Enhanced Barrier Precaution.</p> <p>On 2/27/2025 at 12:20 PM, the DON was informed of the findings and gave no response.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47200</p> <p>Based on observation and interview it was determined the facility failed to 1) ensure the maintenance of the facility's exterior environment and 2) ensure that repairs were made, as needed, in resident areas as identified in 3 resident rooms/bathrooms. This was evident for 2 out of 2 facility buildings observed during the recertification/complaint survey process.</p> <p>The findings include:</p> <p>1) On 2/18/25 at 7:30AM upon initial surveyor entrance and tour of the facility, surveyors observed various areas of black and green debris/staining present on the outside exterior surface of the facility's main building.</p> <p>On 2/18/25 at 8:15AM the surveyor observed several windows with a white cloudy appearance on the facility's additional building.</p> <p>On 2/27/25 at 11:52 AM the surveyor conducted an additional observation of the exterior condition of the facility's main building and observed the following concerns: various areas of black and green debris/staining on the outside exterior building surfaces, two broken and frayed window screens, and approximately 13 windows were noted to have a white, cloudy appearance.</p> <p>On 2/27/25 at 11:55AM the surveyor requested to tour the exterior of the building with Director of Maintenance (DM) #4.</p> <p>On 2/27/25 at 12:00PM the surveyor conducted a dual observation and interview with DM #4 who stated the following in response to the surveyor's inquiry of the maintenance department's exterior preventative maintenance regarding the staining/debris observed on the building's exterior, two broken and frayed window screens, and approximately 13 windows noted to have a white, cloudy appearance: This has been like this for ten years, I asked about painting but we don't have anything currently scheduled, but I can call them now, the facility was bought in 2022 and prior to that, one of the needed repairs on the facility's list had been window replacement, the windows cannot be cleaned, the seals are the problem and moisture is getting in. DM #4 further reported to the surveyor that although power washing of the exterior had not been yet scheduled, it had been recommended in the past by an outside painting contractor for the exterior of the building to be soft power washed to remove the staining present. At this time, the surveyor's interview was paused in order to hear from a family member of a resident who expressed concern about the exterior appearance and maintenance of the building, and was observed pointing to their loved one's broken window screen, and reported to the surveyor that additionally, the interior window shade was not in working order so the resident could not see out of the window in their room even if the screen was to be repaired. At this time, DM #4 confirmed and acknowledged understanding of both the surveyor's concerns and the family member's concerns.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/27/25 at 12:05PM the surveyor requested for a dual observation of the building's exterior with the facility's Administrator. The surveyor showed the facility's Administrator their concerns and noted that when they showed them the black and green areas of staining/debris present on the exterior surface of the building, the concern was dismissed by the Administrator, and they stated the following: It's the paint, it's the color of the paint. The surveyor then shared their concerns again, and the facility Administrator confirmed and acknowledged understanding of the concerns and stated: Okay, thank you.</p> <p>On 2/27/25 at 12:25PM the surveyor observed additional areas of black debris/staining present on the exterior surface of the main building located within the resident patio area.</p> <p>42507</p> <p>2) On 2/18/2025 at 8:40AM, during initial pool screening, surveyor observed stained ceiling tile (from water damage) above toilet pot in shared bathroom in resident room [ROOM NUMBER].</p> <p>On 2/18/2025 at 9:00AM, surveyor observed stained ceiling tile (from water damage) above toilet pot and loose ceiling tiles in shared bathroom in resident room [ROOM NUMBER].</p> <p>On 2/21/2025 at 8:56 AM during an interview with Resident #139, surveyor observed that the resident's headboard had a pressboard that was damaged on the right side. The pressboard vinyl was off exposing the interior of the wood.</p> <p>Follow up observation was made of the resident's bathroom: The ceiling tile above the toilet pot in the bathroom still had the stains from water damage.</p> <p>On 2/21/2025 at 10:57 AM surveyor conducted an interview with the Maintenance Director, Staff # 4, who has worked in the facility for about [AGE] years, regarding how maintenance issues were communicated. He stated that the facility had 2 ways: 1) Maintenance logs on every unit and 2) TELS system (electronic system for repairs) that staff send request to. He added that maintenance staff look at the maintenance logs at least every other hour and TELS gives an alert to his phone every time a work request was put into the system.