STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215148	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Waugh Chapel	1221 Waugh Chapel Road Gambrills, MD 21054

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with residents and facility staff it was determined that the facility failed to ensure the resident call bell system was functioning properly. This was found to be evident in 4 Resident's (#68, #125, #106, #74) rooms in 3 of 3 units observed for call light function and response. Findings include: 1. An initial tour of the facility was conducted on 5/3/26 at approximately 10:50 AM on the 100 hallway. During an interview with Resident # 68 the resident stated that s/he wanted to express concerns regarding call response times of staff. The resident stated that it takes up to three hours to get assistance to go to the bathroom. The resident stated that there are times that the call light does not work. At this time the surveyor asked the resident to turn the call light on, and the call light did not light up on the wall unit, the dome located outside of the resident room did not light up and the call light did not light up at the nurse station. At this time the surveyor conducted a dual observation with the unit supervisor (Staff #7) who confirmed each of the findings. The supervisor stated that the facility has been having problems with the call system and stated that she would get the resident a ring bell to alert staff and also notify maintenance about the call light issue. 2. An interview was conducted on 5/3/26 at 11:15AM with Resident #125 and s/he stated that on the weekend, it takes staff greater than one hour to respond to the call light. The resident also stated that the call light was not working on one night last week. The call light was tested and functioned at the time of testing. A meeting was conducted with the Nursing Home Administrator (NHA #1) on the same date at 12:50 PM. The Administrator was made aware that Resident #68's call light was not working and that the supervisor stated that there have been some concerns with the call system. The Administrator confirmed with the survey team that there are concerns regarding the call system and that the facility is currently working on this issue. The NHA provided documentation dated 5/3/26 and 5/4/26 of residents being offered a room change, but the call system repair invoice document was dated 5/1/26. The NHA was unable to provide an explanation as to why the residents were not offered a room change option at the time of the identified concern, and a call ring bell to alert staff when in need of assistance. On 5/6/26 at the time of the exit conference, the NHA stated that the repair team was in the building working on the call system. 3. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation tour of clinical unit, 200 on 05/03/2026 at 11:12 AM the surveyor interviewed Resident #106 in room [ROOM NUMBER]. The resident stated that the call bell light had not been working since April 2026. Also, Resident #106 stated that the portable call bell on his/her bedside table did not guarantee that staff would respond. Additionally, the resident stated that often he/she would ambulate to the doorway to find staff to assist him/her. The surveyor tested the call light in room [ROOM NUMBER] and no staff responded to the call light and no staff were observed in the hallway. 4. At 11:20 AM on 05/03/2026 the surveyor interviewed Resident #74 in room [ROOM NUMBER]. Resident #74 stated that his/her call light had not been working for the past month. Also, Resident #74 stated that he/she would sometimes contact their daughter and the daughter would call the facility supervisor in order for the resident to obtain assistance from the clinical unit staff. The surveyor tested the call bell in room [ROOM NUMBER] and the call light was not functional, and no staff members responded to the call light. At 11:30 AM the surveyor interviewed GNA #18 regarding the non -functioning call bells in rooms [ROOM NUMBERS]. GNA #18 stated that the facility had been having issues with call bells not functioning in certain rooms for approximately three weeks. Additionally, GNA #18 stated that rooms most often with non-working call bells were on the 200 and 300 units and that the administration was aware of the problem. GNA #18 walked to the rooms [ROOM NUMBERS] to assess whether the residents had any current needs. On 05/04/2026 at approximately 09:26 AM the surveyor provided the administrator and the DON with the results of the resident interviews and the observations related to non-functional call lights for rooms [ROOM NUMBERS]. The administrator stated that the facility had contracted with a company to repair specific call lights originally but still experienced failures after the work was completed. However, the plan now was to replace 15 call light strips that included rooms 214 through room [ROOM NUMBER]. Additionally, the administrator stated that he could provide the quote for the call light strip replacement.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, it was determined that the facility failed to maintain resident dignity by leaving a resident's urinary catheter tubing uncovered and in public view. This was evident for 1 (resident # 35) out of 1 resident observed with a urinary catheter during the survey.The findings include:During observation rounds on 05/03/2026 at approximately 10:47 AM, Surveyor observed Resident #35 sitting in a geriatric chair in the facility dining room with a urinary catheter in place. The catheter tubing was uncovered and exposed in public view. Further observation revealed the resident was not fully clothed and lacked a blanket or sheet to cover the catheter tubing while in the common dining area.During an observation and interview conducted on 05/03/2026 at approximately 10:50 AM, Geriatric Nursing Assistant (GNA) Staff #5 observed the resident and agreed with the findings, stating, I will take care of it.

