STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215165	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined the facility staff failed to notify the Responsible Party when a resident (Resident #2) Pressure Ulcer worsened. This was evident for 1 of 5 residents reviewed during the complaint survey.The findings include:Resident #2 was admitted to the facility with diagnoses which included Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Pressure Ulcer of Sacral Region, Pressure-Induced Deep Tissue Damage of Right Heel and Pressure-Induced Deep Tissue Damage of other site. The resident expired in [DATE].On [DATE] at 7:45 AM a review of Resident #2's clinical record revealed that the resident was admitted to the facility from the hospital on [DATE] with several injuries to the skin including an Unstageable Pressure Ulcer of Sacral Region.On [DATE] the facility's Wound Consultant assessed Resident #2's skin injuries and treatment recommendations were implemented. The consultant conducted weekly evaluations of the wounds.Further review of the clinical record revealed that the Pressure Ulcer to the Sacrum was resolved on [DATE]. The record also revealed that the Pressure Ulcer reopened on [DATE]. A Change in Condition/ Concurrent Review 2.0-V13 Form was completed and the documentation revealed that the Responsible Party (RP) was notified in person on [DATE] at 11:25 AM. The Wound Consultant evaluated the reopened wound as a Stage 3 Pressure ulcer. Weekly evaluation of the wound by the consultant continued.The resident was transferred to the hospital on [DATE] for a change in condition and returned to the facility on [DATE].On [DATE] the Wound Consultant evaluated Resident #2's Sacral Ulcer and documented the wound as a worsening Stage 4 Pressure Ulcer. A new treatment order for Santyl and Calcium Alginate dressing was implemented.Further review of the clinical record failed to reveal documentation to indicate the RP was informed of the worsening of the Pressure Ulcer on Resident #2's Sacrum.In an interview on [DATE] at 10:24 AM the Director of Nursing stated that her expectation was for the nursing staff to notify the RP of any change in the resident's condition. She stated that the Pressure Ulcer worsening to a Stage 4 was considered a change in condition and the RP should have been notified. The DON stated that that she would further review the clinical record to ascertain whether any notification to the RP was documented. Later at 11:34 AM on [DATE] the DON notified the surveyor that she reviewed the clinical record and could not find any documentation to show that the RP was notified of the worsening of Resident #2's Pressure Ulcer.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215165	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on record review and interview, it was determined that the facility failed to develop a baseline care plan within 48 hours. This was evident for 1 (Resident #5) of 5 residents reviewed during the complaint survey.The findings include:The baseline care plan is a document that outlines how to provide care for a new nursing home resident. It's created within 48 hours of admission. The plan's purpose is to reduce the risk of adverse events and ensure the resident receives quality care.On 1/8/26 at 11:30 AM, a review of Resident #5's medical record showed an admission date of 10/13/25. However, the baseline care plan was not completed and signed until 10/28/2025, exceeding the 48-hour requirement. This was confirmed by the Resident Representative.On 1/8/25 at 12:23 PM, during an Interview with the Director of Nursing (DON), she confirmed that baseline care plans must be completed and signed within 48 hours of admission, with a copy provided to the resident or their Representative. The DON was informed of this concern and acknowledged the finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215165	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of complaints, interviews and record reviews, it was determined that the facility failed to 1) hold a care plan meeting of the Interdisciplinary Team for a resident at the time of the quarterly revision of their care plans and 2) review and revise the care plan to meet resident's needs. This was evident for 2 (Resident #2 and #5) of 2 resident reviewed for care planning during complaint survey. The findings include: 1) Minimum Data Set (MDS) is a core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. Resident #2 was admitted to the facility in [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Pressure Ulcer of Sacral Region, Pressure-Induced Deep Tissue Damage of Right Heel and Pressure-Induced Deep Tissue Damage of other site. The resident expired in [DATE]. On [DATE] at 9:50 AM in an interview with the surveyor, Resident #2's Responsible Party (RP) stated that he/she was not invited to participate in care plan meetings. On [DATE] at 10:00 AM the surveyor reviewed Resident #2's clinical record. The review revealed that Resident #2's quarterly MDS assessments were completed on [DATE], [DATE] and [DATE]. There was no evidence in the clinical record to indicate that care plan meetings were held with the Resident/RP and the Interdisciplinary Team within 7 days or around the time the quarterly MDS assessments were completed. In an interview on [DATE] at 10:16 AM the Social Services Director, who recently joined the facility (7days ago), stated that she checked the records and could not find documentation of the care conferences held for Resident #2 nor documentation of the RP being invited. On [DATE] at 1:10 PM in an interview, the Administrator stated that he had been in contact with the previous Social Worker and she indicated that numerous attempts to contact the RP were unsuccessful. The Administrator stated that he believed the care conferences were held and would provide the surveyor with the documentation. At the time of exit, the Administrator did not provide the documentation to the surveyor. 