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	04/10/2026

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. Based on Resident and staff interviews and surveyor record reviews it was determined that the facility failed to ensure that 1) care plan meetings were conducted and documented for Resident # 13, and 2) care plans were updated and revised following changes in Resident's condition. This finding was found to be evident for 4 (Resident #7, #11, # 72, and #23) out of 5 Residents reviewed for care planning. The findings include: Care Plan is a personalized comprehensive roadmap addressing an individual's health, social, and functional needs. It covers activities of daily living (ADL), assessment of needs, safety modifications, health and medical care, including diagnoses. Care plan must be reviewed regularly by the interdisciplinary team (IDT) and updated to reflect changes in health status or care needs. The care plan includes problems, goals, interventions and evaluations. 1) On 4/6/26 at 8:13 AM, the surveyor conducted an interview with Resident #13. During the interview Resident #13 stated that he/she had not had a care plan meeting in a while. On 4/7/26 at 7 AM, the surveyor reviewed Resident #13's medical record. The review revealed that Resident # 13's last care plan meeting documented in the medical record took place on 5/9/25. On further review Resident #13 had a Minimum Data Set Assessment (MDS) on the dates after the May 9th care plan meeting: Annual on 3/16/26, Quarterly 12/12/25, Quarterly 9/3/25 and Quarterly 8/24/25. On 4/7/26 at 7:28 AM, the surveyor conducted an interview with The Director of Nursing (DON). During the interview the surveyor reviewed the concern that Resident #13's last documented care plan meeting was completed in May of 2025 and had multiple MDS assessments following, with no care plan meetings. The DON confirmed that care plan meetings were missed following Resident #13's MDS assessments. 2) On 4/6/26 at 9:33 AM, the surveyor conducted an interview with Resident #7. During the interview Resident #7 stated that he/she did not have care plan meetings. On 4/7/26 at 8:17 AM, the surveyor interviewed the Social Services Director Staff #5. During the interview Staff #5 stated she had started working at the facility a few months ago and confirmed that Resident #7 had not had a care plan meeting documented since July of 2025. She further stated that her process for scheduling care plan meetings was to review the Minimum Data Set (MDS) assessment calendar. Staff #5 confirmed that Resident #7 should have had multiple care plan meetings after each MDS assessment and was currently scheduled to have one next week. 3) In an interview with Resident #11 at 11:38 AM on 4/6/2026 the Resident stated that he/she was (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not aware of a care plan meeting. The surveyor conducted a record review of Resident #11's medical record at 3:15 PM on 4/6/2026. Record review revealed that Resident #11 had a care plan meeting on 6/4/2025 as there was a progress note in Resident's medical record dated 6/4/2025 at 15:20 PM. There was no further documentation located in the medical record for Resident #11 of care plan meetings over the past year. In an interview with the Social Services Director (SSD) at 4:15 PM 4/6/2026 the surveyor asked for the process for care plan meetings and the SSD stated that emails or phone conversations occurred with Resident's Responsible Party for notification of care plan meetings and that the interdisciplinary team (IDT) met with Resident and/or Responsible Party to review care plans quarterly. The surveyor conveyed to the SSD that Resident #11's medical record did not reveal that Resident had a care plan meeting since 6/4/2025. The SSD stated that stated that she would see what she could find as she had been at the facility for only a few months. At 8:20 AM on 4/7/2026 in a follow up interview with the SSD she provided documentation of the care plan meeting for 6/4/2025 at 15:20 PM that was in the progress notes of the medical record for Resident #11. Additionally, SSD provided a letter dated 4/6/2026 for an invitation to care plan meeting scheduled for 4/16/2026 at 1:30 PM. The surveyor confirmed with the SSD that the only documentation in Resident #11's medical record for care plan meetings in the past year was the one on 6/4/2025 and the SSD stated, that was all that was located in the medical record. 