STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of resident council meeting notes and interviews it was determined that the facility failed to have an effective system in place to ensure grievance/concerns expressed during Resident Council were addressed and followed up on. This was found to be evident for three out of the past seven months of resident council meeting minutes reviewed. The findings include: On 6/5/25 review of the Resident Council Minutes for the meetings held from October 2024 through May 2025 revealed they were a typed word document that does not include specific sections to address follow up of old business. These notes included the name of different departments followed by concerns related to that department, if any. An interview with the Activity Director (Staff #16) on 6/5/25 at 4:24 PM revealed she had started in the position in October 2024. She reported that during the meetings they read the old minutes first for each category and go over what the complaint was and what was done to fix it. When asked how she informs the department heads of concerns she reported she emails them first and then speaks to them the next day. She also reported that the documentation in RED is what the staff responded. Further review of the meeting minutes failed to reveal documentation in RED prior to the minutes for February 2025. Review of the November 21, 2024 Resident Council minutes revealed in the section for Nursing: Resident said that they don't put in pain pills if they run out. They must wait for them to order more. No documentation was found in the November minutes to indicate this concern was addressed. No meeting was held in December. Review of the January meeting failed to reveal follow up regarding the nursing concern identified in November. During an interview with the Director of Nursing (DON) on 6/11/25 at 10:27 AM, when asked how he is made aware of concerns that arise at Resident Council, he reported that the staff, specifically the Activity Director, who attends the meeting is suppose to tell them. When asked how this communication is to take place, the DON responded: if a concern maybe do a concern form and let us know. Review of the grievance/concern logs for November and December 2024 revealed no concerns documented. Review of the January Grievance Log revealed one concern for the month, this concern was in regard to medications, however it was in regard to a specific resident who had not attended the resident council meetings. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the February 27, 2025 meeting minutes revealed in the section for Nursing: Residents said they are not getting meds. Although there is some documentation in RED addressing some of the councils concerns, there was no documentation found to indicate this nursing concern was addressed. Review of the February 2025 Grievance Log revealed there were no concerns documented. Review of the March 27, 2025 Resident Council meeting minutes revealed: The following is a list of Nursing concerns discussed during the meeting: 1. Nursing staff are mean, they push, they pull, and they are scared. 2. They come at 4:00am in the morning and try to change the room temperature after the resident said they are fine, then the nursing staff yells at you. Review of the March 2025 Grievance Log revealed documentation of four grievances, dated 3/27, from the Resident Council. These involved housekeeping, maintenance, kitchen, and activities. No documentation was found on this log to indicate the nursing concerns identified during the meeting were addressed. No documentation was found in the March or April 2025 meeting minutes to indicate the nursing concerns identified in the March meeting were addressed by nursing or other members of the facility administration. On 6/5/25 at approximately 4:00 PM surveyor reviewed with the Director of Nursing (DON) the list of concerns for nursing from the March 27, 2025 meeting notes. The DON indicated he was not aware of these concerns. During the interview on 6/5/24 at 4:24 PM with the Activity Director, surveyor reviewed the concern that there was no RED response to the nursing concerns documented in the March meeting minutes. When asked what she thought these statements sounded like, the Activity Director responded: I would say abuse. She then went on to say she did not consider this to be an abuse allegation but that the residents were sleeping and startled awake. When asked if anyone was informed of these concerns, the Activity Director was able to show an email that indicated the meeting minutes were sent to the department heads, including the current DON and Nursing Home Administrator (NHA), on 3/28/25. On 6/10/25 at 4:32 PM surveyor reviewed the concern with the NHA regarding the failure to follow up regarding the nursing concerns identified in the March 2025 Resident Council. On 6/11/25 at 10:27 AM during an interview with the DON and the corporate nurse (Staff #7) surveyor reviewed the concerns regarding the failure to follow up about the medication concerns identified in the November and February meetings as well as the issues identified in March. The corporate nurse reported there will be a different process moving forward. Cross reference to F 684

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on record reviews and interviews, it was determined that the facility failed to ensure quarterly statements for personal funds were provided to the residents. This was evident in 1 (Resident #54) of 1 resident reviewed for personal funds. The findings include: Resident #54 was admitted into the facility in late 2020. A quick look into the resident's medical record revealed a comprehensive assessment with a reference date of 7/30/24, that indicated an intact cognitive pattern. The medical record also indicated that the resident was his/her own responsible party (RP). Resident #54 was interviewed on 6/4/25 at 11:54 AM. During the interview, the resident reported that s/he had a personal funds account that was being managed by the facility and when asked if the facility provided him/her, at a minimum, quarterly statements of his/her account, s/he stated, last one I got was January. I need to get a new statement. The business office manager (Staff #18) was interviewed about personal funds on 6/9/25 at 3:05 PM. During the interview, Staff #18 reported her process in providing quarterly statements to residents and/or RP. Staff #18 indicated that she hand delivers quarterly statements to residents who are capable, have them sign the statement and then keeps a copy of the signed statements in a binder in her office. Staff #18 confirmed that Resident #54 had a personal funds account with the facility and that the resident was one that she hand delivers the quarterly statements to. When Staff #18 was asked if the resident had received last quarters statement, she answered, I've been behind and busy, so I still have his/hers to give to him/her. A review of the binder for quarterly statements was conducted with Staff #18 on 6/9/25 at 3:15 PM. The review revealed the last statement signed by Resident #54 was for the period 10/1/24 to 12/31/24. Staff #18 printed a copy of the resident's statement for the period 1/1/25 to 3/31/25 and indicated that she would also give it to the resident and have him/her sign it for her records. On 6/9/25 at 3:40 PM, the Nursing Home Administrator (NHA) was interviewed about personal funds. The NHA indicated that Staff #18 had already informed her of the concern that Resident #54 had not received his/her personal funds statement for the 1st quarter of this year. The NHA verbalized understanding and acknowledged the concern.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 2.) On 6/4/25 at 1:37 PM the surveyor observed the spa room on the third floor and noted cracked tile and discoloration in the two shower stalls. On 6/09/25 at 12:35 PM an observation of the spa room on the first floor revealed an out of order sign on one of the three showers. The shower was noted to have a missing shower head and multiple missing tiles. On 6/11/25 at 11:31 AM the Maintenance Director (Staff #8) reported staff informed him of maintenance concerns both verbally and in a maintenance log on each unit. He reported the maintenance logs are checked twice a day. In regard to showers, Staff #8 reported there are six that were currently working and two that were down, but that the one that was out of order on the first floor would be ready later today. On 6/11/25 at 1:08 PM the surveyor observed that one of the three showers in the second floor spa room did not have a shower head, unit nurse manager (Staff #13) reported this shower was out of service and confirmed that it was out of order due to the shower head. Review of the third floor maintenance log with Staff #8 on 6/11/25 at approximately 11:40 AM failed to reveal documentation that indicated the shower rooms were in need of repair. Then, observation of the third floor spa room, with Staff #8, revealed two functioning shower stalls. The stall on the right was noted to have brown discoloration on the grout where the wall met the floor; additionally small black splotches were noted on multiple tiles on the lower portions of walls, and several of the floor tiles were noted with gray discoloration. The stall on the left had similar gray discoloration on the floor tile; brownish stains noted along some of the grouting as well as several tiles on the lower portion of the walls; at least eight of the lower wall tiles were observed to have significant cracks; and the grouting around the drain was noted to have brown discoloration. On 6/11/25 at approximately 12:15 PM, during a follow up observation of the third floor shower room, surveyor noted there were dirty washcloths in both of the shower stalls, and a shower chair was present in the stall on the left. During this observation Nurse (Staff #19) entered the spa room, she confirmed that both shower stalls were used to shower residents. Based on observations, record reviews, and staff interviews, it was determined that the facility failed to provide a clean, comfortable, and homelike environment for residents. This was evident by (1) stained privacy curtains in a resident's room that remained unaddressed over multiple days despite awareness by staff, and (2) broken shower areas in disrepair that were used for resident bathing without timely repair or documentation in maintenance logs. These failures were observed in two (first floor and third floor) of six functioning resident shower areas and one (Resident #94) resident room during the recertification survey. The findings include: 1.) During the initial tour of the first-floor unit on 6/4/25 at 11:08 AM, an observation of Resident #94's privacy curtains was made. The privacy curtains were noted with dark brown stains. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent observation on 6/10/25 at 7:04 AM showed that Resident #94's privacy curtains continued to contain dark brown stains. In an interview on 6/10/25 at 7:32 AM in Resident #94's room, Staff #6, unit manager for the first-floor unit, confirmed the concerns and added that the environmental services department was aware of the stained privacy curtains but was unsure why they were not changed. During an interview on 6/10/25 at 8:39 AM, Staff #4, the environmental services supervisor, confirmed that Resident #94's privacy curtains were stained with dark brown substance. Staff #4 also added that she was responsible for changing all the residents' privacy curtains every 6 months or whenever they were stained but was not aware that Resident #94's privacy curtains were stained. In a subsequent interview with Staff #4 on 6/10/25 at 9:55 AM, she reported that she had changed all the stained curtains after the surveyor's intervention.

