STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215001	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ballenger Creek	347 Ballenger Drive Frederick, MD 21701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide the resident or representative with an outcome and/or resolution following the conclusion of a grievance investigation for 1 (Resident 5) of 1 sampled resident.Findings included:A review of a facility policy titled, Resident and Family Grievances, dated 12/23/22 with a review date of 11/3/2025, revealed .Policy Explanation and Compliance Guidelines.10. Procedure: . e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances.g. In accordance with the resident's rights to obtain a written decision regarding their grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include, at a minimum: i. The date the grievance was received. ii. The steps taken to investigate grievance, iii. A summary of the pertinent findings or conclusions regarding the residents' concerns. iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility because of grievance. vi. The date the written decision was issued. For investigations regarding allegations of neglect, abuse, injuries of unknown source, and/or misappropriation of resident property, a report of the investigative results will be submitted to the State Survey Agency, and other officials in accordance with State law, within five working days of the incident.A resident demographic record revealed the facility admitted Resident (R) 5 on 3/19/24. The resident had a medical history that included cerebral infarction, aphasia, heart failure, atherosclerotic heart disease, type 2 diabetes mellitus, cardiomyopathy, protein-calorie malnutrition, hypothyroidism, depression, atrial fibrillation, chronic kidney disease stage 4, cognitive communication deficit, traumatic brain injury, and recent pleural effusion.An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed R5's Brief Interview for Mental Status (BIMS) score was 15/15, indicating s/he was cognitively intact. However, a quarterly MDS dated [DATE] revealed a BIMS score of 3/15, indicating severe cognitive impairment following a recent hospital stay.The grievance report dated 9/5/25 was reviewed and addressed three topics, one of which addressed an allegation of abuse. The alleged verbal/mental abuse was reported to have occurred on 9/4/25. It was witnessed by a family friend who reported it to the complainant, who then reported it during the resident's care meeting on 9/5/25. The complainant reported that Licensed Practical Nurse (LPN4) called the resident a racist, banged on his/her bed, and bullied the resident. The allegation of abuse was not addressed in the outcome or resolution. An interview with Guest Services (GS) 9 on 11/19/25 at 12:20 p.m. revealed she had received a grievance form from Registered Nurse (RN) 12 on 9/5/2025. When asked to review the grievance forms related to the alleged verbal abuse by LPN6 and the bowls and containers dated 9/5/25, GS9 noticed the primary complaint was regarding the nurse's alleged verbal/mental abuse. Still, the majority of the resolution addressed the paper bowls and containers, noting that the facility replaced them and that the resident and the family were satisfied with the resolution. When she reviewed the grievance, she said that there did not appear to be a resolution included for the complaint regarding LPN6, and there was no evidence of education provided to staff regarding abuse. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Assistant Director of Nursing (ADON) 3 on 11/18/25 at 1:35 p.m. revealed she was involved in the grievance regarding LPN6's alleged verbal abuse. ADON3 gave the same account as GSC9 regarding the resolution of the grievance dated 9/5/25. ADON3 said she reviewed the resident's record with RP2 without any concerns noted, and this was related to the care plan meeting that was held on the same day. ADON3 confirmed the grievance did not appear to address the resolution or outcome of the alleged verbal/mental abuse by LPN6, and there was no evidence of education provided to staff regarding abuse. In an interview with RN12 on 11/18/25 at 2:55 p.m., RN12 reviewed the grievance forms dated 9/5/25 and stated that she became aware of the alleged verbal abuse by Responsible Party (RP) 2 on 11/5/25 during R5's care plan meeting. RN12 initiated the grievance form and submitted it to GS9 for processing, further explaining that GS9 would then follow up with the appropriate department or person, such as the Administrator or Director of Nursing (DON) 2. RN12 did not witness the incident and was only present during the care plan meeting when RP2 reported the allegations. In an interview with the DON2 on 11/18/25 at 3:10 p.m., she reviewed the grievance dated 9/5/25 regarding LPN6's behavior and alleged verbal/mental abuse. She said the incident occurred on 9/4/25 and was brought to the facility's attention by RP2 at R5's care plan