</p> <p>On 2/21/2025 at 11:05 AM, the surveyor did an observational environmental tour with the Maintenance Director (Staff #4): The following observations were made:</p> <p>A) Resident #139's head board had a damaged pressboard. Staff #4 stated that the bed was one of the older beds in the facility and he (Staff #4) was going to get the number and order a new headboard.</p> <p>B) Stained ceiling tile in the bathroom in resident room [ROOM NUMBER]: Staff #4 stated that there was a toilet on the 2nd floor directly on top of the one in room [ROOM NUMBER]. He stated that when that toilet overflows, the water leaks into the ceiling below it. However, he stated that he was going to replace the stained ceiling tile. Staff #4 added that they usually went around at least once a month checking and replacing damaged ceiling tiles. When asked if he was aware that the ceiling tile in the bathroom in room [ROOM NUMBER] was stained/damaged, Staff #4 stated he did not get a work order and did not know.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>C) Stained ceiling tile (from water damage) above toilet pot in shared bathroom in resident room [ROOM NUMBER] and loose ceiling tile. Staff #4 stated that it was as a result of the water leakage from the bathroom on the 2nd floor that was directly above this one in room [ROOM NUMBER]. He stated that he was going to replace it.</p> <p>D) The following observations were made in the bathroom in resident room [ROOM NUMBER]: VCT flooring behind toilet pot had some floor tiles with brownish/tan stains on them. The Baseboard (Cove base) behind the toilet pot was loose and hanging off the wall. Ceiling paint was chipped on some areas around the light bulb. Staff #4 stated that the chipped paint on the ceiling was because they had replaced a bigger light bulb that used to be there with a smaller light bulb. He stated that the loose Cove base will need to be glued back in place, the VCT flooring will need to be replaced, and they will have to sparkle and paint all the ceilings that had light bulbs replaced.</p> <p>On 2/26/2025 at 8:18 AM In an interview with the DON, surveyor reviewed findings of the above environmental observations/concerns mentioned above.</p> <p>On 2/26/2025 at 12:00 PM In an interview with the Nursing Home Administrator (NHA), surveyor reviewed the above environmental concerns: Resident #139's damaged headboard, stained and loose ceiling tiles in residents' bathrooms in rooms 102 and 105, and observations made in room [ROOM NUMBER] bathroom. NHA stated he was going to follow up to see if the concerns were addressed by maintenance and get back to the surveyor.</p> <p>On 2/27/2025 at 11:00 AM, prior to survey exit, NHA informed the surveyor that the aforementioned environmental concerns had been fixed except for the stained floor tiles (VCT flooring) in the bathroom in room [ROOM NUMBER]. However, these repairs were done after surveyor intervention.</p>		

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<p>F 0941</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members.</p> <p>51213</p> <p>Based on interviews and record review it was determined that the facility failed to ensure that staff received training in effective communication. This was evident for 9 of 9 (Staff #6, #7, #10, #42, #43, #44, #45, #46, and #47) reviewed during the Extended Survey investigation portion of the recertification/complaint survey.</p> <p>The findings Include:</p> <p>On 2/24/25 at 12:53 PM the Director of Human Resources (Staff #41) was interviewed about the employee training records for Staff #6, # 7, #10, #42, #43, #44, #45, #46, and #47. Staff #41 was asked if they have any additional employee training/ in-services other than what is currently in their files. Staff #41 said they would check their old education system called Care fed, and let the surveyor know tomorrow morning.</p> <p>On 02/24/25 at 2:20 PM the Director of Nursing (DON) was interviewed about employee files missing various training courses and that some staff had no name and no supervisor signature to verify the training. The DON said to check with the Director of Human Resources and that they would look into this issue.</p> <p>On 02/25/25 9:00 AM Additional staff education documentation was received from Staff #41 for Staff #6, # 7, #10, #42, #43, #44, #45, #46, and #47.</p> <p>On 02/25/25 9:41 AM Record review of the employee educational files revealed that all 9 files reviewed had no documentation for effective communication training. Staff #41 was informed that there was no documentation for Staff #6, # 7, #10, #42, #43, #44, #45, #46, and #47 for effective communication.</p> <p>On 02/27/25 at 10:00 AM Staff # 41 was asked who oversees staff education. Staff #41 replied, I am, I do the on boarding education for new hires and then the DON or nursing does the annual staff education. We currently do not have a staff educator. Staff #41 was asked once more; do you have any additional employee education or training records? Staff #41 replied no, I do not.</p>		