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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. Based on document review and interview it was determined that the facility failed to implement their grievance policy. This was evident for two (# 16, #517) of two residents reviewed for personal property during the survey. The findings include: 1) On 6/5/25 Intake #MD00216136 was reviewed. The review revealed a concern that Resident #16, a long-term resident of the facility, was missing some clothes. The concern was submitted in March 2025. On 6/10/25 at 8:18 AM The Environmental Services Supervisor (EVS) (Staff #4) supervisor was interviewed regarding her role in helping to locate missing laundry. During the interview she reported that she had a discussion with Resident #16 and the resident's family member. The discussion took place around March 2025. Staff #4 reported that both Resident #16 and the Resident's son told her that Resident #16 was missing some of his/her clothing. Staff #4 stated that she was unable to find the missing clothes. Staff #4 reported that she did not fill out a grievance form nor forward the concern to the Director of Nursing or Nursing Home Administrator regarding the missing clothing. On 6/10/25 at 9:05 AM The Social Service Director (Staff #9) was interviewed. During the interview he reported that he did not have a grievance form regarding Residents #16 missing clothes for the year 2025. On 6/11/25 08:41 The Administrator provided an attendance sheet for an Inservice with the Topic of Grievance Policy Personal Belongings and role of Social worker. The Inservice was dated 12/6/24. Review of the attendance sheet revealed that the EVS director attended the grievance training. On 6/11/25 The facility's policy titled Resident and Family Grievances. was reviewed. The review revealed the following: The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. On 6/11/25 at 10:16 AM The above concerns were discussed with the Administrator. During the interview she reported that the most recent grievance form regarding Resident's clothing was dated 9/16/2024. She failed to provide a grievance form for the Residents #16 recent concerns. At this time the concerns were discussed that the grievance process was not followed when the EVD received the complaint. No other information was provided prior to the end of the survey. 2) On 6/5/25 at 11:58 AM, Resident #517's family member, the complainant, was interviewed. When I visited on December 28, 2024, the day after admission, my dad/mom was asleep- curled up. I checked-in with the nursing station and dropped off supplies in a green bin. When I came back 48 hours later, on December 30, 2024, in the afternoon, s/he was in the same clothes and same curled up position, clothes were soiled, and the room was dark. It didn't look like anyone had been in to give basic care. I immediately made a complaint about the conditions to a nurse, a male nurse. My family and I met with a male nurse, the Social Worker and two other females, I'm unsure if they were nurses or administrators. The meeting was confrontational and hostile. After the meeting, the nurse helped us clean up dad/mom. I moved dad/mom to another facility as soon as possible. The interviewee confirmed that no further communication was received from the facility regarding the complaint. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25, a record review of Resident # 517's closed record revealed the date of admission as 12/27/2024 and in an interview with Staff #17, she confirmed Resident #517 was a resident from December 27, 2024, to January 8, 2025. On 6/6/25 at 8:41 AM in an interview with the Director of Social Services (Staff #9), employed at this facility since February 2022, indicated a faint recollection of Resident #517 but denied any recollection of the complaint described above. He detailed that a complaint or grievance would have been initiated once he heard about it. He indicated that he would follow up about the complaint, initiate a grievance form and take it to the Unit Manager. The Unit Manager had 48 hours to investigate and return the form to him. He saved it in the Grievance Log. He acknowledged that he had written no concerns in the December 2024 Grievance Log. On 6/6/25 at 9:14 AM a record review of Birch Manor's Resident and Family Grievance Policy revealed, in part, that grievance(s) will be active until resolution. The process includes receiving and tracking of the complaint and issuing a written notice of the grievance decision(s) to the residents or family members by the Grievance Official or designee. Initiating grievance(s) may be verbal or written and submitted anytime to any staff members or directly to the Grievance Official. Staff members will record the nature and specifics of the grievance onto the facility's grievance form commencing the investigation of the grievance. Allegations of neglect will be immediately reported to the administrator. Resident and/or family will be informed of the progress towards resolution. A written decision will be made at the conclusion of the investigation. On 6/6/25 at 10:21 AM the Staff #8 acknowledged that he had never read the Grievance Policy. On 6/6/25 at 10:26 AM in an interview with the facility's designated Grievance Official, the Nursing Home Administrator (NHA), she detailed that anybody could make a grievance either to me or staff, either verbally or email, whatever. She indicated that there is not a specific process to file a grievance. She continued, depending on the nature, I might include Staff #8 to keep a log as the tracking mechanism. Staff would investigate and verbally communicate with the residents involved. Not everyone knows the grievance process. NHA reviewed the 2024 Grievance Log and acknowledged that the facility did not follow the grievance process. On 6/9/25 at 10:32 AM during an interview with Staff #8, he acknowledged that he was at work, in the facility, on December 30, 2024, and stated, If I was involved in Resident #517's care on December 30th, I would have written a note. A record review in PointClickCare (PCC), an electronic health record, revealed a Care Plan Meeting note indicating an initial meeting and Staff #8 will continue to assist and follow; no grievance note was entered. On 6/10/25 at 9:02 AM the Director of Nursing (DON) acknowledged that the grievance process was broken. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 9:18 AM during an interview, the NHA acknowledged that the facility needed to fix the grievance process. A record review of other facility documents for the relative period, December 27- December 30, 2024 revealed: 1. the facility had sufficient staffing, 2. Resident #517 had documented care Tasks completed by Geriatric Nurse Assistants (GNAs), and 3. Resident #517 had documented medication administration and vital signs.

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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 record reviews and interviews, it was determined that the facility failed to report allegations of abuse. This was evident for one (Resident #50) out of three investigated for Abuse. The findings include: Resident #50 has medical conditions that include a traumatic brain injury, anxiety, depression, a seizure disorder, and problems with thinking and memory (cognitive impairment). On 6/4/25 at around 10:15 AM, the surveyor reviewed complaint MD00216414. The complaint stated that Resident #50 had been taken to the local hospital's emergency room on 4/5/25 following an episode in which the resident became combative. While there, the resident told a nurse that s/he had been hit and punched by staff at [NAME] Lake Birch Manor. The hospital staff examined the resident and found two small bruises-one under the left eye and one on the middle-left side of their back. On 6/06/25 at 4:17 PM, the surveyor reviewed the progress notes for Resident #50. The notes showed that the resident had been readmitted to the facility on [DATE]. A nurse wrote: A head-to-toe skin check was done with the wound nurse and unit manager. The resident had a healing yellow-colored bruise near [their] left eye and a round bruise, about 2 cm in size, in the middle of [their] chest. No other bruises or open areas were found at this time. Further review of Resident #50's medical record revealed a physician's progress note dated 4/9/25 (late entry for visit on 4/8/25): Upon evaluation today, patient was guarded and refused to talk in [their] room for concern that roommates may overhear [them] talking and was taken to the Social Worker Director's office to complete the telehealth visit in privacy. When asked what led to [the] recent psychiatric hospitalization, the patient was vague regarding details but alleged that s/he was punched by a black male staff member for asking for medication for a migraine s/he was experiencing and kicked by him. S/he denied any verbal altercation taking place. On 6/6/25 at 4:38 PM, the surveyor interviewed the Nursing Home Administrator (NHA). The surveyor asked if the NHA was aware of any reports of abuse since the beginning of April 2025, and she replied, No, none that I know about. The surveyor then asked the NHA to review the physician's note from 4/9/25 for Resident #50, which said that the resident had claimed a black male staff member punched and kicked them. The surveyor asked what should be done if a resident reports abuse. The NHA said, I did not know about it. I know I should report all allegations of abuse to the Office of Healthcare Quality (OHCQ) within two hours and start an investigation immediately. On 6/09/25 at 9:01 AM, the surveyor reviewed the facility's Abuse, Neglect, and Exploitation policy and procedure, dated 11/13/2023. It states the following (in part): VII. Reporting/Response 1.All alleged violations must be reported to the Administrator, state agency, adult protective services, and any other required agencies. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Reports must be made immediately, but no later than 2 hours after the allegation is made, if the situation involves abuse or results in serious bodily injury. On 6/09/25 at 3:20 PM, the surveyor asked the Director of Nursing (DON) if they had reported the allegation, and he stated, No, not yet, we will soon. On 6/09/25 at approximately 4:30 PM, the surveyor spoke with the Nursing Home Administrator (NHA) and asked if the facility had reported the allegation of abuse. She said that they did not, explaining that she didn't realize they were supposed to because it happened in the past. On 6/09/25 at 5:33 PM, the Director of Nursing (DON) notified the surveyor that the facility had reported the allegation of abuse to OHCQ. The surveyor was able to confirm that the allegation was reported on 6/09/25 at 4:40 PM intake # MD00218617.

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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 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 reviews and interviews, it was determined that the facility failed to investigate allegations of abuse. This was evident for one (Resident #50) out of three investigated for Abuse. The findings include: Resident #50 has medical conditions that include a traumatic brain injury, anxiety, depression, a seizure disorder, problems with thinking and memory (cognitive impairment). On 6/4/25 at around 10:15 AM, the surveyor reviewed complaint MD00216414. The complaint stated that Resident #50 had been taken to the local hospital's emergency room following an episode in which the resident was combative. While there, the resident told a nurse that s/he had been hit and punched by staff at [NAME] Lake Birch Manor. The hospital staff examined [the resident] and found two small bruises-one under the left eye and one on the middle-left side of [their] back. On 6/06/25 at 4:17 PM, the surveyor reviewed the progress notes for Resident #50. The notes showed that the resident had been readmitted to the facility on [DATE]. A nurse wrote: A head-to-toe skin check was done with the wound nurse and unit manager. The resident had a healing yellow-colored bruise near [their] left eye and a round bruise, about 2 cm in size, on the middle of [their] chest. No other bruises or open areas were found at this time. Further review of Resident #50's medical record revealed a physician's progress note dated 4/9/25 (late entry for telehealth visit on 4/8/25): Upon evaluation today, patient was guarded and refused to talk in [their] room for concern that [their] roommates may overhear [them]talking and was taken to the Social Worker Director's office to complete the interview in privacy. When asked what led to [the] recent psychiatric hospitalization, the patient was vague regarding details but alleged that s/he was punched by a black male staff member for asking for medication for a migraine s/he was experiencing and kicked by him. S/he denied any verbal altercation taking place. On 6/6/25 at 4:38 PM, the surveyor interviewed the Nursing Home Administrator (NHA). The surveyor asked if the NHA was aware of any reports of abuse since the beginning of April 2025, and she replied, No, none that I know about. The surveyor then asked the NHA to review the physician's note from 4/9/25 for Resident #50, which said that the resident had claimed a black male staff member punched and kicked them. On 6/09/25 at 9:01 AM, the surveyor reviewed the facility's Abuse, Neglect, and Exploitation policy and procedure, dated 11/13/2023. Which, in part, revealed the following (the policy and procedure explains the facility process for handling abuse, neglect, and exploitation): IV. Identification of Abuse, Neglect and Exploitation Possible indicators of abuse include, but are not limited to: 1. Resident, Staff, or family report of abuse 2. Physical marks such as bruises (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Investigation of alleged Abuse, Neglect, and Exploitation A. An immediate investigation is warranted when suspicion of Abuse, neglect, exploitation, or reports of abuse, neglect, or exploitation occur. B. Written procedures for investigations include: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause, and providing complete and thorough documentation of the investigation. VI. Protection of the Resident The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples were provided that included an immediate physical exam of the alleged victim, increased supervision of the victim and other residents, room or staffing changes, protection from retaliation, emotional support and counseling, revision of care plan. On 6/09/25 at 11:49 AM, the surveyor spoke with Resident #50 and asked if s/he recalled an incident in which s/he reported an allegation of abuse. S/he stated that they had previously been hit and kicked by a staff member. The surveyor asked if the facility had followed up with them about the alleged abuse, and s/he stated that they had not. On 6/09/25 at 1:33 PM, the surveyor spoke with the Director of Nursing (DON) about the allegation of abuse that Resident #50 had reported to their psychiatrist during a telehealth meeting held in the social worker's office. He stated that the facility did not investigate the allegation because the doctor did not inform the facility that it had been made. The surveyor asked if it is the expectation that the physician report such allegations, and he said it is. The surveyor then asked if the facility reviews physician notes, and the DON said they do, and that they should have caught it. He also mentioned that on the day the resident was sent to the hospital, they [Resident #50] had been combative, and a soft file about the incident was started. The DON did not provide any investigation documentation. On 6/09/25 at 1:52 PM, the surveyor interviewed the Director of Nursing (DON) and the Regional Director of Nursing (RDON). The surveyor asked which staff are responsible for reviewing physician notes. The DON stated that the current process is for the clinical team to review the notes. The surveyor then asked why the allegations of abuse reported by Resident #50 were not followed up on, since they were documented in the physician's note. The DON stated, This particular note was missed. He further explained that typically, the team receives alerts about physician notes to review, called 24-hour look-back notes. The surveyor asked if the allegation should have been noticed during the 24-hour look-back review, the DON said, yes. The RDON added, Our normal practice is that we take the allegations very seriously, and we realize this was missed. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/09/25 at approximately 4:30 PM, the surveyor spoke with the Nursing Home Administrator (NHA) to inquire about the status of the investigation. She stated that she didn't understand why it needed to be investigated, since we have already investigated and know what happened. The surveyor informed the NHA that the Director of Nursing (DON) stated there had been no investigation because the facility didn't know about the allegation of abuse. The NHA replied, Well, we know what happened that day, so it's just semantics now. The surveyor asked again, Did you know about this allegation? Because I was told you didn't. She replied that they knew details about what happened that day but not that the resident had alleged abuse by a staff member. On 6/09/25 at 5:33 PM, the Director of Nursing (DON) notified the surveyor that the facility had reported the allegation of abuse to OHCQ. The surveyor was able to confirm that the allegation was reported to OHCQ on 6/09/25 (intake number MD00218617). At the time of exit the facility had not produced evidence of an investigation into the allegation of abuse.