2) According to CMS (Centers for Medicare and Medicaid Services), in long-term care facilities, care plans should be reviewed and updated at least every 90 days, or more frequently if a resident's condition changes significantly. On [DATE] at 11:15 AM, a family member of Resident #5 submitted a complaint regarding wound care. A subsequent review of the resident's wound progress notes at 11:30 AM revealed the following skin conditions were present upon admission on [DATE]: 1. Sacrum: Stage 3 pressure ulcer/injury 2. Suprapubic area: skin tear (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215165	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Left and Right heel: callus However, the care plan initiated on [DATE] failed to specify and address these ongoing skin conditions, stated only that Resident #5 was at risk for alteration in skin integrity. Furthermore, a review of the wound progress notes, indicated a new wound acquired on [DATE], yet the facility failed to revise the care plan or its interventions. On [DATE] at 12:23 PM, during an interview with the Director of Nursing (DON), she stated that the residents' care plans were initiated upon admission by the admitting nurse and updated by the Unit Manager or a designated staff member when there a change in condition or as needed. The DON was informed of these concerns and acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215165	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 review of a complaint, record review, and interview, it was determined that the facility failed to write a physician's order for a warm compress. This was evident for 1 (Resident #4) of 5 residents reviewed during the complaint survey.The findings include:On 1/5/26 at 1:20 PM, a review of complaint #2662431 indicated that Resident #4 was reported with a swollen lip on 11/5/25. A care plan meeting note dated 11/6/25 suggested, Resident #4 was reassessed and noted that he/she may have bitten his/her left lip due to jarred teeth or potentially due to mouth care.On 1/6/26 at 7:45 AM, a review of the progress notes identified the following entries that stated that the Physician was notified and a new order was received to apply warm compress:1. 11/5/25 at 10:29 PM, Change in condition: Resident was noted with left lip swollen with the skin intact, on assessment resident was not notice to be in pain, and no new wound noted. Resident was noted with left lip swelling. MD (Doctor of Medicine) notified, new order to apply warm compress.2. 11/6/25 11:01 AM, General Nurses Note: Resident was noted with left lip swollen with the skin intact, on assessment resident was not notice to be in pain, MD notified new order to apply warm compress.3. 11/6/25 1:40 PM, General Nurses Note: Resident observed with swelling to the left lower lip. On assessment, no swelling noted to the tongue. Airway remains patent. no complaints of pain observed at the time. On-call physician was notified. New order received to apply warm compress to the affected area.4. 11/7/25 11:10 AM, General Nurses Note MD notified new order to apply cold compress, routine mouth care and Vaseline applied to moistened mouth.On 1/6 26 at 9:05 AM, a review of the physician orders revealed no evidence that the order to apply warm compress was ever written.On 1/6/25 at 11: 43 AM, the Director of Nursing (DON) confirmed that warm compress order was not documented for Resident #4.On 1/6/26 at 12:20 PM, during an interview with Licensed Practical Nurse (LPN #2), he/she stated that when a change in condition occurred, the nurses would notify the physician and the Resident Representative. If a telephone order was received; the nurses were expected to record the order in the medical record.On 1/7/26 at 9:59 AM, the Nursing Home Administrator (NHA) and the DON were informed of this concern and acknowledged the finding.On 1/8/25 at 7:38 AM, a review of the facility's Consulting Physician/ Practitioner Orders policy implemented on 1/2/23 and reviewed on 10/27/25, confirmed the following: Guideline #3 For consulting physician/practitioner orders received via telephone, the nurse will:a. Document the order on the physician order form, notating the time, date, name and title of the person providing the order, and the signature and title of the person receiving the order. b. Call the attending physician to verify the orderc. Document the verification of the order by entering the time, date, name and title of the physician/practitioner verifying the order, and the signature and title of the person receiving the verification orderd. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication and treatment administration record.