meeting, along with complaints regarding the bowls and containers. DON2 confirmed that the alleged verbal abuse was not addressed in the grievance resolution, and there was no report made of the alleged verbal abuse. She also confirmed there was no education provided as a means of preventing potential verbal/mental abuse within the grievance investigation. In an interview on 11/19/25 at 3:30 p.m., the Administrator stated the complaints made by RP2 at the care plan meeting were not considered verbal abuse, saying, They just didn't want LPN6 assigned to her, when asked why the self-report was not made. When asked about the outcome or resolution to the allegation of verbal/mental abuse, the Administrator said they obtained LPN6's statement and the resolution was documented in the grievance investigation; however, she was unable to point out the statement or the resolution, stating, it (the outcome) covered everything. There was no evidence of education provided to staff regarding abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to 1.) ensure misappropriation of resident property was reported immediately, not later than 24 hours, to the administrator and to other officials for one of one facility-reported incident reviewed for misappropriation of resident property and 2.) implement its abuse policy and procedure for immediately reporting an allegation of staff-to-resident verbal abuse to the State Agency, local law enforcement, and to Adult Protective Services within the required time frame. This was for 1 (Resident 6) resident sampled for misappropriation of property and 1 (Resident 5) of 6 sampled residents reviewed for abuse. Findings included: The facility policy titled, Abuse, Neglect, and Exploitation, dated 11/13/2023 with a review date of 10/17/25, .V. A., An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. VII. Reporting/Response. A. 1. Reporting of all alleged violations to the Administrator, state agency.within specified timeframes. b. Not later than 24 hours if the alleged violation involves. misappropriation of resident property and does not result in serious bodily injury. A resident record indicated that the facility admitted Resident (R) 6 on 08/16/2025. The record states that the resident had a medical history including diagnoses of anemia, coronary artery disease, and hypertension.An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/22/2025, revealed R6's Brief Interview for Mental Status (BIMS) score of 15/15, indicating R6 was cognitively intact. Care plans and progress notes were reviewed without any concerns. The resident's record included an inventory sheet upon admission, listing upper and lower dentures and a pair of eyeglasses; however, it did not include R6's wallet or its contents. Daily observations of the entire facility, from 11/17/2025 to 11/20/2025, were conducted during the survey. The observation revealed that no surveillance cameras were noted within the facility. The two witnesses identified in the facility's investigation as having been in R6's room on 8/26/24 were not available for interviews. The housekeeper was no longer employed with the facility, and the Geriatric Nurse Aide (GNA) was unavailable for interview.In an interview with Guest Services (GS) 9 on 11/18/2025 at 12:00 p.m., she stated she assisted in investigating the incident as part of the grievance process. GS9 received a call from Licensed Practical Nurse (LPN) 5 at approximately 4:30 p.m. on 8/26/2025. LPN5 also initiated the missing items form at that time. GS9 and the Assistant Director of Nursing (ADON) 3 were notified and immediately began the investigation. GS9 confirmed that suspected resident misappropriation of property should be reported to the Administrator immediately. She also stated that there are no cameras within the building for reviewing activities. GS9 stated that R6's family said she would check the hospital for the wallet and report back. R6's family member reported to GS9 on 8/28/2025 at 11:00 a.m. that the wallet was not found at the hospital with R6. GS9 then reported the missing wallet to the Administrator on 8/28/2025 at 11:05 a.m. GS9 confirmed she did not report the missing wallet to the Administrator when it was reported on 8/26/25, stating, We were waiting for (R6's sister) to report back from the hospital. She added that she did not follow up with the family member during this time. GS9 reviewed the missing item investigation form and confirmed it had not been completed or resolved. In an interview on 11/18/2025 at 1:45 p.m., ADON3 stated LPN5 reported the missing wallet to her and GS9 on 8/26/2025 at approximately 4:30 p.m. ADON3 stated missing items should be reported to the Administrator immediately.An interview with LPN5 on 11/18/2025 at 2:02 p.m. revealed that he received a report of the missing wallet from a family member of R6 at approximately 4:30 p.m. on 8/26/2025. She initiated a missing item form and called GS9 and ADON3 immediately to report