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	215136	A. Building B. Wing	06/11/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review and interview it was determined that the facility failed to provide written notice of the bed hold policy and transfer to the resident's responsible party; and failed to ensure all required information was included in the forms currently being used to provide notification of transfer and bed hold. This was found to be evident for one (Resident #76) out of four residents reviewed for hospitalization during the survey. The findings include: On 6/5/25 review of Resident #76's medical record revealed the resident was not capable to make health care decisions and a Responsible Representative was identified for the resident. On 6/9/25 the resident was sent to the hospital via emergency medical services. Review of the Change in Condition Review form, dated 6/9/25 revealed the Responsible Representative was not present at time of discharge but that the Bed Hold Policy and the Reason for Transfer/Discharge was sent to the Representative. This form was signed by nurse (Staff #20). On 6/10/25 at 3:13 PM when asked how the Bed Hold and Transfer Notice were sent to the representative, Nurse #20 reported they give a copy to the Social Worker who sends it out. Surveyor requested a copy of the information that was sent. Review of the Notification of Resident Hospital Transfer form, provided by Nurse #20 for Resident #76 revealed documentation that the resident was sent to the hospital on 6/9/25, but in the area to choose a reason for the transfer none of the 8 options (including other) was marked. Additionally, in the area to document the location of the transfer, none of the four hospitals listed were marked. The form was signed by facility staff on 6/9/25. At the bottom of the Notification of Resident Hospital Transfer form the following statement was found: You have the right to appeal this decision to the appropriate state long term care agency at the address show below. In addition, you may wish to contact the Office of State Long-Term Care Ombudsman or the state agencies responsible for the protection and advocacy of developmentally disabled or mentally ill individuals. There was no additional information, or addresses included with this form. The Notification of Resident Hospital Transfer form being utilized by the facility failed to include the following required information: -The name, address (mailing or email), or the telephone number of the entity which receives such requests; or information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; -The name, address (mailing or email) or the telephone number of the Office of the State Long-Term Care Ombudsman. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Bed Hold Notice for Resident #76 revealed the nurse signed the form on 6/9/25 under the Request for Bed Hold section, and the resident's name and room number had been filled in at the bottom. All of the other sections that indicated answers should be filled in are noted to be blank. The form failed to document why the form was being provided; failed to indicate if a Request for Bed Hold was made or if there was a Release of Bed. The section I understand that the basic per diem rate is $_____ per day. failed to include a monetary amount. The Bed Hold Notice also stated: This notice fulfills requirements to remind you of this facility's bed hold policy (see attached). Please read carefully and indicate whether or not you wish to reserve your room. There was no attached bed hold policy provided with this notice. On 6/11/25 a review of the Bed Hold Notice policy, with a revision date of 4/28/2025, was conducted. The policy provided failed to include the facility name or the name of the corporation running the facility. The policy stated that the facility will provide the resident and/or the resident representative written information that specifies: the duration of the State bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; and the reserve bed payment policy in the state plan policy, if any. This policy fails to state if the facility intends to hold a resident's bed for a specific length of time. Continued review of the Bed Hold Notice form revealed the following statement : Maximum number of days the State Plan pays for resident is 14 days. In 2012 the state of Maryland stopped paying for bed holds. On 6/10/25 at 3:46 PM the Social Worker (SW Staff #9) was interviewed in regard to the provision of the Transfer Notice and the Bed Hold Notice. The SW #9 reported he calls the family, and tells them: we have a bed hold policy; we will hold the bed for the patient, when or if they want to come back we will have a bed for them; the bed hold policy says 14 days but if after the 14 days we will still have a bed for them. If they want that specific bed I tell them it might be a payment but try our hardest to hold that bed. The SW confirmed that he only sends a copy of the bed hold if the representative requested that it be sent. The surveyor then provided the resident's Notification of Resident Hospital Transfer form for Resident #76 to the SW to review. After review, the SW denied discussing this form with family. He indicated he will send this form with the bed hold notice, if the family requests. SW reports he does not document the phone calls to the family and that he had not yet contacted Resident #76's representative. Surveyor reviewed the concern that the nursing staff had already documented that both these forms had already been sent to the representative. On 6/10/25 at 4:09 PM surveyor reveiwed the concern with the SW that the Bed Hold Notice failed to include the per diem rate, he was unable to provide the current rate, and stated it varies depending on the location of the bed. On 6/10/25 at 4:18 PM surveyor reviewed the concern with the NHA that the transfer notice fails to include required information and the report from the Social Worker that he is only mailing out the information if the representative request it be sent.

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately documented. This was evident for 1 (#94) out of 2 Residents reviewed for dental care. The findings include: The Minimum Data Set (MDS) is an assessment of the Resident that provides the facility with the necessary information to develop a care plan, deliver appropriate care and services to the Resident, and modify the care plan based on the Resident's status. 1a) An observation on 6/4/25 at 11:13 AM showed that Resident #94 was edentulous (had no teeth). The Resident stated at that time that s/he wore complete dentures. However, they were left at home. A review of Resident #94's record contained a Nursing admission assessment completed on 1/12/25. The assessment recorded that Resident #94 had no natural teeth. However, a continued review of Resident #94's MDS assessment dated [DATE] showed an answer NO to the statement No natural teeth or tooth fragment(s) (edentulous) in section L, which meant that the Resident had natural teeth. In an interview on 6/5/25 at 2:52 PM, Staff #24, a Geriatric Nursing Assistant, reported that Resident #94 had no natural teeth. During an interview on 6/10/25 at 8:53 AM with Staff #25, MDS Coordinator, she said that Resident #94's dental status recorded on his/her MDS assessment dated [DATE] was documented in error. 1b) A review of Resident #94's MDS assessment dated [DATE] contained a signature page in section Z that recorded that sections CDEQ of the MDS were completed by Staff #26, a Social Worker. During an interview on 6/10/25 at 8:13 AM, Staff #9, the Social Services Director, reported that Staff #26 was a Social Services Assistant and not a Social Worker. In an interview on 6/10/25 at 8:53 AM, Staff #25, an MDS coordinator, stated that Staff #26 was not a Social Worker and that she would contact her corporate office about the inaccurate information on the signature page of the MDS assessment.

