STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215029	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chevy Chase	8700 Jones Mill Road Chevy Chase, MD 20815

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, document review, and facility policy review, the facility failed to timely report an allegation of abuse to the state survey agency for 1 (Resident #1) of 7 sampled residents reviewed for abuse.Findings included: A facility policy titled, Abuse, Neglect and Exploitation, reviewed/revised 11/13/2023, revealed VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. An admission Record revealed the facility admitted Resident #1 on 04/17/2024. According to the admission Record, the resident had a medical history that included a diagnosis of other sequelae of cerebral infarction (stroke). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Contained within the facility's investigation was handwritten statement from Licensed Practical Nurse #4 dated 07/12/2025, which indicated It was about 7:10 AM (on 07/11/2025) when oncoming nurse came to the nursing station with two police officers asking for the assigned GNA [geriatric nursing assistant] for [Resident #1's room]. Writer informed them that she already left for the day; writer was unaware that the resident called 911. Writer and the policy officers went to the resident's room to ensure what happened? Resident stated that the GNA was rough during incontinence care and fastened [his/her] adult brief so [he/she] was unable to use the urinal for urine specimen. During an interview on 10/15/2025 at 10:30 AM, the Director of Nursing (DON) stated around 10:00 AM to 11:00 AM (on 07/11/2025), she and Unit Manager (UM) #1 interviewed Resident #1 and during the interview, the resident reported they had called the police. The DON stated the expectation was that abuse was reported to the state survey agency within two hours of staff becoming aware of an allegation. Contained within the facility's investigation file was a handwritten statement from UM #1 dated 07/11/2025, which indicated The resident in {Resident #1's room} was interviewed by writer and [he/she] stated the GNA was rough and rushed with [him/her] when turning [him/her] on [his/her] side for incontinence care. Contained within the facility's investigation was a typed statement signed by the DON and dated 07/11/2025, which indicated, This writer interviewed [Resident #1] in the presence of the Unit Manager, [UM #1]. {Resident #1] stated the GNA, [GNA #2], was rough when she was changing [him/her]. {Resident #1] stated [GNA #2] had taken care of [him/her] multiple times before, but it was different this time. When asked what the difference was, [Resident #1] said [GNA #2] was rushing. [Resident #1] stated that [he/she] called the policy to report her. [Resident #1] was asked if there was a reason why [he/she] did not inform the supervisor instead,. [Resident #1] said that [he/she] will call the policy anytime [he/she] feels disrespected. During an interview on 10/15/2025 at 11:21 AM, the Administrator acknowledged she was the facility's abuse coordinator. The Administrator stated allegations of abuse should be reported within two hours to the state survey agency. According to the Administrator, the incident regarding Resident #1 and GNA #2 occurred during the 11:00 PM - 7:00 AM shift; she was notified by the DON of the incident and the incident was not reported to the state agency until 07/11/2025 at 2:00 PM.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to perform hand hygiene between glove changes during wound care for 1 (Resident #4) of 3 sampled residents reviewed for pressure ulcers.Findings included: A facility policy titled, Clean Dressing Change, dated 12/13/2022, indicated, It is the policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross-contamination. The policy indicated, 7. Wash hands and put on clean gloves. 8. Place a barrier cloth or pad next to the resident, under the wound to protect the bed linen and other body sites. 9. Loosen the tape and remove the existing dressing. If needed to minimize skin stripping or pain, moisten with prescribed cleansing solution or use adhesive remover to remove tape. 10. Remove gloves, pulling inside out over the dressing. Discard into appropriate receptacle. 11. Wash hands and put on clean gloves. 12. Cleanse the wound as ordered, taking care not to contaminate other skin surfaces or other surfaces of the wound. Pat dry with gauze. 14. Wash hands and put on clean gloves. 15. Apply topical ointments or creams and dress the wound as ordered. Protect surrounding skin as indicated with skin protectant. 16. Secure dressing. [NAME] with initials and date. 17. Discard disposable items and gloves into appropriate trash receptacle and wash hands. An admission Record indicated the facility admitted Resident #4 on 05/31/2015. According to the admission Record, the resident had a medical history that included a diagnosis of peripheral vascular disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/08/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had one unstageable pressure ulcer. Resident #4's Care Plan Report included a focus area initiated 07/15/2025, that indicated the resident had an opened area to the sacrum noted on readmission. Interventions directed staff to administer treatment as per physician order. During an observation on 10/15/2025 at 11:39 AM, Registered Nurse (RN) #14 and Geriatric Nursing Assistant #15 performed wound care for Resident #4. RN #14 removed the old dressing from the resident's sacrum, which exposed a very large deep unstageable wound that was covered with yellow slough. RN #14 removed his gloves and put on a new pair of gloves without performing hand hygiene and then wiped the wound and the peri-wound with sterile water-soaked gauze then RN #14 applied body soap and a foaming cleansing soap on a 4 x 4 gauze, made the gauze sudsy, and covered the wound bed with the soap. RN #14 wiped the soap off with a gauze soaked in sterile water, not rinsing off the soap completely, and left visible soap on the wound. RN #14 patted the wound dry with gauze, removed his gloves, and put on a new pair of gloves without performing hand hygiene. RN #14 then soaked gauze with Dakin's solution then squeezed out all the liquid from the gauze and placed the gauze on the wound bed. He removed his gloves and put on a new pair of gloves without performing hand hygiene and placed dry sterile 4 x 4 gauze on top of the wet gauze. RN #14 removed his gloves and put on a new pair of gloves without performing hand hygiene then covered the wound with four individually wrapped 4 x 4 bordered gauze. He removed his gloves and retrieved a pen out of his pocket to date the dressing. RN #14 then went to the bathroom to wash his hands. During an interview on 10/15/2025 at 12:02 PM, RN #14 stated hand hygiene should occur between glove changes. He confirmed that he did not perform hand hygiene every time he changed his gloves but should have. During an interview on 10/16/2025 at 4:26 PM, the Director of Nursing stated hand hygiene should occur before the procedure and during the wound care, and anytime the staff removed their gloves they should perform hand hygiene in between the glove changes.