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	04/03/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review and staff interview, it was determined the facility staff failed to ensure Minimum Data Set (MDS) assessments were accurately coded. This was evident for 1 (#7) of 3 residents reviewed for pressure ulcers. The findings include Minimum Data Set- The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. On 3/31/26 at 1:11 PM, a review of Resident #7's medical record revealed Resident #7 was admitted to the facility in the beginning of January 2026 for rehab following an acute hospitalization. On 1/9/26 at 3:19 PM, in a Skin and Wound Note, the Nurse Practitioner (NP) indicated Resident #7 was seen as a new admission and s/he had an existing ulcer on the left heel and sacrum. The NP further documented Resident #7 had 3 pressure ulcers (PU), a Stage 1 PU on the right heel, a Stage 3 PU on the left heel, and an Unstageable PU on the coccyx. Review of Resident #7's admission MDS with an assessment reference date (ARD) of 1/14/26, Section M, Skin Conditions, documented Resident #7 had one unhealed PU that was a Stage 3. The MDS failed to capture Resident #7 had a Stage 1 PU on the right heel, and an unstageable pressure ulcer on the coccyx. The above concern was discussed with Staff #2, Registered Nurse (RN), MDS Coordinator on 4/2/26 at 12:46 PM and Staff #2 confirmed the findings at that time.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, it was determined that the facility staff failed to timely develop and implement a comprehensive, resident centered care plan for a resident admitted to the facility with preexisting pressure ulcers. This was evident for 1 (#7) of 3 residents reviewed for pressure ulcers. The findings include: The MDS (Minimum Data Set) is a federally mandated, comprehensive assessment tool to ensure each resident's needs are identified, that care is planned based on those individualized needs, and that the care is provided as planned to meet the needs of each resident. A baseline care plan is an immediate, preliminary plan developed within 48 hours of a resident's admission to provide the minimum healthcare information necessary to properly care for a resident until a comprehensive care plan can be completed. A comprehensive care plan is a guide that addresses each resident's unique needs. It is used to plan, assess and evaluate the effectiveness of the resident's care, and must be completed within 7 days after the completion of the comprehensive assessment (MDS), and no later that 21 calendar days after admission on [DATE] at 1:11 PM, a review of Resident #7's medical record revealed Resident #7 was admitted to the facility in the beginning of January 2026 for rehab following an acute hospitalization. The medical record documented Resident #7 had preexisting pressure ulcers (PU) and was followed weekly by a wound Nurse Practitioner (NP) for evaluation and treatment of the PU. In a Skin and Wound Note, on 1/9/26 at 3:19 PM, the wound NP documented Resident #7 was seen as a new admission and the resident had an existing ulcer on the left heel and sacrum. The NP further documented Resident #7 had 3 pressure ulcers, a Stage 1 PU on the right heel, a Stage 3 PU on the left heel, and an Unstageable PU on the coccyx. Review of Resident #7's MDS revealed an admission MDS with an assessment reference date (ARD) of 1/14/26 had been completed, and documented the resident was at risk for pressure ulcers and had an unhealed pressure ulcer. On 4/2/26 at 9:42 AM, a review of a baseline care plan (BCP) for Resident #7 revealed that following the resident's admission to the facility, a preliminary care plan to address Resident #7's preexisting pressure ulcer had not been implemented. Further review of Resident #7's care plans revealed care plans that addressed Resident #7's pre-existing pressure ulcers were not developed timely. The care plans, Resident #7 has skin alteration related to Left heel wound, Resident #7 has skin alteration related to the right heel, and Resident #7 has skin alteration related to wound on the coccyx, were initiated on 1/30/26, which was 16 days after the completion of the resident's admission assessment and admission. The facility failed to timely develop and implement a comprehensive care plan that addressed care and management of Resident #7's pre-existing pressure ulcers. The above concerns were discussed with the Nursing Home Administrator (NHA) and the Director of Nurses (DON) on 4/3/26 at approximately 7:00 PM. The NHA and DON acknowledged the concerns offered no further comments at that time.