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 4. On 6/5/25 at 9:36 AM Resident #76 was observed in bed, the resident replied to surveyor greeting with a thumbs up but did not verbally respond. Review of Resident #76's medical record revealed the resident had resided at the facility for more than a year and was totally dependent on staff for activities of daily living such as dressing, eating, transferring from bed to wheelchair and mobility. According to the resident's care plan, the resident had a communication problem related to expressive aphasia (unable to communicate verbally) but was able to communicate by pointing and gestures. On 6/9/25 a further review revealed it was very important to the resident to listen to music s/he likes and to do things with groups; it was somewhat important to be around animals, keep up with the news, go outside to get fresh air when the weather is good and attend religious services. Review of the resident's care plan revealed two separate plans which addressed activities, both with revision dates of 2/25/25. The Care Plan initiated 2/14/24 had the following focus: [name of resident] is unable to plan [her/his] day and is dependent on staff for meeting emotional, intellectual, physical, and social needs has had little involvement in activity programs. And a goal of: [name of resident] will be encouraged to have good facial expressions, give hand gestures during encourage/provide modified social interaction of individualized visits to support enhance [her/his] daily living through the next 92 days. The interventions included: All staff to converse with [name of resident][while providing care; Invite [name of resident] to scheduled activities; Provide with activities calendar. Notify [name] of any changes to the calendar of activities; [name] needs 1:1 bedside/in-room visits and activities if unable to attend out of room events; and [Name] needs assistance/escort to activity functions. The Care Plan initiated on 11/25/24 had the following focus : [name of resident] will receive 1 on 1 visit with the activity staff 2 times a week. There will be music and story reading. And a goal of: Will have the opportunity to enjoy activities of choice through the next review date. However, the Interventions included the following: If resident cannot be redirected during verbal outburst towards others, assist Resident to a quiet area with decreased stimulation, such as [her/his] room or outside courtyard, and allow [him/her] to express [his/her] feelings; Notify nurse of all negative behaviors that occur during activities, regardless of redirection outcome; Staff to provide 1:1 room visits as desired/available; and Staff to provide a monthly calendar. During a 6/9/25 interview with the Activity Director #16, she reported that for Resident #76 they did hand massages at least twice a week for 1:1 and read the resident the daily bread (small bible reading) and the daily chronical. Further review of the care plans failed to reveal documentation about provision of hand massages. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the 6/9/25 interview, the Activity Director went on to report that she completed an assessment on March 7 with a family member and that the family said the resident liked Christian music. Later in the interview, the Activity Director clarified that the family said the resident was Christian, but did not specify what type of music the resident liked. When asked how staff would know what type of music to play for the resident, the Activity Director reported that staff had access to the assessment. Further review of the medical record revealed an Annual Activities Assessment, with an effective date of 3/7/25 and signed by the Activity Director (Staff #16) on the same date. It indicated current activity patterns included music and watching TV/Movies. In section D. Current Activities it was documented that the resident liked dogs, liked to watch sports including baseball and football and specified the resident's current religion. This form also documented that it was very important to listen to music s/he likes and to do things with groups of people. Further review of the medical record revealed a Activity Quarterly Review, with an effective date of 5/30/25 and signed by the Activity Director #16 on the same date. This form included the following statement: [name of resident] enjoy watching game show, comedy movies and other television shows along with listening to R & B music. In the section for Activity Plan Review revealed the current focus remained appropriate/current as per care plan; the goals were met and the interventions/approaches have been effective in reaching the goals. No changes were recommended for the focus, goals or interventions. Neither of the care plans for activities include information regarding the provision of music for the resident to listen to, or what type of music the resident would prefer. It failed to include what programs the resident would prefer on TV or what type of stories the resident would prefer to have read. The care plan failed to include which religious denomination the resident was affiliated with to assist with provision of religious activities. During an interview with the Activity Director #16 on 6/9/25 at 12:01 PM, she reported that she completes the assessments, develops the care plans and attends the care plan meetings when she has time. Surveyor reviewed the concern that the care plan does not reflect the resident assessments. Cross reference to F679 2. Resident #50 had medical conditions that included a traumatic brain injury, anxiety, depression, a seizure disorder, problems with thinking and memory (cognitive impairment). On 6/04/25 at 10:17 AM, the surveyor spoke with Resident #50 and asked if they participated in any of the facility's activities. The resident stated that they hadn't found anything they enjoyed, but if there were some activities they liked or a group of people to go with, they might attend. The surveyor also asked if the resident had participated in their care planning. The resident stated that they were not sure what a care plan meeting is or whether they had ever participated. An MDS (Minimum Data Set) assessment is a standardized tool used in long-term care facilities to assess a resident's functional, medical, psychosocial, and cognitive status. It's a comprehensive assessment used to collect data on residents in nursing homes, ensuring a standardized way to communicate their needs and condition. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/09/25 at 10:09 AM, the surveyor performed a record review of Resident #50's admission MDS activities assessment dated [DATE] which revealed that the resident reported that is it very important to participate in religious services or practices and very important to have books, newspapers, and magazines to read. Surveyor review of Resident #50's Activities Care Plan revealed the following: -Resident #50 will Continue to do activities that interest her such as Music, TV/Movie, Daily Report and helping hand with the activity staff. -Resident #50 is dependent on staff for activities, cognitive stimulation, and social interaction. - Resident #50 will maintain involvement in cognitive stimulation and social activities as desired through the next 92 days. - All staff are to converse with Resident #50 while providing care. - Resident #50 needs assistance/escort to activity functions. -Encourage ongoing family involvement. Invite Resident #50's family to attend special events, activities, and meals. -Introduce Resident #50 to residents with similar backgrounds and interests, and encourage/facilitate interaction. -Provide an activities calendar and notify Resident #50 of any changes to the calendar. -Thank Resident #50 for attending activity functions. -When Resident #50 chooses not to participate in organized activities, turn on the TV or music in the room to provide sensory stimulation. Review of the care plan revealed that the facility failed to include that Resident #50 was provided with books, magazines, and newspapers, or participation in religious activities. These were activities that the resident had reported were very important to them. 3. Resident #110 has a medical history of cerebral infarction (stroke) with cognitive (thinking and learning), social, and emotional deficits related to the stroke. A cerebral infarction, also known as a stroke, is a medical condition where blood flow to the brain is interrupted, leading to brain tissue damage or death. On 6/04/25 at 10:42 AM the surveyor interviewed Resident #110 who stated that they use their phone and tablet for entertainment but don't attend activities because they would need someone to get them out of bed. The surveyor asked Resident #110 if they participated in their care planning and they replied, My son attends my care planning, but they don't include me because they would have to get me out of bed. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/09/25 at 11:03 AM, the surveyor performed a record review of Resident #110's Activities Care Plan, which revealed the following: -Resident #110 enjoys the daily report/menu and will receive a daily work hunt from the activity staff to complete independently in her room. -Activity staff will visit Resident #110 two times a week for a one-on-one activity of the resident's choice. -Resident #110 will have the opportunity to enjoy activities of choice through the next review date. -Staff are to assist Resident #110 in exploring any new activities of interest. -Staff are to assist Resident #110 with locomotion to activities as desired. -Staff are to encourage Resident #110 to attend activities of interest as they occur. -Staff are to invite the resident to all activities, regardless of previous attendance. -Staff are to provide one-on-one room visits as desired and when available. -Staff are to provide a monthly calendar. Review of Resident #110's care plan did not identify any documentation of the resident's specific activity preferences. On 6/09/25 at 12:01 PM, the surveyor interviewed the facility's Activities Director (AD#16) and asked how she determines what types of activities residents will participate in. AD#16 stated that she conducts an assessment upon admission, asking residents or their family members about activities they previously enjoyed, and then adds that information to the care plan. The surveyor asked AD#16 to review Resident #110's activities assessment, which failed to include the resident's preferences that were gathered during the MDS admission assessment. During interviews, Resident #110 stated that attending church and having access to reading materials-including books, magazines, and newspapers-are very important to them. AD#16 admitted , the plan didn't specifically mention the resident's preferences. The surveyor then reviewed Resident #110's activities documentation and care plan with AD#16 and asked for more detail on how she identifies and documents resident preferences. AD#16 gave a general explanation of her approach using a different resident (not Resident #110) as an example. She stated, I play Christian music for them. When asked whether the resident had said they liked Christian music, she replied, I don't know. I just play it because the resident is a Christian, so I thought they would like it. She added, I also play oldies music. When asked if the resident said they liked oldies, she responded, I don't know, but I like oldies.AD#16 also stated that she reads books to residents. When asked how she selects the reading material, she explained, I choose the books myself, usually poetry. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor expressed concern that the activity care plans were not based on the residents' stated preferences but rather on AD#16's personal assumptions about what residents might enjoy. AD#16 acknowledged the issue and stated she understood the resident's care plan should be based on their preferences and not what the activities director thinks that they might like. On 6/09/25 at 2:15 PM, the surveyor spoke with the Director of Nursing and the Regional Director of Nursing regarding concerns identified during a review of care plans-specifically for Residents #50 and #110. The surveyor noted that the residents' preferences were not clearly reflected. Both the Director and Regional Director of Nursing acknowledged the issue and agreed that the care plans need to be personalized.Based on medical record review and interview it was determined that the faciltiy failed to develop a resident centered care plan that reflected the comprehensive assessment. This was evident for 1) one (#107) of one residents reviewed for care planning, and three (#76, R#50, R#110) of four residents reviewed for activities during the recertification survey. The findings include: 1. A care plan meeting in long-term care is a structured discussion where residents, their families, and the long-term care facility's staff review and adjust the resident's individualized care plan. These meetings ensure the resident's needs and preferences are being met and that the care plan remains effective as their condition evolves. Federal regulation requires a facility to develop a comprehensive care plan within seven days of the completion of the comprehensive assessment or within 21 days of a new admission. On 6/4/25 at 10:27 AM in an interview, Resident #107 stated, I don't know anything about that. He/she indicated no one had ever talked to him/her about care planning. On 6/6/26 at 12:51 PM a record review revealed that Resident #107 was admitted on [DATE], a baseline Care Plan dated 4/7/25 was initiated and the Comprehensive admission Assessment was completed and signed on 4/18/25. No other care plan documentation was available in the electronic health record to review. On 6/6/25 at 3:45 PM Staff #9, Social Services Director, confirmed that a comprehensive care plan should have been completed within 7 days of the comprehensive assessment or 21 days after the resident's admission. It was acknowledged that no documentation existed in the electronic health record. It was also confirmed that there was a lack of documentation indicating IDT services regularly attend care plan meetings. On 6/6/25 at 3:55 PM Staff #9 acknowledged the concern. On 6/6/25 at 4:20 PM the Director of Nursing and Nursing Home Administrator acknowledged the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 2) Review of Resident #59's medical record on 6/6/25, revealed the resident has resided at the facility for several years and had a MDS assessment with an assessment reference date (ARD) of 3/25/25. Further review of the medical record failed to reveal documentation to indicate a care plan meeting had occurred following the March MDS assessment. On 6/6/25 at 3:23 PM an interview with Staff #26 revealed she is sent the MDS dates and her process was to write down every name she sees and then calls the family to schedule a meeting. If she gets a call back then she schedules a meeting. When asked what happens if no call back, Staff #26 stated : usually have a meeting with the unit manager. She went on to indicate she would invite the resident, if deemed capable, and the family. She reported the notification to the resident would be verbal and family notification would be via voice mail. After reviewing the electronic health record, the Staff #26 reported Resident #59 has not had a meeting since January 2024. The Staff #26 went on to report that she has contacted the resident's family and left messages but does not have documentation of this contact. On 6/9/25 at 4:55 PM surveyor reviewed the concern with the corporate nurse (Staff #7) that there was no care plan meeting for Resident #59 since January 2024. As of time of survey exit on 6/11/25 at 2:15 PM no additional documentation was provided to indicate a care plan meeting was held for this resident for more than a year.3) During an interview on 6/4/25 at 11:16 AM, Resident #94 was asked if s/he participated in his/her care plan meetings and responded that s/he was not aware of any care plan meeting. A review of Resident #94's record showed that s/he had resided in the facility since January 2025. The review also noted an MDS assessment for Resident #94 dated 4/12/25, which was completed on 4/22/25. However, the review failed to indicate that a care plan meeting took place following that. In an interview on 6/10/25 at 8:13 AM, staff #9, Social Services Director, reported that IDT care plan meetings were scheduled for Residents based on their MDS schedules. However, the interview and earlier record review lacked documentation that a care plan meeting had occurred following Resident #94's quarterly MDS assessment completed on 4/22/25. 1) 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. They are required to be developed within 7 days of completion of a resident's admission comprehensive MDS assessment and revised at least every quarter (or more often as needed). A Minimum Data Set (MDS) assessment is a federally mandated assessment tool that nursing home staff use to gather information on each resident's strengths and needs. The information collected is used in the resident's care planning decisions. The facility must have care plans developed and revised by an IDT. Including the: attending physician, registered nurse, nursing aide, a representative from dietary services, the resident, and the resident's representative (as practicable). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #50 has medical conditions that include a traumatic brain injury, anxiety, depression, a seizure disorder, and problems with thinking and memory (cognitive impairment). On 6/04/25 at 10:17 AM, the surveyor asked Resident #50 if they had participated in the development of their care plan. The resident stated that they were not sure what a care plan meeting is or whether they had ever participated. On 6/09/25 at 4:03 PM, the surveyor reviewed Resident #50's medical record and admission history, which showed that the resident was originally admitted to the facility in September 2024. The documentation revealed that an interdisciplinary care plan meeting was held on 9/9/24. However, the surveyor was unable to find evidence that any additional care plan meetings had occurred since that time. On 6/09/25 at 4:31 PM, the surveyor interviewed the facility Social Services Assistant (Staff #26) and inquired about whether care plan meeting notes are kept in the electronic record, she responded, Yes. The surveyor then asked where meeting documentation could be found, and Staff #26 stated it should be in the progress notes under the title Care Plan Meeting Note. The surveyor requested evidence that the facility had held care planning meetings for Resident #50 since the admission meeting on 9/9/24. Staff #26 confirmed that the only care plan meeting note in the medical record was dated 9/9/24. On 6/09/25 at 4:53 PM, the surveyor interviewed the Social Services Director (Staff #9) and expressed concern that Resident #50 did not appear to have had any care planning meetings since 9/9/24. Staff #9 responded that he had recently met with Resident #50's son regarding a Medicare waiver they were working on. The surveyor clarified that they were specifically seeking evidence of interdisciplinary care plan meetings and that Staff #26 had confirmed there was no documentation in the medical record indicating that any such meetings had occurred. He stated that he would look into it. On 6/10/25 at 9:00 AM, Staff #9 provided the surveyor with a handwritten note dated 3/11/25, which he identified as documentation of a care plan meeting with Resident #50's son. However, the note only summarized a discussion regarding a Medicare waiver appeal and did not include any evidence that an interdisciplinary care plan was discussed or that other team members were present. The surveyor expressed concern to Staff #9 that most recent MDS assessment for Resident #50 was dated 3/13/25, indicating that a care planning meeting should have occurred after that date, but that the document submitted to the surveyor was dated 3/11/25 and didn't appear to be a care planning summary. The surveyor then asked Staff #9 which staff typically attend care plan meetings, and he responded that he (social work), the rehab manager, and the nurse manager usually attend. The surveyor then asked about the required timing of care plan meetings and Staff #9 stated they should occur upon admission and quarterly after. The surveyor expressed concern that the facility was unable to provide evidence of interdisciplinary care plan meetings for Resident #50 since 9/9/24. Staff #9 then acknowledged that required care plan meetings had not occurred since the original admission meeting that occurred on 9/9/24 and acknowledged the note he presented as a care planning note was related solely to the Medicare waiver appeal and did not reflect a care plan meeting. The surveyor asked if the handwritten note was a part of the medical record and he replied, No. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/10/25 at 11:10 AM, the surveyor spoke with the Director of Nursing (DON) regarding concerns that Resident #50 had not had any care plan meetings since 9/9/24. The DON confirmed that care plan meetings should have taken place, should involve the IDT, and are expected to be documented in the resident's medical record. Based on interviews and record reviews, it was determined that the facility failed to hold resident care plan meetings as required. This was evident for three (R#50, R#59, and R#94) of four residents reviewed for care planning during the recertification survey. The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) On 6/5/25 at 9:36 AM Resident #76 was observed in bed, the resident replied to surveyor greeting with a thumbs up but did not verbally respond. Review of Resident #76's medical record revealed the resident had resided at the facility for more than a year and was totally dependent on staff for activities of daily living such as dressing, eating, transferring from bed to wheelchair and mobility. According to the resident's care plan, the resident had a communication problem related to expressive aphasia (unable to communicate verbally) but was able to communicate by pointing and gestures. On 6/9/25 review of the annual MDS assessment, dated 2/10/25, revealed an interview was conducted with the family, or significant other, for Section F Activities. This assessment revealed it was very important to the resident to listen to music s/he liked and to do things with groups; it was somewhat important to be around animals, keep up with the news, go outside to get fresh air when the weather was good and attend religious services. Review of the resident's care plan revealed two separate plans that addressed activities, both with revision dates of 2/25/25. Both plans indicated the staff were to provide 1 on 1 room visits, but failed to include specific topics or activities the resident would enjoy. One of the plans stated that the resident will receive 1 on 1 visits with activity staff 2 times a week. Further review of the medical record revealed an Annual Activities Assessment, dated 3/7/25, that revealed the resident liked dogs, liked to watch sports including baseball and football and specified the resident's current religion. This form also documented that it was very important to listen to music s/he liked and to do things with groups of people. Further review of the medical record revealed a Activity Quarterly Review, dated 5/30/25 , that included: [name of resident] enjoys watching game shows, comedy movies and other television shows along with listening to R & B music. Neither of the care plans that addressed activities included information regarding the provision of music for the resident to listen to, or what type of music the resident would prefer. The care plans failed to include what programs the resident would prefer on TV or what type of stories the resident would prefer to have read. The care plan failed to include which religious denomination the resident was affiliated with to assist with provision of religious activities. During an interview with Staff #16 on 6/9/25 at 12:01 PM, she confirmed the only activity participation documentation for a resident was in the TASKS section of the electronic health record, this included room visits. She also reported that for Resident #76 they did hand massages at least twice a week for 1 on 1 and read the resident the daily bread (small bible reading) and the daily chronical. Further review of the care plans failed to reveal documentation about provision of hand massages. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Activities documentation form revealed areas for staff to document as needed during the day, evening and night shift. It included a list of current activities that could be documented. For example: M for music; OT for outdoors; P for parties/socials V for 1 on 1 visits; IV for in room visits; and CE for current events. If staff documented an activity they would also document the resident's level of participation: A for Active; P for Passive; or O for observed. Additionally, the following responses for all questions were also always available: RR for resident refused; RN for resident not available and NA for not applicable. Review of the Activities documentation for April 2025 failed to reveal documentation to indicate the provision of activities on April 5, 12, 13, 14, 15, 16, 17, 18. 19, 20, 22, 24, 26, 28, 29 or 30. On several of these dates staff did document NA on either the evening or the night shifts. The only activities that were documented were: in room visits; current events; television and on one occasion (April 6) there was documentation that the resident attended a Movie/Social. No documentation was found to indicate the resident was offered and refused additional group activities. No documentation was found to indicate the resident was unavailble for an activity. No documentation was found to indicate music was provided to the resident during April. Review of the Activities documentation for May 2025 failed to reveal documentation to indicate the provision of activities on May 1, 2, 5, 6, 7, 8, 9, 10, 11,12, 15, 16, 18, 20, 23, 24, 25, 27, 29 and 31. The resident was documented as not being available during day shift for activities on the May 19, 22, 26, 28 and 30; no activity was documented during the evening shift for these dates either. And on May 30th staff documented an in room visit during the day shift despite also documenting that the resident was not available. Current events was documented on 6 occasions and TV was documented on one day. No documentation was found that indicated the resident was offered and refused a group activity. No documentation was found that indicated music or hand massages were provided to the resident during May. Review of the Activities documentation for June 1-8 failed to reveal documentation to indicate the provision of activities on June 1, 2, 3, 4, 5, 6, and 8. Staff documented that the resident was not available on Wednesday June 4th during the day shift as well as the day shift on Saturday June 7th. However, they also documented an in room visit during the day shift on June 7th. On 6/9/25 at 12:09 PM surveyor reviewed the concern with the Staff #16 that the current care plan did not reflect the resident's assessment regarding preferred activities and the review of the staff documentation failed to support the provision of the twice weekly 1 on 1 visits as indicated in the care plan.4) A Brief Interview for Mental Status (BIMS) is a score ranging from 0 to 15 that measures an individual's cognitive ability. Zero represents no cognitive ability and 15 represents total, intact cognitive ability. On 6/4/25 at 10:27 AM Resident #107's untouched food tray was observed at the bedside; the resident was wearing a hospital gown and was awake but resting with eyes closed. The resident indicated that s/he had been in the facility for over a month and stated, I've never been offered activities. Resident #107 did not know information about the Resident Council nor the names of the Social Worker or Activities Director. On 6/6/25 at 12:51 PM numerous record reviews for Resident #107 revealed: admission date as 4/7/25 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS dated [DATE] revealed Resident #107's status: BIMS of 14 The resident indicated little interest or pleasure in doing things, sleeping difficulties and feeling tired. Preferred to be involved in routine activities as very important or somewhat important. The Care Area Assessment (CAA) Summary triggered Activities, yet it was not included in the care planning decision. The Care Plan dated 4/7/25 revealed daily visits from the activity staff, offered coffee and encouraged the resident to join group activities. On 6/10/25 a record review of Resident #107's 14-day look back Activity list revealed: 7 out of 11 days documented no activity for Resident #107. 5/30/25- at 1:52 PM one to one visit, current events and television 5/31/25- at 10:15 PM blank 6/1/25- at 7:00 PM blank 6/2/25- at 4:48 PM blank 6/3/25- missing 6/4/25- at 2:59 PM one to one visit, current events, television, coloring page and crossword puzzle 6/5/25- missing 6/6/25- at 2:59 PM current events, television, crossword puzzle 6/7/25- missing 6/8/25- missing 6/9/25- at 2:59 PM in room visit, current events and television On 6/10/25 at 12:06 PM in an interview with Staff #16, she acknowledged that Resident #107's level of participation indicated active. Staff #16 indicated, the Activities Department drops off The Daily Chronicle (a front- and back-page detailing menu, activities and trivia) and offered the resident coffee or juice 3 times a week. Staff #16 reviewed the 14-day look back Activity list and acknowledged a concern for Resident #107's activities and stated, I don't like neglecting my bedbound or dementia residents. I need more staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/25 the Director of Nursing (DON) and Nursing Home Administrator (NHA) were made aware of the activities concern. 1) The Minimum Data Set (MDS) is a comprehensive assessment of the resident's status so that the facility can develop a plan of care and provide the appropriate care and services to the residents, including activities. Resident #50 has medical conditions that include a traumatic brain injury, anxiety, depression, a seizure disorder, problems with thinking and memory (cognitive impairment). On 6/04/25 at 10:17 AM, the surveyor spoke with Resident #50 and asked if they participated in any of the facility's activities. The resident stated that they hadn't found anything they enjoyed, but if there were some things they liked or a group of people to go with, they might attend. On 6/09/25 at 10:09 AM, the surveyor performed a record review of Resident #50's Activities Care Plan, which revealed the following: * Resident #50 is dependent on staff for activities, cognitive stimulation, and social interaction. * Resident #50 will maintain involvement in cognitive stimulation and social activities as desired through the next 92 days. * All staff are to converse with Resident #50 while providing care. * Resident #50 needs assistance/escort to activity functions. * Encourage ongoing family involvement. Invite Resident #50's family to attend special events, activities, and meals. * Introduce Resident #50 to residents with similar backgrounds and interests, and encourage/facilitate interaction. * Provide an activities calendar and notify Resident #50 of any changes to the calendar. * Thank Resident #50 for attending activity functions. * When Resident #50 chooses not to participate in organized activities, turn on the TV or music in the room to provide sensory stimulation. The surveyor further reviewed Resident #50's activity attendance records dated 5/11/25 through 6/8/25 (30-day lookback period), which revealed that on 14 occasions, activities were marked as N/A. Additional review showed that the Activities Director had documented on Resident #50's MDS Activities Assessments dated 9/10/24, 12/2/24, 2/4/25, and 4/8/25 that the resident reported religious services are very important to [Resident #50]. The surveyor could not find any record that the resident had attended religious services, and the care plan did not include involvement in religious services. 2) Resident #110 has a medical history of cerebral infarction (stroke) with cognitive (thinking and learning), social, and emotional deficits related to the stroke. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A cerebral infarction, also known as a stroke, is a medical condition where blood flow to the brain is interrupted, leading to brain tissue damage or death. On 6/04/25 at 10:42 AM the surveyor interviewed Resident #110 who stated that s/he uses their phone and tablet but doesn't attend activities because s/he would need someone to get them out of bed. The surveyor observed a daily chronicle and monthly calendar at the resident's bedside. On 6/09/25 at 11:03 AM, the surveyor performed a record review of Resident #110's Activities Care Plan, which revealed the following: * Resident #110 enjoys the daily report/menu and will receive a daily work hunt from the activity staff to complete independently in her room. * Activity staff will visit Resident #110 two times a week for a one-on-one activity of the resident's choice. * Resident #110 will have the opportunity to enjoy activities of choice through the next review date. * Staff are to assist Resident #110 in exploring any new activities of interest. * Staff are to assist Resident #110 with locomotion to activities as desired. * Staff are to encourage Resident #110 to attend activities of interest as they occur. * Staff are to invite the resident to all activities, regardless of previous attendance. * Staff are to provide one-on-one room visits as desired and when available. * Staff are to provide a monthly calendar. The surveyor further reviewed the resident's activities attendance records dated 5/13/25 through 6/8/25, which indicated that no one-on-one activities occurred during the 28-day lookback period, and N/A was documented on six occasions. There was no evidence discovered to show that the resident received the daily work hunt, nor was there documentation or evidence of locomotion to activities, encouragement to attend activities, or invitation to activities. On 6/09/25 at 12:01 PM, the surveyor interviewed the facility's Activities Director (Staff#16) and asked how she determines what types of activities residents will participate in. Staff#16 explained that she conducts an assessment upon admission, asking residents or family about activities they previously enjoyed, and then adds that information to their care plans. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor asked how Staff#16 identifies residents who are not attending activities as expected. She responded that she checks the electronic medical record (EMR) for declines in participation and then encourages those residents to participate. When asked if she runs a report to monitor participation, she stated, There isn't a report to run, but added that she reviews each resident's record individually at least weekly. The surveyor then presented an activities log found during the medical record review and asked whether she was aware of it. Staff#16 said she was not and asked the surveyor to show her how to access it. After the surveyor demonstrated how to locate the log, Staff#16 confirmed it was indeed an activities log. The surveyor asked Staff #16 what N/A means on the log. Staff #16 initially guessed it meant not available, but then noticed that not available appeared as a separate option. After reviewing the log, she said she didn't understand why staff would select N/A. The surveyor then asked Staff #16 to review Resident #50's activities care plan assessment, which states that church attendance is very important to the resident. However, this was not reflected in the care plan. When asked how the facility ensures that residents who want to attend church are accommodated, Staff #16 stated that staff regularly invited Resident #50 to church, but she often refused. She acknowledged that staff should have documented those refusals. Staff #16 could not find any records that showed attendance, refusals, or evidence that church attendance was important to the resident. The surveyor then asked Staff #16 to review Resident #110's activities record and care plan. When asked where the documentation showed the resident received the daily work hunt as planned, Staff #16 responded that staff should have documented it under puzzles, but acknowledged that the record did not reflect that the activity was being provided. The surveyor also asked where documentation of the twice weekly 1 on 1 visit could be found and Staff #16 confirmed that no 1 on 1 visit was documented. The surveyor asked for more detail about how Staff #16 determined residents' individual preferences. She gave an example of a resident who was a Christian and said s/he played Christian music for them. When asked if the resident had said s/he liked Christian music, she replied, I don't know. I just play it because s/he is a Christian, so I thought s/he would like it. She added that she also played oldies music. When asked if the resident said s/he liked oldies, she said, No, but I like oldies. Staff #16 also stated that she read books to residents. When asked how she selected reading material, she said she chose the books herself, usually poetry. The surveyor expressed concerns that the residents' preferences were not being considered when activity plans were developed. Based on resident and staff interviews, observations, and record reviews, it was determined that the facility failed to provide an ongoing resident-centered activities program that met the physical, mental, and psychosocial well-being and individual interests. This was evident for four (R #50, #110, R#76, and R#107) of four residents reviewed for activities during the recertification survey. The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review and interview it was determined that the facility failed to ensure staff provided medication as ordered. This was found to be evident for one (Resident #59) out of five residents reviewed for unnecessary medication. The findings include: Review of Resident #59's medical record revealed the resident had an order, in effect from 9/19/23 until it was changed on 5/23/25, for Lorazepam (also known as Ativan) 0.5 mg tablet three times a day related to anxiety disorder. Review of the resident's Medication Administration Record for April 2025 revealed documentation that indicated it was administered to the resident as ordered every day in April. Review of the Controlled Drug Administration Record for the Lorazepam 0.5 mg tablets revealed on 4/28/25 at 2:00 PM the last tablet of a supply of 30 was removed. This indicated there were no tablets left in the supply for this resident. Further review of the Controlled Drug Administration Record for the Lorazepam 0.5 mg tablets revealed a new 30 tablet supply was received at the facility on 4/29/25 and the first tablet was removed for the dose due on 4/29/25 at 8:00 AM. Further review of the medical record failed to reveal documentation to indicate the Lorazepam was not administered on 4/28/25 when it was due at 8:00 PM. The nurse documented it was administered as ordered on 4/28/25 at 8:00 PM. Review of the medications available in the interim supply revealed Lorazepam 0.5 mg is normally available. The facility utilizes an automated machine to dispense interim supply medications and the pharmacy has records when staff access this supply. On 6/09/25 at 3:30 PM surveyor reviewed with the Director of Nursing (DON) the concern that the last dose of a supply of Lorazepam was administered on 4/28 at 2 pm, and the next dose pulled was 4/29 at 8 am but staff documented having administered the 4/28 dose that was due at 8:00 PM. Surveyor asked if there was documentation to account for where the dose for 4/28 at 8:00 PM came from. On 6/9/25 at 4:19 PM the corporate nurse reported that she was going to reach out to pharmacy regarding the 4/28 evening dose to see if it was pulled from the interim supply. On 6/11/25 at 8:28 AM as of this time no documentation has been provided to indicate staff accessed the interim supply of Ativan for the dose documented as given on the evening of 4/28/25. On 6/11/25 at 10:30 AM, during an interview with the DON and the corporate nurse, the corporate nurse reported the pharmacy was unable to provide documentation to indicate the ativan was obtained from the interim supply. Surveyor reviewed the concern that this was a regularly scheduled medication that was not re-ordered in timely manner and that staff failed to obtain it from the interim supply yet documented that they administered it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review it was determined that the facility failed to have an order to monitor a resident's air mattress. This was found to be evident for one (Resident #76) of four residents reviewed for pressure ulcer care and prevention. The findings include: Review of Resident #76's medical record revealed the resident resided at the facility for more than a year and was totally dependent on staff for activities of daily living such as dressing, eating, transferring from bed to wheelchair and mobility. On 6/5/25 at 9:36 AM surveyor observed, with Nurse #29, the resident in bed. An air mattress control was observed at the foot of the bed but no lights were on and it was noted to be unplugged. When surveyor asked if the air mattress was being used, the nurse indicated it was and proceeded to plug in the mattress and it began to inflate. Surveyor observed it was set at 240 lbs and the nurse confirmed this observation. The nurse went on to report that the resident required total care and was unable to wheel self when in the wheelchair. On 6/5/25 at 1:00 PM review of the medical record revealed a current order, in place since March 2025 for a pressure reducing mattress in place at all times. The most recent weight found for the resident was 115.8 lbs on 6/3/25. No documentation was found to indicate the resident currently, or recently, had a pressure ulcer. On 6/5/25 at 1:15 PM surveyor observed the resident in the bed, the air mattress was on and the control was currently set at 240 lbs. Review of the Operating Instructions for the air mattress revealed staff should Determine the patient's weight and set the control knob to that weight setting on the control unit. An air-filled mattress compresses on the side to which a person moves, thus raising the center of the mattress and lowering the side. This may make it easier for a resident to slide off the mattress. On 6/5/25 at 1:20 PM an interview with the unit nurse manager (Staff #20) revealed the order for a pressure reducing mattress referred to the regular mattresses that they have in the facility, not an air mattress. The surveyor and the unit nurse manager then observed the resident in the bed with the air mattress still on and set to 240 lbs. The unit nurse manager reported: I know they recently swapped the beds, did not know this bed had an air mattress. The unit nurse manager then proceeded to adjust the control setting to 120 lbs. The surveyor reviewed the earlier observation with Nurse #29, who had plugged in the mattress and confirmed the 240 lb setting. On 6/5/25 at 4:04 PM the Director of Nursing (DON) reported air mattresses were usually for residents' with Stage 3 or 4 pressure ulcers and once it was determined that a resident needed an air mattress an order was put in place. In regard to Resident #76, the DON reported the resident did not require an air mattress and he told staff to take off the air mattress. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/09/25 at 4:55 PM the unit nurse manager #20 reported that she had not been able to determine how the resident wound up with an air mattress. Surveyor reviewed the safety concern that the air mattress was put in place without orders for monitoring, the resident was on the mattress without it being inflated and when inflated it was set at a level for a resident weighing much more than the resident actually weighed.