the missing item. LPN5 confirmed that missing items should be reported immediately, which she did by contacting GS9 and ADON3 to initiate the form and by contacting GS9 and the supervisor, ADON3. An interview with a family member of R6 on 11/19/2025 at 1:49 p.m. revealed that the resident was sent to the hospital on 8/26/2025, around the time of his/her in-house dialysis (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appointment. When the family member went to the facility to retrieve R6's items on 8/26/2025 between 4:00 p.m. and 4:30 p.m., she discovered R6's wallet was missing and immediately reported it to the nurse. The wallet was the only item that was missing. It had been in R6's room the previous day, wrapped inside a pair of dark-colored sweatpants s/he was going to wear for an outside appointment on 8/26/25 after dialysis. R6's family member stated that R6 never had the chance to put on the clothing that was prepared for the appointment. On 11/19/25 at 1:55 p.m., a call was placed to R6. There was no answer. A voicemail was left, but the survey's conclusion received no return call.In an interview with ADON3 on 11/19/15 at 2:00 p.m., he stated that R6 was in the hospital for a few days and returned to the facility in a different room. R6's original room was a single room without a roommate. ADON3 did not report the missing item to the Administrator.An interview with the Administrator on 11/19/25 at 4:00 p.m. revealed that she was notified of the missing wallet by GS9 on 8/28/25 at 11:05 a.m. The Administrator stated they did not consider the item to be missing nor suspicious of misappropriation until confirmed by the family member that it was not at the hospital; however, she did confirm that a missing item was reported to the facility on 8/26/25 at approximately 4:30 p.m., indicating suspected misappropriate would be no different than suspected abuse as outlined in the facility policy which would require an investigation to determine if it was verified, not verified, or inconclusive. The facility investigation was reviewed. It was discovered that the missing items form was initiated but not completed for the missing wallet. Statements obtained from the housekeeper and a GNA who had been in the room revealed that the housekeeper did not see a wallet, and the GNA did see one on the bedside table after the housekeeper reported being in R6's room. No alleged perpetrators were identified, and the facility does not have surveillance cameras. There was documentation on staff training regarding the misappropriation of property. The investigation concluded that the allegation was inconclusive, noting that insufficient information prevented verification of what happened to the wallet. 2.A review of a facility policy titled Abuse, Neglect, and Exploitation, dated 11/13/23 with a review date of 10/17/25, revealed .V. A., An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. VII. Reporting/Response. A. 1. Reporting of all alleged violations to the Administrator, state agency.within specified timeframes. b. Not later than 24 hours if the alleged violation involves abuse, .and does not result in serious bodily injury. Further review of the abuse policy revealed, .Compliance Guidelines: .3. Prevention: . The facility will identify, correct, and intervene in situations in which abuse, neglect, and/or misappropriation of resident property is more likely to occur. A resident demographic record revealed the facility admitted R5 on 3/19/24. The resident had a medical history that included cerebral infarction, aphasia, heart failure, atherosclerotic heart disease, type 2 diabetes mellitus, cardiomyopathy, protein-calorie malnutrition, hypothyroidism, depression, atrial fibrillation, chronic kidney disease stage 4, cognitive communication deficit, traumatic brain injury, and recent pleural effusion.An annual MDS with an ARD of 2/12/25 revealed R5's BIMS score was 15/15, indicating s/he was cognitively intact. However, a quarterly MDS dated [DATE] revealed a BIMS score of 3/15, indicating severe cognitive impairment following a recent hospital stay. The grievance report dated 9/5/25 was reviewed and addressed three topics, one of which concerned an allegation of abuse. The alleged verbal/mental abuse was reported to have occurred on 9/4/25. It was witnessed by a family friend who reported it to the complainant, who then reported it during the resident's care meeting on 9/5/25. The complainant reported that LPN4 called the resident a racist, banged on his/her bed, and bullied the resident. The allegation of abuse was not addressed in the outcome or resolution. There was no evidence to support the allegation reported to the State agency, nor was there evidence that education was provided to staff following a report/allegation of suspected abuse. In an interview on 11/17/25 at 3:45 p.m., Responsible Party (RP) 1 talked about an incident with a nurse that was witnessed by family friends, for which R5's