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on medical record review and staff interviews, it was determined that the facility failed to provide care consistent with professional standards of practice to prevent pressure injuries and promote the healing of a pressure injury. This was evident for 1 (#7) residents reviewed for pressure ulcers. The findings include: Pressure ulcers (bedsores) are localized skin/tissue injuries caused by prolonged pressure, staged by severity. Stage 1 involves intact skin with non-blanchable redness. Stage 2 is partial-thickness skin loss (shallow, open blister). Stage 3 involves full-thickness skin loss with visible fat. Stage 4 involves deep tissue loss with exposed muscle, tendon, or bone. A deep tissue injury (DTI) pressure ulcers are defined as purple or maroon localized area of discolored intact skin or bloodˆfilled blister due to damage of underlying soft tissue from pressure and/or shear. Once a DTI opens to an ulcer, the ulcer would be reclassified into the appropriate stage On 3/31/26 at 1:03 PM, a review of complaint #2740369 alleged the care Resident #7 received in the facility was not adequate to prevent an existing pressure ulcer from getting worse. The complaint alleged that when Resident #7 was admitted to the facility, s/he had a bedsore on the sacrum (base of spine, above the tailbone) that was the size of a quarter and later in the month, when Resident #7 transferred to the hospital for a change in condition, the resident's bedsore on the sacrum was huge. On 3/31/26 at 1:11 PM, a review of Resident #7's medical record revealed Resident #7 was admitted to the facility in the second week in January 2026 following an acute hospitalization and transferred back to the hospital at the end of January 2026 and subsequently discharged from the facility. The medical record documented Resident #7 had multiple medical diagnosis, and pre-existing pressure ulcers. 1) Review of Resident #7's medical record revealed the resident had existing pressure ulcers when s/he was admitted to the facility and was followed by the wound care Nurse Practitioner (NP). On 1/9/26 at 3:19 PM, a skin and wound note, the wound NP documented Resident #7 was a new admission with multiple wounds including a pre-existing pressure ulcers. The NP documented the resident had a right (Rt) heel Stage 1 PU, a left (Lt) heel Stage 3 PU, and an unstageable PU on the coccyx. The NP documented the pressure ulcer measurements were: Rt heel cm (centimeter) 4 cm x 4 cm x 0 cm, Lt heel 3 cm x 4 cm x 0.5 cm, and Coccyx 1.7 cm x 0.5 cm x 0.3 cm, and the NP recommended the following treatment orders:- Right heel PU - Apply Skin Prep to base of the wound, leave open to air twice per day (BID).- Left heel PU - Cleanse with normal saline, apply Silver alginate to base of the wound, secure with Rolled gauze and change daily .- Coccyx PU - Cleanse with wound cleanser, apply Manuka HS Hydrogel to base of the wound, secure with Silicone Bordered Gauze, and change the dressing daily and PRN (as needed) A review of Resident #7's medical record failed to reveal evidence that the wound treatment orders recommended by the NP on 1/9/26 had been entered into the resident's record, and 2) In a skin and wound note on 1/12/26 at 2:54 PM, the wound NP wrote that when Resident #7 was seen by a different wound NP, the resident was found to have multiple wounds. The NP wrote that during his/her visit with Resident #7, the resident was agitated and only allowed the NP to see the resident's left heel wound. The NP wrote that it was discussed with the wound nurse to continue the treatments to the rest of the wounds as ordered on 1/9/26. 2a) Review of Resident #7's January 2026 Treatment Administration Record (TAR) revealed a 1/15/26 treatment order to cleanse the left heel PU with NSS, pat dry, apply silver alginate and cover with dry dressing daily, every day shift. The order was consistent with the NP recommendation on 1/12/26, however, the order was not entered into the medical record until 1/15/26, which was not timely, resulting in a delay in care. The review of the TAR also revealed a 1/14/26 order to apply skin prep to right heel DTI every day and evening shift, however no treatments for Resident #7's coccyx PU were found for that time frame. 2b) Review of Resident #7's medical record and January TAR failed to reveal evidence that following the wound NP's visit on 1/12/26, treatments were provided to the rest of the resident's wounds as ordered on 1/9/26 as recommended by the NP and discussed with the wound nurse on 1/12/26, as none of the wound treatment recommendations from the NP on1/9/26 had not (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been entered as orders in the resident's medical record at that time. 3) In a skin and wound note on 1/19/26 at 4:20 PM, the wound NP documented Resident #7's right heel PU remained a Stage 1, the left heel Stage 3 PU was healing, and the Coccyx PU remained unstageable. The treatment to the Rt heel PU was unchanged, and the NP made the following treatment order recommendations:- L heel Pressure Ulcer treatment - Cleanse with normal saline, apply Calcium alginate, Medical grade honey to base of the wound, secure with rolled gauze and change daily .- Coccyx Pressure Ulcer Treatment - Cleanse with wound cleanser, apply Medical grade honey to base of the wound, secure with Silicone.,3a) Review of Resident #7's January 2026 TAR revealed a 1/19/26 order, cleanse coccyx with NSS (normal saline), pat dry, apply Medihoney and cover with silicone bordered form, daily, every day shift. This was the first coccyx PU treatment found for Resident #7 since his/her admission to the facility with an existing pressure ulcer on the coccyx. 