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, interviews and record review, it was determined that the facility failed to provide necessary respiratory care consistent with professional standards of practice for tracheostomy residents. This was evident for one (Resident #109) of two residents reviewed for respiratory care during this survey. The findings include: A tracheostomy is a surgical opening created through the neck into the trachea (windpipe) to allow breathing to occur. A breathing tube is usually placed through this opening to provide an airway and to remove secretions from the lungs. The nose and mouth naturally filter out harmful pollutants, irritants and germs. However, a tracheostomy provides direct access into the lungs requiring strict infection control measures during care. Care for tracheostomy residents can only be performed by licensed and trained personnel. On 6/5/25 at 9:05 AM Resident #109 was observed in bed. The head of bed was raised at approximately 30-45 degrees. The resident had shortness of breath with audible breath sounds. Oxygen was observed and set at 3.5 liters per minute and connected to the resident's tracheostomy. On 6/5/25 at 12:43 PM in an interview, Respiratory Therapist (Staff #21), indicated that respiratory therapy provided care for any resident with a tracheostomy, shortness of breath, or a respiratory diagnosis. It was stated that all nurses were trained in tracheostomy care including suctioning. On 6/5/25 at 1:00 PM in an interview, the Unit Manager, Registered Nurse (Staff #13) confirmed that nurses perform and document tracheostomy care including suctioning on the Treatment Administration Record (TAR) in PointClickCare (PCC), an electronic health record. On 6/5/25 at 1:06 PM a record review of June's 2024 TAR revealed that Licensed Practical Nurse (Staff #22) had documented suctioning on the night shift. On 6/6/25 at 6:20 AM Resident #109 was observed asleep in bed. A dirty (used) suction catheter was observed on the bedside table. On 6/6/25 at 6:24 AM Staff #22 left the nurse's station and entered Resident #109's room. This surveyor entered the resident's room at 6:30 AM and observed that the dirty suction catheter was no longer on the bedside table. On 6/6/25 at 6:40 AM, in an interview, Staff #22 acknowledged that she had provided care to Resident #109 on night shift including suctioning. She acknowledged that suctioning is a sterile technique and confirmed that she had discarded the dirty suction catheter. On 6/6/25 at 7:16 AM Staff #13, the Unit Manager was made aware of the concern. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/25 at 7:29 AM a review of the Tracheostomy Care-Suctioning Policy stated the facility will ensure that residents who need respiratory care, including tracheal suctioning, are provide care consistent with professional standards of care. The document lists the procedural steps #7 as: using sterile technique, open the suction catheter etc. On 6/6/25 at 8:00 AM a review of the Tracheostomy Care Policy stated the facility will ensure staff responsible for providing tracheostomy care including suctioning are trained and competent according to professional standards of practice. On 6/6/25 the Director of Nursing acknowledged the concern.