4) In an interview with Resident #72 at 12:33 PM on 4/6/2026 the Resident stated that he/she does not know about care plans or the care plan meetings. The surveyor conducted a record review of Resident #72's medical record at 3:50 PM on 4/6/2026. Record review revealed that Resident #72 had a care plan meeting on 4/11/2025 as there was a progress note in the Resident's medical record dated 4/11/2025 at 18:04 PM. There was no documentation for the care plan meetings over the past year after that meeting on 4/11/2025. In an interview with the Social Services Director (SSD) at 4:15 PM 4/6/2026 the surveyor asked for the process for care plan meeting and the SSD stated that emails or phone conversations occurred with Resident's Responsible Party for notification of care plan meetings and that the interdisciplinary team (IDT) met with Resident and/or Responsible Party quarterly to review care plans. The surveyor conveyed to the SSD that Resident #72's medical record did not reveal that Resident had a care plan meeting since 4/11/2025. The SSD stated that stated that she would see what she could find as she had been at the facility for only a few months. At 8:20 AM on 4/7/2026 in a follow up interview with the SSD she provided documentation of the care plan meeting for 4/11/2025 at 18:04 PM that was in the progress notes of the medical record for Resident #72. Additionally, SSD provided a letter dated 4/6/2026 for an invitation to care plan meeting scheduled for 4/14/2026 at 12:00 PM. The surveyor confirmed with the SSD that the only documentation in Resident #72's medical record for care plan meetings in the past year was the one on 4/11/2025 and the SSD stated, that was all that was located in the medical record. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5) On 4/7/2026 at 6:45 AM the surveyor conducted a record review of Resident #23's medical record. Review of the medical record revealed that Resident #23 was admitted to Accent Hospice Services on 3/22/2024 and discontinued from Accent Hospice Services on 7/18/2025 at the request of Resident's daughter. Further review of Resident #23's medical record revealed that Resident had an active physician order for Accent Hospice and an active care plan for unavoidable decline due to Hospice status, on hospice care. In an interview with the Director of Nursing (DON) at 12:40 PM on 4/7/2026 the surveyor conveyed to DON that Resident #23 had an active physician order for Hospice Services and a care plan for hospice status and care, but Resident was no longer on Hospice services. DON acknowledged the surveyor and stated that she would follow up on this. At 2:15 PM on 4/7/2026 the DON provided a copy of the progress note date stamped for 7/15/2025 at 14:49 PM which indicated that Resident #23's daughter no longer wanted Hospice services for the Resident as she did not see the assistance that the Hospice services stated that they would provide for the Resident. With the DON in attendance the surveyor interviewed the Business Office Manager (BOM) at 2:20 PM on 4/7/2026 who confirmed that Resident #23 was admitted to Hospice services on 3/22/2024 and discharged from Hospice services on 7/18/2025. At 15:40 PM on 4/7/2026 in an interview with the DON the surveyor conveyed that Resident #23's care plan was not updated with a revision to reflect the change in Resident's condition when Resident was no longer on Hospice care. DON acknowledged the care plan concern. The Licensed Nursing Home Administrator (LNHA) was notified on 4/8/2026 at 4:45 PM of the concerns with lack of care plan meetings and revision of care plan after Resident change in condition.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interviews with staff, it was determined that the primary medical provider failed to review the total program of care for 1 (Resident #7) out of 50 residents reviewed during the survey.A suprapubic catheter (SPC) is a surgically created connection between the urinary bladder and the skin in the abdomen used to drain urine through a tube from the bladder to a collection bag in individuals with obstruction of normal urinary flow.Foley catheter is a flexible tube inserted through the urethra into the bladder to drain urine. It is held in place by a small, water-filled balloon.Percutaneous Endoscopic Gastric (PEG) tube, also known as a g-tube or feeding tube, is placed in a procedure that inserts a tube from the abdomen into the stomach to deliver nutrition, fluids, and medications directly into the stomach.The findings include:On 4/7/26 at 7:15 AM, the surveyor reviewed Resident #7's medical record. The review revealed that on 4/1/26 Nurse Practitioner (NP) #33 wrote a progress note after a follow-up visit. The note stated Resident #7 was a poor historian due to cognitive/psychiatric impairment. It further stated that Resident #7 had a neurogenic bladder with a suprapubic catheter (SPC). It also documented that Resident #7 had a Percutaneous Endoscopic Gastric (PEG) tube used for medications and hydration.On