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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 random observations and interviews it was determined that the facility failed to provide services in the facility with reasonable accommodation of resident needs and preferences (dependent resident preference for linen changes and to be out of bed at least daily). This was evident for 1 (Resident #94) of 20 residents interviewed and investigated for reasonable accommodations needs / preferences. The findings include:On 05/05/2026 at 11:17 AM the surveyor was informed by GNA# 18 that Resident #94 wanted to speak with a surveyor. The surveyor entered Resident 94's room and observed that the resident's over the bed table had a small portable call bell in place. The resident stated that the GNAs on 3PM-11PM and 11PM to 7AM shift were slow to respond to call bells on the dates of 05/02 and 05/03, 2026. Additionally, the resident stated that the GNAs did not ensure the resident was out of bed on Saturday or Sunday, 05/02 and 05/03, 2026. Also, the resident stated that he/she requested to have his/her linen changed because he/she frequently feels wet, but the GNA staff would not believe him/her and refused to change his/her linens. Resident #94 stated that in past he/she has called the nursing supervisor or the Ombudsman, and / or 911 in the recent past if his/her clinical requests were not met.On 05/06/2026 at 9:35 AM the surveyor interviewed GNA #19 who stated that he/she worked 7AM-11PM on both Saturday and Sunday this past weekend, May 2nd and May 3rd, 2026 and was assigned to Resident #94. GNA #19 stated that she did tell the resident that he/she was not wet and /or that the resident's bed linens were not wet and did not change the resident's bed linen two times. The GNA #19 stated that the day and evening shifts were very busy and that there may have been delays answering the call bells as well.On 05/06/2026 at 09:41 AM the surveyor spoke with the unit manager, ADON 1 Staff #16 and she was unaware of the resident's concern on the 3-11PM and 11PM to 7AM shifts this past Saturday and Sunday, May 2nd and 3rd, 2026. The ADON was advised that there was one GNA who verified that the resident's bed on 3-11 PM shift this past weekend was not changed when the resident made the request and that there had been delays in responding to the call bells because the unit GNAs were busy with other residents. The ADON stated that she would talk to the GNA and the resident regarding the events over the weekend. The ADON stated that she was not aware of Resident 94's concerns.On 05/06/2026 at approximately 10:30AM the surveyor spoke with the DON Staff #2, and shared the information that Resident #94 had provided the surveyor. The surveyor requested the schedule for both May 2nd and 3rd, 2026 that included GNA # 18 and GNA # 19. The surveyor reviewed the schedules and verified that GNA #19 had worked 7AM to 11 PM on May 2nd and May 3rd, 2026.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure medications were administered and documented in accordance with physician orders, accepted standards of nursing practice, and the facility's established medication administration time parameters for 2 (#98, #18) of 5 residents observed during medication administration observations.Findings include:This deficient practice had the potential to affect the effectiveness of medications intended to manage hypertension, pain, constipation, anxiety, and provide prophylactic and supplemental treatment.During a medication administration observation conducted on 5/3/26 beginning at 10:15 AM with Licensed Practical Nurse (LPN) Staff #4, review of the Medication Administration Record (MAR) for Resident #98 revealed physician-ordered medications scheduled for administration at 9:00 AM had not been administered within the facility's established medication administration timeframe. Observation revealed the medications were administered at approximately 10:29 AM. The medications included:-Aspirin 81 mg by mouth for deep vein thrombosis prophylaxis-Multivitamin one tablet by mouth for supplement-Vitamin B3 by mouth for supplementDuring an interview conducted at the time of observation, LPN Staff #4 stated he got a late start.During a medication administration observation conducted on 5/3/26 beginning at 10:35 AM with LPN Staff #5, Resident #18 was observed receiving medications at approximately 10:45 AM despite physician-ordered administration times of 8:00 AM or 9:00 AM according to the MAR. The medications included:-Hydralazine 20 mg by mouth for hypertension, scheduled for 8:00 AM-Calcium-Vitamin D 500 mg-125 mg one tablet by mouth for supplement, scheduled for 9:00 AM-Colace 100 mg by mouth for constipation, scheduled for 9:00 AM-Amlodipine Besylate 5 mg by mouth for hypertension, scheduled for 9:00 AM-Sertraline HCL 100 mg by mouth for anxiety, scheduled for 9:00 AM-PreserVision AREDS 2 tablets by mouth for vision support, scheduled for 9:00 AM-Tylenol Extra Strength 500 mg one tablet by mouth for pain, scheduled for 9:00 AMFurther review of the medication administration audit record and medication reconciliation conducted on 5/4/26 at 2:00 PM revealed the medications administered on 5/3/26 were not documented on the MAR as administered until 5:21 PM on 5/3/26.During an interview conducted on 5/4/26 at approximately 2:15 PM, the Director of Nursing acknowledged medications are expected to be administered within the facility's established acceptable medication administration timeframe and documented promptly following administration in accordance with professional standards of nursing practice and facility policy.