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record reviews and interviews, it was determined that the facility failed to provide routine dental services to a Medicaid funded residents. This was evident in 1 (Resident #71) of 1 resident reviewed for dental care. The findings include: Resident #71 was admitted into the facility in early 2023. The resident's medical record indicated his/her cognitive pattern as severely impaired. On 6/4/25 at 1:06 PM, Resident #71's responsible party (RP) was interviewed. During the interview, the RP reported dental concerns and that the resident had not seen a dentist. The RP stated, when I've asked about that (Dental services) in the past, they (Facility staff) said we would have to sign him/her up for that. I'm not sure of the status, I have not gotten any update about dental care or seeing a dentist. A review of Resident #71's medical record was conducted on 6/6/25 at 9:49 AM. The review revealed a comprehensive assessment with a reference date of 2/22/23, where section L coded the resident with obvious or likely cavity or broken natural teeth; and mouth or facial pain, discomfort or difficulty with chewing. On 6/6/25 at 11:41 AM, an interview about dental services was conducted with the Director of Nursing (DON). During the interview, the DON reported that a Dentist and/or a dental hygienist comes in the facility 1 to 2 times a month to provide services. The DON indicated that all residents are seen routinely and by recommendation when there is a problem reported by staff. The DON also reported that the dental care group sends him a monthly report with a list of all the residents that were seen. The DON was asked to provide a copy of the reports for the past year for review. On 6/6/25 at 2:20 PM, a review of the dental services reports provided by the DON and review of Resident #71's medical records were conducted. The review failed to show evidence to indicate that the resident had seen a dentist and/or a dental hygienist. Later at 2:42 PM, the finding was discussed with the DON and he indicated that he would review Resident #71's medical record and call the dental provider to find out. On 6/9/25 at 10:02 AM, the DON reported that Resident #71 was discharged from dental services due to being uncooperative and provided a copy of 2 dental service documentation dated 12/23/22 that noted patient uncooperative and on 4/15/23 that noted Patient discharged . The DON stated, but the resident had been re-enrolled for the service as of today. A subsequent interview with the DON was conducted on 6/11/25 at 9:06 AM. During the interview, the 2 dental service documentation's were reviewed and revealed that they were from the prior long term care facility that the resident was admitted to, where dental services were provided by the same dental group. The DON confirmed during this interview that Resident #71 had not been seen by a dentist and/or a dental hygienist since being admitted into the facility.