other adult daughter (RP2) had filed a complaint and a grievance. RP1 said to ask RP2 about that incident, stating it was something about eyedrops and calling (parent) a racist. An interview with (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON3 on 11/18/25 at 1:35 p.m. revealed that she was involved in the investigation of the grievance regarding LPN6's alleged verbal abuse. ADON3 gave the same account as GS9 regarding the resolution of the grievance dated 9/5/25. ADON3 said she reviewed the resident's record with RP2 without any concerns noted, and this was related to the care plan meeting that was held on the same day. ADON3 confirmed the grievance did not appear to address the resolution or outcome of the alleged verbal/mental abuse by LPN6, and there was no evidence of education provided to staff regarding abuse. ADON3 deferred to the Administrator and Director of Nursing (DON) 2 to answer the remaining questions regarding LPN6. In an interview with Registered Nurse (RN) 12 on 11/18/25 at 2:55 p.m., RN12 reviewed the grievance forms dated 9/5/25 and stated that she became aware of the alleged verbal abuse by RP2 on 11/5/25 during R5's care plan meeting. RN12 initiated the grievance form and submitted it to GS9 for processing, further explaining that GS9 would then follow up with the appropriate department or person, such as the Administrator or DON2. RN12 did not witness the incident and was only present during the care plan meeting when RP2 reported the allegations.In an interview with DON2 on 11/18/25 at 3:10 p.m., she reviewed the grievance dated 9/5/25 regarding LPN6's behavior and alleged verbal/mental abuse. She said the incident occurred on 9/4/25 and was brought to the facility's attention by RP2 at R5's care plan meeting, along with complaints regarding the bowls and containers. DON2 confirmed that the alleged verbal abuse was not addressed in the grievance resolution, and there was no report made of the alleged verbal abuse. She also confirmed there was no education provided as a means of preventing potential verbal/mental abuse within the grievance investigation. An attempt was made to contact LPN6 on 11/19/25 at 11:18 a.m. No return call was received. During an interview with the complainant, who is also RP2 on 11/19/25 at 11:25 a.m., she said she is not R5's Power of Attorney (POA). She said she and RP1 are R5's responsible parties and emergency contacts, equally. When asked the reason for the 20-day delay in reporting, RP2 stated, I was coordinating with getting email addresses, making sure everything was good, and I was worried about retaliation. The more we say something, the care becomes worse. RP2 could not give examples of retaliation or worsening care or treatment. When asked if grievance had been filed with the facility and if a resolution had been provided, RP2 answered, They were aware of it; we talked about it in the care plan meeting. I do not know. They never got back to me. However, RP2 then said that GS9 and a social worker told her that LPN6 would no longer see R5. RP2 said that LPN6 did not work with R5 after the incident, adding that there were no additional concerns. An interview with GS9 on 11/19/25 at 12:20 p.m. revealed she had received a grievance form from RN12 on 9/5/2025. When asked to review the grievance forms related to the alleged verbal abuse by LPN6 and the bowls and containers dated 9/5/25 GS9 noticed the primary complaint was regarding the nurse's alleged verbal/mental abuse. Still, the majority of the resolution addressed the paper bowls and containers, noting that the facility replaced them and that the resident and the family were satisfied with the resolution. When she reviewed the grievance, she said that there did not appear to be a resolution included for the complaint regarding LPN6, and there was no evidence of education provided to staff regarding abuse. In an interview on 11/19/25 at 3:30 p.m., the Administrator stated the complaints made by RP2 at the care plan meeting were not considered verbal abuse, saying, They just didn't want LPN6 assigned to her, when asked why the self-report was not made. When asked about the outcome or resolution to the allegation of verbal/mental abuse, the Administrator said they obtained LPN6's statement and the resolution was documented in the grievance investigation; however, she was unable to point out the statement or the resolution, stating, it (the outcome) covered everything. She acknowledged there was no evidence of education provided to staff regarding abuse related to the grievance.