further review Resident #7 had orders written for all medications (absorbed in the gastrointestinal tract) to be given by mouth or orally and not through the PEG tube as the note had described. Additionally, there was an order written for staff to flush the suprapubic catheter with 60 ml of normal saline every shift and a different order for Resident #7 to be on enhanced barrier precautions related to the foley catheter. The surveyor noted that orders were written for two different types of urinary catheters at the same time.On 4/7/26 at 11:29 AM, the surveyor conducted an interview with Unit Manager (UM) #4. During the interview UM #4 confirmed that Resident #7 had a foley catheter not a SPC. When asked why the provider documented a SBP UM #4 stated Resident #7 may have had one in the past but currently had a foley catheter and that she had recently changed the catheter. Next the surveyor asked how Resident #7 takes his/her medications. UM #4 stated Resident #7 gets his/her medication through the PEG tube. When asked why the orders were written for orally and yet the provider notes stated via PEG tube, UM #4 stated she was not sure why the order did not match the provider's note. On 4/8/26 at 11:33 AM, the surveyor conducted a phone interview with Nurse Practitioner (NP) #33. During the interview the surveyor reviewed the discrepancies with NP #33. NP #33 stated she had documented the SPC in error. She further stated that Resident #7 had advanced in his/her diet so he/she could take medications orally. She stated that her notes did not reflect this and she would have to fix the errors. NP #33 also stated that she had evaluated Resident #7 on 4/7/26 and determined that he/she was capable of making his/her own decisions and that the cognitive impairment documented was not accurate. The surveyor reviewed the concern that the assessment of the resident did not match the documentation or orders written.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and staff interview it was determined that the facility failed to have call light cords accessible for Residents and failed to ensure that the resident's call system was functioning properly. This finding was found to be evident in 2 (Resident #68 and #76) out of 28 Residents reviewed call light accessibility and 1 (Resident #7) of 1 call light reviewed for call light functionality.The findings include:Resident Call System is a mandatory communication network in healthcare facilities, allowing Residents to alert staff from their bedside or bathrooms. These systems, ranging from traditional wired pull cords to advanced wireless pendants with fall detection and real time location systems, improve safety and care coordination. Every Resident must have a way of calling for assistance from their bedside and in their bathrooms. 1.On 4/6/2026 at 8:05 AM the surveyor toured the North Nursing Unit. The surveyor observed at 9:05 AM on 4/6/2026 that Residents #68 and #76 did not have an accessible call light in the Resident room. Both Residents were alert, ambulatory and in no distress. Further observation of the call lights for both Residents revealed that the call light cords were found on the floor next to the wall curled up and tied together. At 9:10 AM on 4/6/2026 the surveyor notified the North Unit Nurse Manager of the call lights not accessible for both Residents #68 and #76. The Unit Manager observed the call light cords on the floor next to the wall curled up and tied together in Resident #68 and #76's room and stated, who would have done this and proceeded to untie the call light cords. The Licensed Nursing Home Administrator (LNHA) was notified of the findings at 4:45 PM on 4/8/2026. 2. On 4/6/26 at 9:30 AM, the surveyor conducted an interview with Resident #7. During the interview Resident #7 stated that his/her call light did not always work. The surveyor requested that Resident #7 push his/her light. The call light did not illuminate in the room nor the light above the door in the hallway. On 4/6/26 at 9:36 AM, the surveyor informed Geriatric Nursing Assistant (GNA) #3 that Resident #7's call light was not working. GNA #3 then tried to push the call light herself and confirmed that it was not working. GNA #3 stated that sometimes the adaptors in the wall can get loose. After GNA #3 adjusted the adapter Resident #7's call light was functional. On 4/8/26 at 12:56 PM, the surveyor asked the Nursing Home Administrator (NHA) to evaluate if Resident #7's call light was functioning properly. Next the NHA pushed the call light and noted the call light did not light up. The surveyor reviewed that this was the second time the call light did not function properly. The NHA stated that he would have maintenance look into the issue.