STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215141	A. Building B. Wing	10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Patuxent River	14200 Laurel Park Drive Laurel, MD 20707

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation and staff interview it was determined that the facility staff failed to ensure a resident had access to their call bell plunger. This was evident for 1 (Resident #8) out 8 residents that were part of the survey sample during the complaint survey.The findings include:This surveyor went to Resident #8's room on 10/16/25 at 12:15 PM. The resident's call bell plunger (handheld part used to sound an alarm alerting staff the resident needed assistance) was observed to be on the floor on the right side of the bed. This surveyor left the room and told the nurse (Staff #20). She came to the room, put on gloves, and picked up the plunger. She then put the plunger on the bed.This surveyor went to Resident #8's room on 10/17/25 at 9:10 AM. The call bell plunger was observed to be hanging down from the bed near the top of the right-side transition rail. The resident was asked if they knew where their call bell was and the resident shook their head no.The Director of Nursing was interviewed on 10/17/25 at 10:35 AM. She was informed of the call bell observations. She responded by saying she would talk to the nursing staff and address it with them.

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint #2635993, record reviews, observation, and interviews, it was determined that the facility failed to ensure the physician was notified of changes in resident condition. This was evident for 1 (Resident #4) of 6 complaints reviewed during the survey process.The findings included:On 10/16/2025, a review of complaint #2635993 alleged that Resident #4 had rashes that were not being treated.On 10/16/2025 at 11:55 AM, a review of Resident #4's chart revealed that weekly skin evaluations on 9/18/2025 and 9/12/2025 identified no skin issues; however, weekly skin evaluation on 10/9/2025 at 2:48 PM identified a rash and pressure ulcer. On 10/17/2025, a review of Resident #4's care plan, developed on 12/18/2020, revealed that the resident had developed skin rashes and actual skin impairment to the arms, legs, and trunk related to skin dermatitis periodically, and received treatment each time.On 10/17/2025 at 9:25 AM, the resident was observed awake and alert to self, with no observable rashes noted on her face or arms.On 10/17/2025 at 9:27 AM, during an interview with RN #27, he was asked if Resident #4 had any rash on his/her skin. He explained that approximately 3-4 months prior, the resident had a fungal rash on his/her upper back and buttocks. When asked about additional locations, RN #47 explained that the resident also had the rash on his/her face once, but it healed after treatment was administered. He was asked what actions he would take if the known rash worsened, and he stated that he would notify the doctor. When asked about the current status of the resident's skin, he stated that the resident did not have any skin impairment.On 10/17/2025 at 11:21 AM, during an interview with GNA #28, he was asked if Resident #4 had any skin impairment. He stated that the resident had a skin problem on the back and that he had applied a cream to his/her back. The surveyor asked when he first noticed the issue, and he stated that he noticed it approximately a month prior when he started working with the resident. The surveyor accompanied GNA #28 to the resident's room to observe the resident's skin. The surveyor observed a large dry area on the resident's sacrum and upper back with a small open area below the left buttocks. The GNA was asked to show the surveyor what he had been using, and he showed the surveyor a jar of [NAME] butter cream.On 10/17/2025 at 11:45 AM, during an interview with RN #27, the surveyor informed him that the resident had an evident skin impairment and referenced GNA #28's previously mentioned statement.On 10/17/2025 at 11:29 AM, during an interview with LPN #29 (unit manager), she was informed that Resident #4 had skin impairment and that GNA #28 had stated he applied a cream ([NAME] butter cream, identified at bedside). However, the resident's nurse (RN #27) stated he was not aware of Resident #4's skin impairment and that the GNA did not report the issue to him, even though the skin assessment completed on 10/9/2025 by RN #27 revealed that the resident had a skin impairment identified as a rash and pressure ulcer. LPN #29 acknowledged that the [NAME] butter was not appropriate for a rash and stated that she would complete a skin assessment with the resident's nurse