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to take appropriate corrective action as a result of investigation findings by not educating staff on abuse after an allegation of abuse occurred for two incidents related to 1(Resident #5) of 1 sampled resident.Findings included:A review a facility policy titled, Abuse, Neglect, and Exploitation, dated 11/13/2023 with a review date of 10/17/25, revealed .V. A., An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. VII. Reporting/Response. A. 1. Reporting of all alleged violations to the Administrator, state agency.within specified timeframes. b. Not later than 24 hours if the alleged violation involves abuse, .and does not result in serious bodily injury. Further review of the abuse policy revealed, .Compliance Guidelines: .3. Prevention: . The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. A resident demographic record revealed the facility admitted R5 on 3/19/24. The resident had a medical history that included cerebral infarction, aphasia, heart failure, atherosclerotic heart disease, type 2 diabetes mellitus, cardiomyopathy, protein-calorie malnutrition, hypothyroidism, depression, atrial fibrillation, chronic kidney disease stage 4, cognitive communication deficit, traumatic brain injury, and recent pleural effusion. An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed R5's Brief Interview for Mental Status (BIMS) score was 15/15, indicating s/he was cognitively intact. However, a quarterly MDS dated [DATE] revealed a BIMS score of 3/15, indicating severe cognitive impairment following a recent hospital stay. During an observation on 11/17/25 at 3:45 p.m., Resident (R) 5 was noted to be clean, well-groomed, happy and very hard of hearing requiring a very elevated voice to hear this surveyor. R5's adult daughter, Responsible Party (RP) 1, was present and was equally as hard of hearing as R5. Conversation and questions were directed to R5; however, when s/he would begin to speak, RP1 would gesture for him/her to stop talking, and RP1 would answer. This surveyor respectfully asked RP1 to allow R5 to answer questions. RP1 began to protest but refrained, making a frustrated gesture with her face and arms as if to indicate, go ahead. During observations 11/18/25 between 10:00 a.m. and 10:45 a.m., no foul odors, pests, or other environmental concerns were noted. Call lights were answered in a timely manner, and respectful interactions were observed. During an observation o 11/18/25 at 3:15 p.m., R5 was noted to be clean, well-groomed, and happy while lying in bed watching television. In an interview with on 11/17/25 at 3:45 p.m. RP1 talked about an incident with a nurse that was witnessed by family friends for which R5's other adult daughter (RP2) had filed a complaint and a grievance. RP1 said to ask RP2 about that incident, stating it was something about eyedrops and calling (parent) a racist. An interview with Assistant Director of Nursing (ADON) 3 on 11/18/25 at 1:35 p.m., revealed she was involved in the investigation of the grievance regarding Licensed Practical Nurse (LPN) 6 alleged verbal abuse. ADON3 gave the same account as Guest Services (GS) 9 regarding the resolution of the grievance dated 9/5/25. ADON3 said she reviewed the resident's record with RP2 without any concerns noted, and this was related to the care plan meeting that was held on the same day. ADON3 confirmed the grievance did not appear to address the resolution or outcome of the alleged verbal/mental abuse by LPN6, and there was no evidence of education provided to staff regarding abuse. ADON3 deferred to the administrator and Director of Nursing (DON) 2 to answer the remaining questions regarding LPN6. In an interview with ADON3 on 11/18/25 at 1:35 p.m., she reviewed the grievance dated 10/2/2025, and she was asked to define medication administration to which she replied, The nurse should verify the patient's birthday, name, room, picture and follow the 10 rights and provide the reason for the medication to the patient. The nurse should be with them while they complete their medications and then sign off on that medication, adding that medication administration is not complete if it left in the medicine cup on a beside table and that the nurse should return to the administer the medications later when a patient is not ready. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When ADON3 followed up with RP1, RP1 vehemently denied LPN4, who signed the Medication Administration Record (MAR), as the person who left the medications on the table that were discovered by RP1 on 10/2/25. ADON3 stated that RP1 said to her, It's not [LPN4], despite LPN4 having been the nurse on duty and the nurse who signed the MAR for that morning and the two (2) mornings prior. The grievance did not have any evidence of education regarding medication administration. In an interview with LPN4 on 11/18/25 at 2:45 p.m., she said she had worked at the facility for approximately four (4) years. LPN4 defined medication administration as, Follow the five (5) rights, don't leave meds in a room at the bedside, and stay until the patient takes the meds. LPN4 said if the resident refused the medications at that time, she would contact the provider to get orders for the resident to have their medications later or document the refusal. Per record review (reference record review below), LPN4 was