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<p>F 0946</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide training in compliance and ethics.</p> <p>51213</p> <p>Based on interviews and record review it was determined that the facility failed to ensure that all staff received their annual training for the compliance and ethic program. This was evident for 5 of 9 (Staff #42, #43, #44, #46 and #47) reviewed during the Extended Survey investigation portion of the recertification/complaint survey.</p> <p>The findings Include:</p> <p>On 2/24/25 at 12:53 PM the Director of Human Resources (Staff #41) was interviewed about the employee training records for (Staff #42, #43, #44, #46 and #47). Staff #41 was asked if they have any additional employee training/ in-services other than what is currently in their files. Staff #41 said they would check their old education system and let the surveyor know tomorrow morning.</p> <p>On 02/24/25 at 2:20 PM the Director of Nursing (DON) was interviewed about employee files missing various training courses and that some staff had no name and no supervisor signature to verify the training. The DON said to check with the Director of Human Resources and that they would look into this issue.</p> <p>On 02/25/25 at 9:00 AM Additional staff education documentation was received from Staff #41 for Staff # 42, #43, #44, #46 and #47.</p> <p>On 02/25/25 9:41 AM Record review of the employee educational files revealed that 5 of 9 files reviewed had no documentation for compliance and ethics training. Staff #41 was informed that there was no documentation for Staff #42, #43, #44, #46 and #47 for compliance and ethics training.</p> <p>On 02/27/25 at 10:00 AM Staff # 41 was asked who oversees staff education. Staff #41 replied, I am, I do the on boarding education for new hires and then the DON or nursing does the annual staff education. We currently do not have a staff educator. Staff #41 was asked once more; do you have any additional employee education or training records for Staff #42, #43, #44, #46, and #47? Staff #41 replied no, I do not.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>51213</p> <p>Based on interviews and record review it was determined that the facility failed to complete the annual nurse aide in-service training. This was evident for 1 of 3 (Staff #6 GNA) reviewed during the recertification/complaint survey.</p> <p>The findings Include:</p> <p>On 2/24/25 at 12:53 PM the Director of Human Resources (Staff #41) was interviewed about the employee training records for Staff #6, GNA. Staff #41 was asked if they have any additional employee training/ in-services other than what is currently in Staff #6, GNA employee file. Staff #41 said they would check and let the surveyor know tomorrow morning.</p> <p>On 02/24/25 at 2:20 PM the Director of Nursing (DON) was interviewed about employee files missing various training courses and that some staff had no name and no supervisor signature to verify the training. The DON said to check with the Director of Human Resources and that they would look into this issue.</p> <p>On 02/25/25 9:00 AM Additional staff education documentation was received from Staff #41 for Staff #6, GNA.</p> <p>On 02/25/25 9:41 AM Record review of the employee educational files revealed that 1of 3 GNA files reviewed had no documentation for annual nurse aide training. Staff #41 was informed that there was no documentation for Staff #6, GNA for their annual nurse aide training .</p> <p>On 02/27/25 at 10:00 AM Staff # 41 was asked who oversees staff education. Staff #41 replied, I am, I do the on boarding education for new hires and then the DON or nursing does the annual staff education. We currently do not have a staff educator. Staff #41 was asked once more; do you have any additional employee education or training records for Staff #6, GNA? Staff #41 replied no, I do not.</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>51213</p> <p>Based on interviews and record review it was determined that the facility failed to ensure that all staff received behavioral health training. This was evident for 3 of 9 (Staff #10 #43, and #46) reviewed during the Extended Survey investigation portion of the recertification/complaint survey.</p> <p>The findings Include:</p> <p>On 2/24/25 at 12:53 PM the Director of Human Resources (Staff #41) was interviewed about the employee training records for (Staff #10, #43, and #46). Staff #41 was asked if you have any additional employee training/ in-services other than what is currently in their files. Staff #41 said they would check their old education system and let the surveyor know tomorrow morning.</p> <p>On 02/24/25 at 2:20 PM the Director of Nursing (DON) was interviewed about employee files missing various training courses and that some staff had no name and no supervisor signature to verify the training. The DON said to check with the Director of Human Resources and that they would look into this issue.</p> <p>On 02/25/25 9:00 AM Additional staff education documentation was received from Staff #41 for Staff #10, # 43 and #46.</p> <p>On 02/25/25 9:41 AM Record review of the employee educational files revealed that 3 of 9 files reviewed had no documentation for behavioral health training. Staff #41 was informed that there was no documentation for Staff #10, # 43 and #46 for behavioral health training.</p> <p>On 02/27/25 at 10:00 AM Staff # 41 was asked who oversees staff education. Staff #41 replied, I am, I do the on boarding education for new hires and then the DON or nursing does the annual staff education. We currently do not have a staff educator. Staff #41 was asked once more; do you have any additional employee education or training records for Staff #10, #43, #46? Staff #41 replied no, I do not.</p>		