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, it was determined the facility failed to post the required nurse staffing data and post it in a prominent place readily accessible to visitors and residents. This was evident on 1 out of 2 nursing stations observed during the survey. The findings included:During observational rounds on 05/03/2026 at 10:50 AM of the facility Long-Term Care Unit, this surveyor was unable to locate the daily data requirements for the current nurse staffing information for units 4 and 5. During interview and observation on 05/03/2026 at 10:55 AM with manager on duty Staff #7, a Daily Assignment Sheet Nursing form was found in a hard plastic sign holder located on a counter behind the nursing station which was not in a prominent place or accessible for residents and visitors in wheelchairs. The manager on duty stated, This is the wrong sheet and not the nurse staffing information. I will get the correct one. The manager further agreed that the sign holder was not located in a prominent place, was not assessable for residents and visitors in wheelchairs, and would be the sign holder where required daily staffing information would be placed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders and within the facility's established medication administration time parameters for 2 (#98, #18) of 5 residents observed during medication administration observations. The facility also failed to ensure prompt documentation of medication administration following administration.Findings include:During a medication administration observation conducted on 5/3/26 beginning at 10:15 AM with Licensed Practical Nurse (LPN) Staff #4, review of the Medication Administration Record (MAR) for Resident #98 revealed physician-ordered medications scheduled for administration at 9:00 AM had not been administered within the facility's established medication administration timeframe. Observation revealed the medications were administered at approximately 10:29 AM. The medications included:-Aspirin 81 mg by mouth for deep vein thrombosis prophylaxis-Multivitamin one tablet by mouth for supplement-Vitamin B3 by mouth for supplementDuring an interview conducted at the time of observation, LPN Staff #4 stated he got a late start.During a medication administration observation conducted on 5/3/26 beginning at 10:35 AM with LPN Staff #5, Resident #18 was observed receiving medications at approximately 10:45 AM despite physician-ordered administration times of 8:00 AM or 9:00 AM according to the MAR. The medications included:-Hydralazine 20 mg by mouth for hypertension, scheduled for 8:00 AM-Calcium-Vitamin D 500 mg-125 mg one tablet by mouth for supplement, scheduled for 9:00 AM-Colace 100 mg by mouth for constipation, scheduled for 9:00 AM-Amlodipine Besylate 5 mg by mouth for hypertension, scheduled for 9:00 AM-Sertraline HCL 100 mg by mouth for anxiety, scheduled for 9:00 AM-PreserVision AREDS 2 tablets by mouth for vision support, scheduled for 9:00 AM-Tylenol Extra Strength 500 mg one tablet by mouth for pain, scheduled for 9:00 AMFurther review of the medication administration audit record and medication reconciliation conducted on 5/4/26 at 2:00 PM revealed the medications administered on 5/3/26 were not documented on the MAR as administered until 5:21 PM on 5/3/26.During an interview conducted on 5/4/26 at approximately 2:15 PM, the Director of Nursing acknowledged medications are expected to be administered within the facility's established acceptable medication administration timeframe and documented promptly following administration in accordance with professional standards of nursing practice and facility policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined the facility failed to maintain accurate and complete medical records in accordance with accepted professional standards and practices. This was evident in 3 (#12, #83, #95) of 5 resident medical records reviewed. The findings include: 1. Review of Resident #12's medical record on 05/04/2026 at 09:05 AM revealed a PSYCHIATRIC EVALUATION & CONSULTATION visit note dated 04/10/2026 with no name, address or phone number of the company that provided the service. During an interview on 05/04/2026 at 10:09 AM the Nursing Home Administrator (NHA #1) stated the name of the contracted company that provides psych services to facility residents. The NHA was made aware that the contracted company name, address, and phone number was not on visit note dated 04/10/2026 for Resident #12 and verified that the company that provided the service was in fact the company contracted with the facility. 