identified as the nurse assigned to R5 on the day of and the two (2) days prior to when the medication was found by RP1, and she was also the nurse who signed the MAR as having administered R5's morning medications for those three (3) days. LPN4 reviewed the MAR and agreed she was the nurse who signed as having given the morning medications to R5 on 10/2/25 as well as the two (2) days prior. When asked to explain how a family member may find a medicine cup with medications in it if they were documented in the MAR as having been administered, LPN4 responded, A nurse must have signed off that the patient took it but did not ensure they had taken it, adding, but I never leave medication at the bedside. LPN4 acknowledged she had been trained on medication administration but could not recall the last time, stating, We're always getting education, probably at least quarterly. I had it within the last few months. In an interview with Registered Nurse (RN) 12 on 11/18/25 at 2:55 p.m., she reviewed the grievance forms dated 9/5/25 and stated she became aware of the alleged verbal abuse from RP2 on 11/5/25 during R5's care plan meeting. RN12 initiated the grievance form and submitted it to GS9 for processing, further explaining the process that GS9 would then follow up with the correct department or person such as the administrator or DON2. RN12 did not witness the incident and was only present during the care plan meeting when RP2 reported the allegations. In an interview with DON2 on 11/18/25 at 3:10 p.m., she reviewed the grievance dated 9/5/25 regarding LPN6's behavior and alleged verbal/mental abuse. She said the incident had occurred on 9/4/25 and was brought to the facility's attention by RP2 at R5's care plan meeting along with the complaints regarding the bowls and containers. DON2 confirmed the alleged verbal abuse was not addressed in the grievance resolution, and there was no report made of the alleged verbal abuse. She also confirmed there was no education provided as a means of preventing potential verbal/mental abuse within the grievance investigation. In an interview with R5 11/18/25 at 3:30 p.m., she was pleasant and engaging. When asked about the incident regarding the abuse allegation related to receiving eyedrops on 10/2/25, R5 recalled the incident with LPN6 and the eyedrops, stating, She was trying to give me the wrong ones, and she really did not want to be here helping me. She was rude, but my friend was here, and she helped me. During an interview with the complainant who is also RP2 on 11/19/25 at 11:25 a.m., she said she is not R5's Power of Attorney (POA). She said she and RP1 are R5's responsible parties and emergency contacts, equally. When asked the reason for the 20-day delay in reporting, RP2 stated, I was coordinating with getting email addresses, making sure everything was good, and I was worried about retaliation. The more we say something, the care becomes worse. RP2 could not give examples of retaliation or worsening care or treatment. When asked if a grievance had been filed with the facility and if a resolution had been provided, RP2 answered, They were aware of it, we talked about it in the care plan meeting. I don't know. They never got back to me. However, RP2 then said that GS9 and a social worker told her that R5 would not be seen by LPN6 anymore. RP2 said that LPN6 did not work with R5 after the incident, adding there were no additional concerns with that. An interview with GS9 on 11/19/25 at 12:20 p.m., revealed she had received a grievance form from RN12 on 9/5/2025. When asked to review the grievance forms related to the alleged verbal abuse by LPN6 and the bowls and containers dated 9/5/24, GS9 noticed the primary complaint was regarding the nurse's alleged verbal/mental abuse but (continued on next page)

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	215001	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ballenger Creek	347 Ballenger Drive Frederick, MD 21701

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the majority of the resolution addressed the paper bowls and containers, noting they were replaced by the facility and that the resident and the family were satisfied with the resolution. When she reviewed the grievance, she said that there did not appear to be a resolution included for the complaint regarding LPN6, and there was no evidence of education provided to staff regarding abuse. In an interview on 11/19/25 at 3:30 p.m., the Administrator stated the complaints made by RP2 at the care plan meeting were not considered verbal abuse, stating, They just didn't want LPN6 assigned to her, when asked why self-report was not made. When asked about the outcome or resolution to the allegation of verbal/mental abuse, the Administrator said they obtained LPN6's statement and the resolution was documented in the grievance investigation; however, she was unable to point out the statement or the resolution, stating, it (the outcome) covered