and notify the doctor to receive orders for treatment, if necessary.On 10/17/2025 at 12:10 PM, during an interview with the Director of Nursing (DON), the DON was notified of the above-mentioned findings. She stated that the resident had a known skin condition and was treated daily. The medication administration record she presented to the survey showed: Ammonium Lactate Solution (Ammonium Lactate), applied topically to the affected area once a day. The surveyor explained that the daily Ammonium Lactate Solution order was initiated on 03/04/2025. Since that date, weekly skin evaluations completed on 9/12/2025 and 9/18/2025 showed no skin impairments. Therefore, the rash identified on 10/9/2025 was a change in the resident's skin condition and should have been reported to the physician in case additional treatment was required. The DON agreed to provide documentation to support Resident #4's physician was notified, if available; however, no documented evidence was provided to the surveyor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, investigation of intake #2601797, and staff interview it was determined that the facility staff failed to 1) ensure a resident's refusal to receiving showers was addressed and 2) ensure an activity of daily living individualized comprehensive care plan included an intervention for transfer status. This was evident for 2 (Resident #8 and Resident #7) out of 11 resident that were reviewed during the complaint survey. The findings include: The Minimum Data Set (MDS) is a required assessment for all residents in Medicare- or Medicaid-certified nursing homes. It evaluates each resident's health and functional status to help staff identify issues. Assessments are conducted at admission and at regular intervals, following set guidelines. A comprehensive care plan is an individualized and collaboratively developed document outlining a resident's medical, nursing, and psychosocial needs, along with planned treatments and activities. It is used to plan, assess and evaluate the effectiveness of the residents care. Activities of Daily Living (ADLs) are basic self-care tasks like bathing, dressing, eating, toileting, and transferring. Nurses assess ADLs to determine a patient's level of independence and care needs. Transfer assistance levels, as defined by the National Institutes of Health, include: Dependent: Patient needs full assistance; mechanical lift and help from others required. Max Assist: Patient does 25% of the task; caregiver does 75%. Mod Assist: Patient and caregiver each do 50%. Min Assist: Patient does 75%; caregiver helps with 25%.Independent: Patient performs the task safely without help. 1) This surveyor investigated concerns raised as part of intake #2601797 regarding Resident #8 not receiving showers. The resident's clinical record was reviewed on 10/16/25 and 10/17/25. The facility nursing staff documented that the resident often refuses showers. A review of the resident's care plans revealed that there was no care plan that specifically addresses the shower refusals. This surveyor interviewed the Director of Nursing (DON) on 10/17/25 at 10:33 AM. This surveyor asked whether or not the resident received showers. She said the resident was offered weekly but refused most of the showers. She added that the nursing staff then gave bed baths. This surveyor asked if the resident had a care plan. She replied that he/she had one where it says he/she was to be offered two showers each week. This surveyor stated that the care plan did not include interventions to address refusals and then asked why the facility staff did not develop a more robust care plan that addressed the refusals. She said she would review the care plans. 2) On 10/16/2025 at 11:49AM, a review of Resident #7's medical record revealed a facility document dated 07/29/2025 titled, Admit/Readmit Screener, question number 7 addresses Chair/bed-to-chair transfer. The Admit/Readmit screener is where staff document a resident's ability to transfer between a bed and a chair/wheelchair upon admission. The selected response for this assessment was Not assessed/no information. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/2025 at 11:49AM, continued review of Resident #7's medical record revealed a facility admission MDS assessment completed on 08/01/2025, which indicated that the resident was dependent for chair/bed-to-chair transfers in Section GG, which documents functional abilities. Further review of Section V Care Area Assessments (CAA) Summary #5, ADL Functional/Rehabilitation Potential, revealed the facility staff would develop a care plan to address the care area for Resident #7; however, the ADL care plan dated 07/29/2025, did not incorporate a transfer status or intervention until 09/02/2025. On 10/16/2025 at 11:49AM, review of a Physical Therapy Discharge Summary with a service date from 07/30/2025 through 08/29/2025, indicated changes dated 08/31/2025 at 2:24 PM for goal status revealed the current function changed from transfers: max assist X1 to X 1-2 (one to two person assist). On 10/16/2025 at 11:49AM, continued review of Resident #7's medical record revealed 37 skilled nursing progress notes from August 15 to August 31, 2025. These notes documented the required level of care for Activities of Daily Living (ADLs), including transfers. Seventeen notes indicated extensive assistance, 3 indicated limited assistance, and 2 indicated independence. In 15 instances, the transfer activity did not occur. In summary, the documentation for transfer assistance completed by the Geriatric Nursing Assistants was inconsistent throughout the month of August. Continued review of Resident #7's medical record revealed a care plan, initiated 07/29/2025, that noted an ADL self-care deficit due to limited mobility. Transfer intervention with a date initiated on 09/02/2025 required two staff and use of side rails/slide board. However, the date the intervention for transfer status was initiated was on 09/02/2025, after an incident on 09/01/2025 that resulted in injury related to a transfer from bed to wheelchair. On 10/16/2025 at 1:32 PM, during an interview Staff #7, the Director of Rehab, stated a transfer status for a resident is determined upon admission by a therapy eval or the nursing GG score. Staff #7 noted nursing and therapy may differ on transfer assistance levels (max assist 1-2 people). Staff #7 confirmed therapy always used a slide board for Resident #7 related to his/her leg weakness and the inability of Resident #7 to stand. On 10/17/2025 at 7:42 AM, during an interview, LPN Staff #10 stated that upon admission, a nurse assesses a resident's transfer status. Therapy also evaluates the resident's strength to determine the required level of assistance (1-2 people). This information is then communicated to nursing and documented on the Kardex. Staff #10 confirmed familiarity with Resident #7, noting that Resident #7 required a two-person assist due to lower extremity weakness. On 10/17/2025 at 8:07 AM during an interview, Staff #13 Geriatric Nursing Assistant (GNA) stated a resident's transfer status would be in the Kardex of the electronic medical record. Staff #13 stated she was familiar with Resident #7 and stated that therapy mostly completed the transfers and used a sliding board. Staff #13 stated although she never transferred Resident #7, she would have used a Hoyer lift to transfer Resident # 7 and indicated Resident #7 had no ability to perform any movements. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2025 at 8:15 AM during an interview, the Director (DON) stated that upon admission, a resident's transfer status is determined by a nurse's assessment, which utilizes hospital records and physical therapy notes as a baseline. The Unit Manager then completes a comprehensive care plan within 48 to 72 hours. Staff can find care instructions, including transfer status, in the Kardex, which is derived from the ADL care plan. An ADL comprehensive care plan should detail all aspects of daily care, including transfer status. Therapy and nursing may have different transfer statuses. Communication between nursing and rehabilitation typically occurs verbally or through weekly Utilization Review Meetings. On 10/17/2025 at 8:27 AM, in an interview, Staff #14 (MDS Nurse) stated when an admission MDS is completed, a comprehensive care plan is to be developed through an Interdisciplinary Team (IDT) process. Staff #14 also confirmed the transfer status was not implemented into the comprehensive ADL care plan until 09/02/25, after an injury sustained during a bed-to-wheelchair transfer. On 10/17/2025 at 9:21 AM, an interview with Staff #15, Occupational Therapist (OT) indicated that Resident #7 required a sliding board to transfer related to the inability to push up from bed or pivot to a chair, which made the sliding board the safest option. Staff #15 stated that Resident #7 was dependent on assistance for transfers. Staff #15 stated, as a therapist she would have a second person present during Resident #7's transfers due to the resident's lower extremity weakness and inability to move or reposition their legs. The second person's role was to prevent Resident #7's legs from getting caught on things, as this often occurred. On 10/17/2025 at 10:40 AM, an additional interview with Staff #7, the Director of Rehab, stated