2. Review of Resident #83's medical record on 05/05/2026 at 08:40 AM revealed a PSYCHIATRIC EVALUATION & CONSULTATION visit note dated 03/06/2026, with no name, address or phone number of the company that provided the service. During an interview on 05/05/2026 at approximately 1:30 PM the Director of Nursing (Staff #2) was made aware that the facility contracted company name, address, and phone number was not on visit note dated 03/06/2026 for Resident #83. 3. On 5/6/26 at 10:05 AM, review of the medical record revealed Resident #95 was admitted to the facility on [DATE] with a Stage II pressure ulcer located on the right buttock/sacral area. Further review of the medical record failed to reveal a corresponding physician treatment order for the identified area. On 5/6/26 at 11:00 AM, an interview was conducted with the Director of Nursing (DON Staff #2). The DON stated the resident's documentation in the medical record was incorrect. The DON stated the resident was admitted with a Stage II pressure ulcer to the left buttock/sacral area; however, when the order was transcribed into the medical record, it was incorrectly documented as the right buttock/sacral area instead of the left. The DON further stated the wound was almost healed and nursing staff had been re-educated regarding the importance of accurate documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview it was determined the facility failed to use appropriate infection control practice for resident urinary catheter care. This was evident for 1 (#35) out of 1 residents observed with a urinary catheter during the survey.The findings include:During observation rounds on 05/03/2026 at approximately 10:47 AM, Resident #35 was found sitting in a geriatric chair in the facility dining room with a urinary catheter in place. The catheter drainage bag was observed resting directly on the floor. This practice increases the risk of contamination and is a potential source of infection for the resident. During an observation and interview on 05/03/2026 at approximately 10:50 AM with Geriatric Nursing Assistant Staff #5 stated, the bag should not be on the floor and should be attached to the chair. I will take care of it.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews with residents and facility staff, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This was found to be evident for 2 (#76, #15) of 100 residents reviewed during observational rounds, and 2 (dirty and clean) of 2 laundry areas observed. Findings include:1.During observation rounds conducted on 5/3/26 at approximately 11:00AM, an interview was conducted with Resident #76 and the resident stated that s/he had a difficult time sleeping. The resident went on to say that the air system in his/her room abruptly came on at approximately 1:45 PM on 5/2/26 and was very loud. The resident went on to say that the air system did not turn off until approximately 7:45 AM on 5/3/26, the next day. The resident stated that s/he got very little sleep due to the noise level.A meeting was conducted with the Nursing Home Administrator (NHA #1) on 5/4/26 at approximately 9:35 AM and he was made aware of the resident's concern. The Administrator went on to explain that with the current system there is one (1) thermostat per four (4) resident rooms and if the vent is shut, the air is shifted to another room, and this contributes to the loud uncomfortable sound. He was made aware of the resident's concern about not getting sleep due to this and stated that he would address it.2. An observation was made of Resident #15's room on 5/3/26 at approximately 11:10AM. There were three (3) long and deep marks located on the wall at the head of the resident's bed. 3.A tour was conducted by two surveyors on 5/5/26 at approximately 10:50AM of the laundry area located in the lower basement area. Immediately upon stepping off the elevator there was a pungent odor of rotten eggs along the hallway. The Nursing Home Administrator (NHA #1) was notified at this time and came to assess. The Environmental Services District Manager (#13) and the Maintenance Director (#11) were also present. The NHA explained that the smell is related to a sewer issue and when it is warm, the odor appears. He went on to explain that the facility receives maintenance services such as hydro jetting (high pressure plumbing tool that shoots water to clear sewer lines) to ensure that there is no blockage present. He went on to say that when the hydro jetting maintenance is done, it does not alleviate the smell. He stated that the facility is looking into other options because they are not eliminating a possible leakage.4.A tour of the laundry room identified the following concerns:In the separate clean area where the dryers are located, there were storage cabinets along the wall with missing top fronts and exposed nails. In the separate area, where the washing maschines are located and dirty laundry is brought to be cleaned, the cabinet baseboards were torn away and dragging on the floor.All concerns (1-4) were discussed with the Administration team at the exit conference on 5/6/26.