everything. She acknowledged there was no evidence of education provided to staff regarding abuse related to the grievance. When asked to review the facility-reported incident dated 8/18/25 regarding alleged physical abuse, the Administrator stated there was no education provided to staff regarding abuse after the conclusion of the investigation because the investigation was inconclusive. In an interview with the Administrator and DON2 on 11/19/25 at 3:30 p.m., when asked to define medication administration, the Administrator agreed with DON2's restatement of her previous statement from the day before. She stated LPN6 was provided verbal education regarding medication administration but not all nursing staff were provided the education, adding that the requirement is annually but .it usually happens quarterly, on average. They agreed there was no evidence in the grievance file to support education was provided to LPN6 or any other nursing staff. A review of R5's medical record revealed an admission date of 3/19/24, s/he and currently resides in the facility. An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed R5's Brief Interview for Mental Status (BIMS) score was 15/15, indicating s/he was cognitively intact. However, a quarterly MDS dated [DATE] revealed a BIMS score of 3/15, indicate severe cognitive impairment following a recent hospital stay. The resident had diagnoses of cerebral infarction, aphasia, heart failure, atherosclerotic heart disease, type 2 diabetes mellitus, cardiomyopathy, protein-calorie malnutrition, hypothyroidism, depression, atrial fibrillation, chronic kidney disease stage 4, cognitive communication deficit, traumatic brain injury, and recent pleural effusion. Orders, assessments, care plans, and progress notes were reviewed, and no were identified. A review of R5's grievances since August 2025 was made and revealed six (6) grievances were filed, one (1) of which revealed concerns regarding reporting, providing outcomes/resolutions, and two (2) regarding mitigating potential abuse by providing education following an allegation. A review of the grievance report dated 9/5/25 was reviewed and addressed three topics one of which addressed an allegation of abuse. The alleged verbal/mental abuse was reported to have occurred on 9/4/25 and was witnessed by a family friend who reported it to the complainant who then reported it during the resident's care plan meeting on 9/5/25. The complainant reported LPN4 called the resident a racist, banged on his/her bed, and bullies the resident. The allegation of abuse was not addressed in the outcome or resolution. There was no evidence to support the allegation was reported to the State agency, and there was no evidence to support that education was provided to staff following a report/allegation of suspected abuse. A review of the facility investigation of the allegation of physical abuse dated 8/18/25 revealed the facility determined the incident to be inconclusive. There was no evidence the facility provided education to staff regarding abuse after the conclusion of the investigation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to administer medication to 1 (Resident 5) of 1 sample resident.Findings included: A review of a facility policy titled Medication Administration and dated 12/14/2022, with a review/revision date of 8/27/2025, revealed .Policy Explanation and Compliance Guidelines: . 15. Observe resident consumption of medication.17. Sign MAR after administered. 20. Correct any discrepancies and report to the nurse manager.A review of R5's Medication Administration Record (MAR) dated October 1-31, 2025, revealed that Licensed Practical Nurse (LPN) 4 signed that morning medications were administered on 10/1/2025 and 10/2/2025.A resident demographic record revealed the facility admitted R5 on 3/19/24. The resident had a medical history that included cerebral infarction, aphasia, heart failure, atherosclerotic heart disease, type 2 diabetes mellitus, cardiomyopathy, protein-calorie malnutrition, hypothyroidism, depression, atrial fibrillation, chronic kidney disease stage 4, cognitive communication deficit, traumatic brain injury, and recent pleural effusion.An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed R5's Brief Interview for Mental Status (BIMS) score was 15/15, indicating s/he was cognitively intact. However, a quarterly MDS dated [DATE] revealed a BIMS score of 3/15, indicating severe cognitive impairment following a recent hospital stay. A review of the grievance dated 10/2/25 revealed that the resident's daughter found a medicine cup containing medication in the resident's room. During the facility grievance investigation, a nurse reviewed the medication in the cup and discovered it contained Tradjenta (to manage blood sugar levels), Lasix (to treat fluid retention), and amiodarone (to treat severe heart rhythm): Eliquis (to prevent blood clots) and senna (to treat constipation). Licensed Practical