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	215136	A. Building B. Wing	06/11/2025

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Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record review, and interviews, it was determined that the facility failed to ensure that residents were served meals according to a predetermined menu that incorporated the residents' preferences. This deficient practice has the potential to affect all residents. The findings include: 1) An observation of Lunch on the first-floor unit on 6/4/25 at 12:54 PM showed that Resident #24 was eating in the dining room. The Resident's tray contained pork chops, buttered corn, roasted potatoes, 1 slice of bread, chilled pears, 1 packet diet sugar, 1 packet pepper, 1 packet salt and a cup of coffee. However, the Resident's meal ticket read Smothered pork chops, buttered corn, [NAME] roasted potatoes, 1 slice bread, 1 packet margarine, chilled pears, 1 package sugar, 1 package pepper, 1 package salt, 8 oz of whole milk, and 6 oz of coffee. Resident #24 reported not getting any milk or butter. Staff #14, a Geriatric nurse aid, was present and confirmed that Resident #24 did not receive milk or butter on his/her lunch tray. 2) Resident #96 was observed eating lunch in the first-floor dining room on 6/4/25. The observation noted from the Resident's meal ticket that s/he was to receive Smothered pork chops, buttered corn, [NAME] roasted potatoes, 1 slice of bread, 1 packet of margarine, chilled pears, sugar, 1 package of pepper, 1 packet of salt, 8 oz of whole milk and 6oz cup of coffee. A continued observation of Resident #96's tray showed that s/he received pork chops, buttered corn, roasted potatoes, 1 slice of bread, chilled peas, 1 packet of sugar, 1 packet of pepper, 1 packet of salt, and a cup of coffee. The observation failed to show that the resident received whole milk and butter on his/her tray. Staff #14 questioned Resident #96 if s/he wanted milk and butter. The resident stated s/he wanted milk and butter but did not get them on his/her lunch tray. 3) An observation of Resident #73's lunch tray on 6/4/25 showed ground pork chops, creamed corn, mashed potatoes, pureed bread, sugar, diet sugar, pepper, and a cup of coffee. Further observation of Resident #73's meal ticket showed that s/he was to receive on his/her lunch tray: Ground smothered pork chops, creamed corn, mashed potatoes, pureed bread, 2 packets of margarine, 1 serving of magic cup, 8 packages of diet sugar, 2 packages of pepper, 8 oz of whole milk and coffee. The observation failed to show that Resident #73 received whole milk, margarine and magic cup on his tray. Staff #14 was present and confirmed that Resident #73 was missing whole milk, margarine and magic cup on his/her tray. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 12:57 PM, Staff #15, Regional Food services Director, was made aware of the concern of missing food items on Residents' trays and she said she would take care of the concern right away.

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	215136	A. Building B. Wing	06/11/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, it was determined that the facility failed to store food in accordance with professional standards. This was evident in 1 out of 3 units observed during the recertification survey. The findings include: An observation of the 2nd-floor unit nourishment room refrigerator on 6/4/25 at 10:13 AM, with staff #12, a Geriatric nurse aid present, showed 4 cups of Jello with an expiration date of 4/24/25. Staff stated they were expired, looked watery, and then disposed of them. In an interview on 6/4/25 at 2:44 PM with staff #13, the unit manager showed that she checked the refrigerator every morning; however, she missed the Jellos. In an interview on 6/11/25 at 7:43 AM, the Director of Nursing was made aware of the concern and stated that he had been informed by staff.

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	215136	A. Building B. Wing	06/11/2025

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Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 1) Review of Resident #59's medical record revealed the resident had resided at the facility for more than a year. The resident was seen regularly by a primary care physician and a nurse practitioner in addition to a pain management nurse practitioner. a. A review of a note written by physician (Staff #30) for a visit on 4/25/25 revealed the visit was a monthly follow-up for ongoing management of dementia with behavioral disturbance, mood disorder, chronic pain and kidney disease. The section titled Plan included the following: Lorazepam 0.5 mg TID [three times a day] PRN [as needed] for anxiety. This Lorazepam (also known as Ativan) order indicated the resident was to receive the medication only when the resident was experiencing symptoms of anxiety and staff would be expected to document the symptoms and the effectiveness of the medication. Review of the physician orders revealed the resident had an order, in effect at the time the 4/25/25 note was written, for Lorazepam 0.5 mg tablet three times a day related to anxiety disorder. This order was originally written 9/19/23. Review of the April Medication Administration Record (MAR) confirmed that the resident was receiving the medication three times a day on a regularly basis. No documentation was found to indicate there was a PRN (as needed) order for Lorazepam in April 2025 or May 2025. Further review of the physician #30 note revealed in the Plan section under Chronic Pain: Continue acetaminophen and Voltaren gel as needed for pain relief. Review of the orders and the MAR revealed the Voltaren gel was ordered as a regularly scheduled medication administered to the resident four times a day. This order was in effect at the time of the 4/25/25 visit, and was originally written 9/19/23. b. A review of a note written by Nurse Practitioner (NP Staff #32) for a visit on 5/1/25 revealed it was signed and reviewed by the NP on 5/7/25. In the section toward the end of the note titled Plan of Care revealed the following statement: CBC, BMP, Depokote level on Monday. CBC, BMP and Depokote levels are all blood tests that would assist in the monitoring of a resident's health status and medications. Review of a note written by Nurse Practitioner (NP Staff #32) for a visit on 5/14/25 revealed it was signed and reviewed by the NP on 5/19/25. In the section toward the end of the note titled Plan of Care revealed the following statement: CBC, BMP, Depokote level on Monday. Further review of the medical record on 6/9/25, failed to reveal documentation to indicate a CBC, BMP or Depokote level were ordered or obtained in May or June 2025. On 6/09/25 at 12:49 PM during an interview with NP #32, surveyor reviewed the concern that the notes she wrote for visits on May 1st and 14 both indicated labs were to be obtained on Monday, but no results or orders for labs were found for May 2025. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/9/25 at 1:45 PM the NP #32 reported it was a documentation issue regarding the plan for labs to be done on Monday. She reported the referenced labs were completed in November. She went on to report that levels obtained in February were back to the resident's baseline and that there was no need for follow up labs. During the 1:45 PM interview NP #32 reported she completed visit notes as soon as able to get to them. Surveyor reviewed the concern regarding the notes being written 5 or more days after the visit occurred. c. A review of a note written by a pain management Nurse Practitioner (NP Staff #31) for a visit on 5/28/25 revealed, in the section titled Plan, the following statements: EMR [electronic medical record] reviewed. Continue Lidocaine & Tylenol as ordered. Further review of the medical record revealed that at the time of the 5/28/25 pain management note the resident was receiving Voltaren Gel topically four times a day to both knees for pain, Gabapentin three times a day for neuropathy (nerve damage that can cause pain and numbness), and had an order for Tylenol to be administered as needed. No documentation was found to indicate the resident had an order in May 2025 for Lidocaine. On 6/9/25 at 4:55 PM surveyor reviewed the concern with the corporate nurse #7 regarding the inaccuracies in the physician note, and nurse practitioners' notes regarding medications and plans for lab work. On 6/11/25 at 9:29 AM interview with pain management NP #31 revealed she saw the long term care residents once a month. NP #31 reported for the long term care residents she didn't review their meds unless they are developing issues. In regard to her notes, the NP reported there was a template and notes carried over and she made changes as needed. During the 6/11/25 interview, NP #32 reported she was familiar with the Resident #59 and was aware that the resident received Gabapentin for neuropathic pain, but after she reviewed the note from May 28th she stated : I think I didn't update this. The NP confirmed that Voltaren is a different medication than Lidocaine, and stated probably an error on my part. The NP #31 then indicated she would do an addendum to correct the note.2) Resident #109 had a tracheostomy and received specialized respiratory care. A tracheostomy is a surgical opening created through the neck into the trachea (windpipe) to allow breathing to occur. A breathing tube is usually placed through this opening to provide an airway and to remove secretions from the lungs. Care for tracheostomy residents can only be performed by licensed and trained personnel. On 6/5/25 at 12:34 PM a record review of Respiratory Therapist (RT #21) notes revealed tracheostomy care including suctioning was performed at 8:00 AM and 11:00 AM. On 6/5/25 at 12:43 PM in an interview, RT #21 confirmed that tracheostomy care was provided to Resident #109. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 1:00 PM in an interview Registered Nurse (RN #13) the Unit Manager, confirmed that in the absence of Respiratory Therapy, nurses perform and document tracheal care in the Treatment Administration Record (TAR). On 6/5/25 at 1:06 PM a record review of Resident #109's Treatment Administration Record (TAR) revealed documentation that the day shift Registered Nurse (RN #27) had performed tracheostomy care including suctioning during the day shift. On 6/5/25 at 1:28 PM in an interview, RN #27 stated, I am documenting that it was done. RN #27 acknowledged that Respiratory Therapy (RT) had performed the tracheostomy care and that the TAR doesn't accurately reflect the resident's care. On 6/5/25 at 1:35 PM the Director of Nursing (DON) and the Regional Director of nursing (RDON) reviewed Resident #109's TAR. They interpreted it as RN #27 had performed tracheostomy care. The surveyor shared concern that RN #27 acknowledged that she had not performed the care. The DON and RDON acknowledged that the TAR does not reflect the resident's experience. 3) Resident #110 has a medical history of cerebral infarction (stroke) with cognitive (thinking and learning), social, and emotional deficits related to the stroke. On 6/09/25 at 4:21 PM, the surveyor performed a record review for Resident #110, which revealed that the resident had been readmitted from the hospital on 4/10/25. However, the surveyor was unable to find any evidence of care planning meeting notes. On 6/09/25 at 4:34 PM, the surveyor met with the Social Services Assistant (Staff#26), who informed the surveyor that care planning notes are kept in the electronic medical record. When the surveyor asked Staff #26 to assist in locating care planning notes for Resident #110, she stated that there did not appear to be a note in the system. On 6/09/25 at 4:53 PM, the surveyor interviewed the Social Services Director (Staff #9) and expressed concern that Resident #110 did not appear to have had any care planning meetings. The Staff #9 responded that they would investigate it. On 6/10/25 at 9:00 AM, Staff #9 provided the surveyor with a handwritten note dated 5/1/25, which he identified as documentation of a care planning meeting for Resident #110. The surveyor expressed concern that the note was handwritten and not included in the electronic record. When the surveyor asked the Staff #9 why the note wasn't part of the medical record, he did not respond. When asked whether the handwritten note was considered part of the medical record, he replied, No. On 6/10/25 at 11:10 AM, the surveyor spoke with the Director of Nursing (DON) regarding concerns that there was no record of a care planning meeting for Resident #110 in the electronic medical record, and that the Staff #9 had only provided a handwritten note after the surveyor was unable to locate the documentation. The DON confirmed that care planning meeting notes are expected to be documented in the resident's medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215136	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Birch Manor	7309 Second Avenue Sykesville, MD 21784

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record reviews and staff interviews, it was determined that the facility failed to ensure that resident records were accurate, complete, and maintained in accordance with accepted professional standards and practices. This was evident for 1) one (R #59) of five residents reviewed for unnecessary medications and, 2) one(R #109) of four residents reviewed for abuse, and 3) one (R #110) of four residents reviewed for care planning. The findings include:

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	215136	A. Building B. Wing	06/11/2025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, it was determined that the facility failed to ensure the development and ongoing implementation of a facility-wide, data-driven Quality Assurance and Performance Improvement (QAPI) program that included at least one current Performance Improvement Project (PIP) in the past 12 months. The findings include: On 06/04/25, the facility provided a copy of its QAPI policy upon entrance for review. The QAPI policy in reference to PIP determination for the facility states, areas for improvement are identified by routinely and systematically assessing quality of care and service, and include high risk, high volume, and problem prone areas. Consideration will be given to the incidence, prevalence, and severity of the problem, especially those that affect health outcomes, resident safety, autonomy, choice quality of life, and care coordination. During an interview on 06/11/25 at 10:49 AM, the Nursing Home Administrator (NHA) confirmed that she was responsible for QAPI at the facility and was asked if there was a PIP the facility had completed within the last 12 months. The NHA stated that there was no current Performance Improvement Project identified or being implemented at the facility. The NHA further indicated that the QAPI committee maintained a book with meeting minutes and highlights of high-risk topics, such as falls, wounds, and maintenance concerns; however, no documentation was provided to demonstrate a structured approach to identifying and systematically addressing quality issues. The NHA further stated that the QAPI meetings served primarily as a notification forum, and that daily clinical meetings were used to review clinical concerns and interventions. The facility did not provide evidence of an active QAPI program being used to systematically investigate root causes of identified issues, implement interventions, or monitor the effectiveness of corrective actions as indicated in the policy provided by the facility. No further evidence that any PIP was performed was provided by the end of the survey.