3b) Continued review of the resident's January 2026 TAR revealed a 1/19/26 order to cleanse left heel with NSS, pat dry, apply Medihoney with calcium alginate and cover with bordered gauze daily, every day shift, however further review of the TAR revealed the 1/15/26 order to cleanse left heel with NSS, pat dry, apply silver alginate and cover with dry dressing daily, every day shift was still an active order in the TAR and the facility staff failed to discontinue the previous order when the new order was given. In addition, the TAR documented both treatments done on 6 days (1/22, 1/23,1/24, 1/25, 1/27, 1/28, 1/29) in January 2026. 4) In a skin and wound note on 1/29/26 at 14:46 PM, the wound NP documented Resident #7's right heel PU which had been a Stage 1 was now restaged as a DTI, indicating that damage had progressed from the surface to deeper soft tissues, his/her Lt heel Stage 3 PU was stable. The NP documented Resident #7's unstageable PU on the Coccyx was worsening, had increased in length and width and now measured 11 cm x 21.5 cm x 0.3 cm. The NP's treatment order recommendations for the Rt and Lt heel PU were unchanged and recommended the following coccyx PU treatment: Cleanse with wound cleanser, apply Medical grade honey, Calcium alginate to base of the wound to base of the wound, secure with Silicone Bordered Gauze, change daily and PRN. Review of Resident #5's January 2026 TAR found orders consistent with the NP's wound treatment recommendations. 5) Continued review of Resident #7's medical record revealed on 1/19/26 at 4:20 PM, in a skin and wound note, the wound NP recommended Resident #7 have an alternating air/low air loss mattress (provides pressure management to prevent and treat pressure injuries) for pressure redistribution, and on 1/29/26 at 2:46 PM, in a skin and wound note, the NP recommended the resident have an alternating air/low air loss mattress for pressure redistribution. Review of Resident #7's January 2026 TAR revealed a 1/30/26 order for Air mattress in place and settings check for optimal effectiveness, every shift for pressure reduction to prevent or heal pressure wounds every shift. Continued review of the medical record failed to reveal evidence following the NP's recommendation on 1/19/26, and prior to 1/30/26, an alternating air/low air loss mattress had been implemented for Resident #7. 6) Review of Resident #7's admission MDS (minimal data set) (standardized assessment tool that measures health status in nursing home residents) with an assessment reference date (ARD) of 1/14/26 documented Resident #7 had one unhealed Stage 3 pressure ulcer. The MDS failed to capture Resident #7 had a Stage 1 PU on the right heel, and an unstageable pressure ulcer on the coccyx. The concern with the MDS inaccuracy was discussed with Staff #2, MDS Coordinator on 4/2/26 at 12:46 PM and the MDS Coordinator confirmed the findings at that time. Cross Reference F 641 7) A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care. Review of Resident #7's care plans failed to reveal a comprehensive care plan with measurable goals had been developed to address Resident #7's pressure ulcers which were present when the resident was admitted to the facility. Cross Reference F656 On 4/2/26 at 12:35 PM, the Nursing Home Administrator (NHA) stated that the facility had a wound nurse who did rounds with the wound NP and put in treatment orders, the nurse on the unit who admits the resident initiates the baseline care plan, and care plans are completed by the Unit Managers. On 4/2/26 at 1:56 PM, during an interview, Staff #1, Registered Nurse (RN), evening supervisor, stated on Mondays and Thursday, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with wounds were seen by the NP. The NP assessed & measured the wounds and recommended wound treatment orders. Staff #1 stated s/he followed the wound NP on those days, and transcribed NP's wound treatment orders into the resident's medical record. Staff #1 recalled Resident #7 came into the facility with multiple wounds, including PU on the sacrum and heels, Staff #1 stated s/he was not aware of any concerns with Resident #7's treatment orders. Staff #1 was then made aware of the above concerns with the delay in the care of Resident #7's pressure ulcers resulting from failing to have PU treatment orders entered in the medical record timely. Staff #1 indicated s/he understood and stated s/he would talk with the DON about the concerns identified by the surveyor. On 4/2/26 at 2:53 PM, Staff #1, RN returned to speak with the surveyor and indicated the reason for the delay Resident #7's wound treatment was because the resident's frequent refusal of care. Staff #1 was again made aware of the concern that PU treatment orders recommended by the wound NP were not entered in the resident's medical record, resulting in a delay in care. Staff #1 was also made aware of the concerns with failing to have a care plan that addressed the resident's pressure ulcers and failing to implement an order timely for an alternating air/low air loss mattress for pressure redistribution as recommended by the NP. Staff #1 acknowledged the concerns at that time, and stated s/he did not know why the treatments orders were not put in the resident's medical record. On 4/3/26 at 7:37 PM, the above concerns were discussed with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The NHA and DON acknowledged the concerns at that time and no further comments were offered.