Nurse (LPN) 4 was identified as the nurse assigned to the resident on 10/2/2025, the day of the discovery. LPN4 was also the nurse who signed the MAR, indicating the medications had been administered. LPN4 stated that the resident took the medicines, and the resident and family vehemently denied that LPN4 was the nurse who failed to distribute them. There was no documentation of education regarding medication administration to LPN4 or any nursing staff. The facility documented the grievance outcome and resolution with the family.In an interview with Responsible Party (RP)1 on 11/18/25 at 3:40 p.m., when asked about the medications being left in the cup on 10/2/25, RP1 said it was impossible to tell how long the medication had been there when she found it, but probably from that morning. That was the third time it had happened. The other two times, I found them hidden behind this basket on the dresser, pointing to a basket on the dresser and moving it to indicate where medications had previously been found on two (2) other occasions. RP1 stated she had not reported those incidents and added, but I know it wasn't LPN4. She wouldn't do that, and she is the best nurse they have here. RP1 did not disclose what was done with the medications she found the previous two times.An interview with R5's family friend and Witness #1 (WN1) on 11/19/25 at 11:18 a.m. revealed her recollection of the incident, indicating that LPN6 had dropped off the cup of meds, left them in R5's room, and did not watch R5 take the medication. She also stated that the nurse allowed her to give the R5 eyedrops medication because LPN6 did not want to bring the medication back to the room in the first place. At the end of the interview with W1, she disclosed that Witness 2 (WN2) was present. WN2 then stated, I agree with everything she said, and I do not have anything to add.An attempt was made to contact LPN6 on 11/19/25 at 11:18 a.m. No return call was received. In an interview with ADON3 on 11/18/25 at 1:35 p.m., she reviewed the grievance dated 10/2/2025, and she was asked to define medication administration to which she replied, The nurse should verify the patient's birthday, name, room, picture, and follow the 10 rights and provide the reason for the medication to the patient. The nurse should be with them while they complete their medications and then sign off on that medication, adding that medication administration is not complete if it is left in the medicine cup on a bedside table, and that the nurse (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should return to administer the medications later when a patient is not ready.In an interview with LPN4 on 11/18/25 at 2:45 p.m., she said she had worked at the facility for approximately four (4) years. LPN4 defined medication administration as, Follow the five (5) rights, don't leave meds in a room at the bedside, and stay until the patient takes the meds. LPN4 said that if the resident refused the medications at that time, she would contact the provider to obtain orders for the resident to receive their medications later or document the refusal. LPN4 reviewed the MAR and agreed she was the nurse who signed that she had given the morning medications to R5 on 10/2/25, as well as the two (2) days prior. When asked to explain how a family member may find a medicine cup with medications in it if they were documented in the MAR as having been administered, LPN4 responded, A nurse must have signed off that the patient took it, but did not ensure they had taken it, adding, but I never leave medication at the bedside. LPN4 acknowledged she had been trained in medication administration but could not recall the last time, stating, We're always getting education, probably at least quarterly. I had it within the last few months. In an interview with the Director of Nursing (DON2) on 11/18/25 at 3:10 p.m., when asked to define medication administration, DON2 said the nurse should follow the physician's orders to administer the medications and verify the medicines, checking the ten (10) rights, including identification, allergies, and the mode of delivery. The nurse should watch the patient take the medication, never leave it at the bedside, and then sign the MAR. When asked how a family member might find a medicine cup containing the medications if they were documented on the MAR as administered, DON2 responded, They should never find it on the bedside table. In an interview with the Administrator and DON on 11/19/25 at 3:30 p.m., when asked to define medication administration, the Administrator agreed with DON2's restatement of her previous statement from the day before. She stated LPN6 provided verbal education on medication administration, but not all nursing staff received it, adding that the requirement is annually, but .it usually happens quarterly on average. They agreed there was no evidence in the grievance file to support the education provided to LPN6 or any other nursing.