that Resident #7 showed poor progress in therapy. Additionally, facility staff had not received formal training on the sliding board transfer intervention, which was added to the ADL plan of care on 09/02/2025. On 10/17/2025 at 11:15 AM in an interview, Staff #16 (Nurse Unit manager) stated upon a resident's admission, staff should await a therapy evaluation to determine the resident's transfer status. The transfer status must be included in the Care Plan to appear on the Kardex. On 10/17/2025 at 11:30 AM in an interview, Staff #19 (Registered Nurse (RN) indicated that a resident's transfer status is determined upon admission, and she would refer to physician orders for this information. On 10/17/2025 at 11:50 AM in an interview, Staff #18 (Registered Nurse (RN) stated upon admission, a resident's transfer status is determined through a nursing assessment. The nurse would also utilize the hospital discharge summary for transfer status determination. Staff #18 stated she was familiar with Resident #7, described the resident as weak and unable to stand, requiring two people assistance for safe transfer. On 10/17/2025 at 1:27 PM in an interview, Staff #21 (GNA) stated facility staff use Hoyer lifts for transfers when unsure of a resident's condition or proper technique, as knowing the resident's condition determines the correct transfer status. On 10/17/2025 at 1:34 PM in an interview, Staff #22 (LPN) revealed that this facility operates under a no-lift policy, requiring staff to use a Hoyer lift for residents who are unable to ambulate or stand. However, there was no evidence of a no lift policy provided by the facility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/2025 at 1:35 PM in an interview, Staff #23(LPN) stated that if a resident is bedbound, has any weakness, and cannot stand, the staff must use a Hoyer lift. On 10/17/2025 at 1:40 PM, in an interview, Staff #24 (LPN) stated a resident's transfer status is determined upon a nursing assessment and would find the resident's transfer status in the progress notes in the electronic medical record. On 10/17/2025 at 1:42 PM, in an interview, Staff #25 (LPN) admitted to being unsure how to find a resident's transfer status and had not located it in the medical record. While searching the medical record with the Surveyor present, she remarked, I think it is this one on the task list- wait this is for eating, not sure. On 10/17/2025 at approximately 2:30 PM, during a second interview with the Director of Nursing (DON), he/she stated that the facility's nursing staff had not received instructions regarding Resident #7's transfer status. The DON added that the ADL care plan should have included a transfer status to guide staff in providing appropriate care and transfers. On 10/17/2025 at approximately 3:40 PM the Administrator and the DON were made aware of the concern.

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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. Based on review of the resident's medical record and interview with resident and facility staff, it was determined that the facility staff failed to maintain accuracy of medical record by not documenting the reason for missed dose of medication in the resident's medical record. This was evident for 1 (Resident #11) of 1 resident reviewed for medication administration during the complaint survey.The findings include:During the investigation of Complaints and Facility Reported Incidents (FRIs) on 10/16/2025 at 1:29 PM, Resident #11 stated that he/she had not received her Vitamin C medication for the past couple days. A medical record review on 10/17/2025 at 11:32 AM revealed an active order written on 5/22/2025 at 09:00 for Vitron-C Oral Tablet 65-125 MG (Iron-Vitamin C), Give 1 tablet by mouth in the morning every other day for anemiaUpon further review of the Medication Administration Record (MAR) for the month of October 1-17, 2025, it was noted on 11 October 2025, the nurse's initials and the number 9.During an interview with the DON on 10/17/2025 at 11:32 AM, when asked what does the 9 mean on the MAR, the DON stated that as per the MAR legend, 9=See Nurse Note. The surveyor asked to see the documented nurse note for the missed medication dose on 11 October 2025.On 10/17/2025 at 11:47 AM, the DON stated that she could not find any documentation as to whether the medication was given and no supporting nurses' notes. The surveyor informed the DON that this was a concern as there were no documentation in the medical record that indicated the reason for the missed dose of medication. The DON agreed and stated that there should have been documentation in the resident's medical record.