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	215136	A. Building B. Wing	06/11/2025

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, it was determined that the facility failed to ensure the Infection Preventionist (IP) attended the Quality Assurance and Performance Improvement (QAPI) committee meetings. The findings include: On 06/05/25 at 11:55 AM, the Nursing Home Administrator (NHA) provided QAPI meeting attendance records for six months, covering December 2024 through May 2025. Review of these records revealed that for the months of December 2024, January 2025, and February 2025, the Director of Nursing (DON) signed the attendance sheets as the IP. On 06/11/25 at 10:12 AM, the NHA stated that the DON was not a certified IP nurse, nor was certified in December 2024, January 2025, or February 2025. On 06/11/25 at 11:01 AM, the NHA was asked to provide QAPI attendance records for June 2024 through November 2024 for further evidence of IP attendance. During the exit conference, the NHA provided a QAPI attendance record for October 2024 which also lacked evidence of a qualified IP nurse in attendance.

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	215136	A. Building B. Wing	06/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and document review it was determined that the facility failed to maintain safe and sanitary conditions to prevent the spread of infection. This has the potential to affect all residents. The findings include: A blood glucose monitoring device, also referred to as a blood glucose meter, is a device that may be used in the home and health care settings to measure the amount of sugar (glucose) in your blood. 1.On 6/04/25 at 10:34 AM a nurse (Staff #5), on the first floor, was observed placing a glucometer into the medication cart. On 6/4/25 at 10:35 AM Nurse (Staff #5) was interviewed regarding the disinfection of the glucometer. Staff #5 reported that she disinfects the glucometers with alcohol wipes. On 6/4/25 at 10:36 AM Nurse (staff #5) was asked to demonstrate how to disinfect the glucometer. The nurse removed the alcohol wipes form a space next to the glucometers in the med cart and preceded to wipe the glucometer with alcohol wipes. During the cleaning nurse #5 reported she would then allow the glucometer to dry before using it again. On 6/04/25 at 10:39 AM Nurse (Staff # 11) was interviewed at the first-floor nursing station. During the interview he was asked how he disinfects the glucometer. Staff #11 reported that he would use alcohol wipes to disinfect glucometers. On 6/4/25 at 10:41 AM an interview was conducted with the infection preventionists (Staff # 10). During the interview she reported that Super Sani-cloth sanitizing wipes were on order. She confirmed that Super Sani-cloth sanitizing wipes were the appropriate wipes to clean the glucometer, and the use of alcohol wipes was not recommended by the manufacturer. On 6/04/25 at 11:36 AM an observation on the first floor nursing unit revealed Super Sani-cloth sanitizing wipes on both med carts on the first floor. On 6/04/25 at 12:13 PM the facility provided a policy titled Glucometer disinfection. Review of the policy revealed that glucometers will be cleaned and disinfected after each use and according to manufactures instructions regardless of whether they are intended for single resident or multiple resident use. On 6/9/25 at 1:12 PM the above concerns were discussed with the Director of Nursing (DON) and No further information was provided prior to the end of the survey. 2. On 6/4/ 25 at 9:35 AM a brief interview was conducted with housekeeping staff #3. During the interview she reported the front room is where the dirty clothes are kept. The clean clothes are kept in the second room. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/04/25 at 9:35 AM an observation was made of the front room (dirty section) of the laundry room. The observation revealed a gray laundry cart with clean linen without a covering within inches form a gray laundry cart full of dirty clothes. Continued observation revealed linen, soiled with a brown and yellow substance laying on the floor. Further observation revealed a wet brief laying open in an open bag laying on the floor. On 6/04/25 at 9:40 AM the environmental Services (EVS) Supervisor (Staff#4) entered the laundry room and confirmed observation. She confirmed that clean clothes were to be covered when being moved form the clean room in the laundry room. The staff removed the soiled brief and linen from the floor and placed a blue cover over the clean laundry basket. On 6//9/25 at 10:50 AM an additional observation of the laundry room was made. The observation was made in the presence of the Administrator, Maintenance Director and EVS Supervisor. The observation revealed the clean room and dirty room were separated by plastic door flaps. Further observation revealed that the plastic door flaps farthest form the entrance door had numerous black spots on the plastic that could be easily wiped off with gentle rubbing. On 6//9/25 at 10:51 AM the administrator confirmed the observation and reported she would have the plastic door flaps cleaned. On 6/09/25 11:15AM an observation of the laundry rooms of plastic door flapping strips revealed that all black marks were removed. 3. On 6/5/25 at 12:40 PM the Maintenance Director Staff #8 was interviewed regarding the facility's measures to prevent the growth of legionella at the facility. He reported that water temperature monitoring was a part of their prevention measures. He provided a binder of recorded water temperatures. He reported that he recorded the temperature of the water at the boiler as the house temperature On 6/5/25, the review of the May 2025 water temperatures revealed the house temperatures were recorded for 16 of 31 days in May 2025. Continued review failed to reveal the boiler water temperatures (house temperature) reached 116 degrees 16 of 16 days the house temperatures were recorded. On 6/05/25 2: 18 PM The administrator and Maintenance director provided the Centers for Disease Control (CDC) reference document the facility uses monitoring water as part of the facilities legionella prevention plan. 06/06/25 01:55 PM The administrator was interviewed. During the interview she reported that the facility had the boiler (which provided water to the residents' rooms) set at 116 degrees Fahrenheit. She said the facility followed the CDC guidelines by maintaining the boiler temp at 116. The May boiler temperature logs were reviewed with the administrator she confirmed that none of the documented temperatures reached 116 degrees Fahrenheit.

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	215136	A. Building B. Wing	06/11/2025

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F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough power supply for lighting all entrances and exits; equipment for fire detection and alarm systems, and extinguishers. Based on record review, observation, and interviews it was determined that the facility failed to ensure that critical medical equipment was plugged into generator power supplied outlets. This was evident for one (Resident #102) out of two residents reviewed for respiratory care. The findings include: Resident #102 has a history of a traumatic brain injury and chronic respiratory failure. The resident has a tracheostomy (trach) and required a continuous supply of oxygen. A tracheostomy is a surgical procedure where a hole is made in the neck and into the windpipe (trachea) to help air reach the lungs. On 6/05/25 at 1:00 PM, the surveyor reviewed the medical record for Resident #102. A nursing progress note dated 2/16/25 stated the following: We had a brief power outage. Another nurse and I switched the resident's equipment to the emergency power outlet. Further review of Resident #102's medical record revealed that the resident had orders for the following medical treatments: *Suction trach every shift and as needed every shift for Respiratory Failure *Suction trach every shift and as needed as needed for excessive secretions *Trach care every shift and as needed every shift for Respiratory Failure * Oxygen Inhalation via trach collar @ 3LPM every shift for Respiratory Failure * Humidification @ 80% FIO2 via trach to loosen up secretions every shift for Respiratory Failure On 6/5/25 at 1:30 PM, the surveyor observed Resident #102 in his/her bed. To the left of the bed, the surveyor observed an oxygen concentrator and suction machine which was plugged into a power strip and the power strip was plugged into a standard wall outlet. The surveyor also noted that the facility had generator-powered outlets, that were identified by red face plates. However, all four of these generator-powered outlets were already being used for other medical equipment. The surveyor observed Respiratory Therapist (Staff #21) enter Resident #102's room and asked which type of outlet the oxygen concentrator and suction machine should be plugged into. She stated that the best practice was to use one with a red faceplate around the outlet. The surveyor then asked her to confirm which outlet the resident's oxygen concentrator and suction machine were currently plugged into. She confirmed they were plugged into a standard wall outlet. The surveyor then asked if the standard wall outlet was also powered by the generator. She said she wasn't sure but didn't think so. (continued on next page)

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F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 1:40 PM, the surveyor then interviewed the Maintenance Assistant (Staff #23) and asked which outlets remained functional during a power outage. Staff #23 confirmed that equipment must be plugged into the outlets with a red faceplate during an outage, as those were connected to the backup generator. The surveyor requested the facility's policy and procedure regarding interruptions of electrical power, and Staff #23 provided a copy. The surveyor then returned to speak again with Staff #21 about Resident #102's care needs and at approximately 1:45 PM, the Director of Nursing (DON) approached the surveyors and Staff #21, having overheard part of the conversation regarding the resident's need for continuous oxygen during an emergency. The DON commented on the discussion, stating that it was not currently an issue that the equipment wasn't connected to the generator backup because there was no current power outage. He added that if an outage were to occur, they would simply move the equipment to a generator-powered (red) outlet. The surveyor then asked the DON and Staff#21 to demonstrate how they would perform this process during a power outage. The DON and Staff#21 entered Resident #102's room as two surveyors observed. They stood in front of the oxygen concentrator and suction equipment and discussed how to safely unplug the equipment and relocate it to the generator-powered outlets, which were already at maximum capacity (no available outlet). The surveyor timed the discussion. After more than a minute had passed, Staff #21 stated that she did not feel comfortable unplugging Resident #102's oxygen without first obtaining a portable oxygen tank to maintain oxygen delivery while rearranging the plugs. Staff #21 then left the room to retrieve the portable oxygen tank. At that point, the surveyor stopped timing the drill, as it was evident that additional time was needed to assess the situation and safely transfer the resident's emergency equipment to the generator-powered outlets. The surveyor returned to Resident #102's room at 2:15 PM and confirmed that the oxygen concentrator and suction machine were now plugged into the generator-supplied (red) outlet. On 6/5/25 at 2:25 PM, the surveyor reviewed the facility policy and procedure titled Emergency Procedure - Interruption of Electricity. The policy was not dated. Review of the policy revealed: An interruption of electrical power can occur at any time and for many different reasons. In all situations, the most important thing to remember is that the life and safety of the residents, staff, and visitors comes above all else. It is important to remember that the facility does have an emergency backup generator wired to provide partial power in the facility. The red outlets throughout the facility are the ones powered by the generator in an emergency. The policy included the following instructions: Nurses and GNA's should ensure that all residents are safe and that any equipment needing electrical power (concentrators, BiPAP machines, etc.) is connected immediately to an emergency outlet. (continued on next page)

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	215136	A. Building B. Wing	06/11/2025

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F 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/25 at 3:44 PM, the surveyor interviewed the Nursing Home Administrator (NHA) regarding the facility's response to a power outage.When asked how emergency power outlets were identified, the NHA stated they were marked with red faceplates. The surveyor expressed concern that the facility policy instructs staff to move equipment to generator-powered outlets after a power outage, rather than requiring critical equipment to be proactively connected. In response, the NHA stated that residents on life-sustaining equipment were always plugged into emergency outlets and added, We perform safety checks on every shift to make sure everything is plugged into emergency backup. Staff are trained during orientation, and we continue to reinforce this in daily practice. When asked if these safety checks were documented, the NHA confirmed they were. The surveyor then asked if the NHA was aware that Resident #102's life-sustaining equipment had recently been found plugged into a standard, non-emergency outlet. The NHA stated she was unaware of the issue. The surveyor requested documentation of the safety checks. As of the survey exit, the facility did not provide the requested documentation.