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

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interviews, and record review, it was determined that the facility failed to provide respiratory care consistent with professional standards for oxygen administration. This was found evident of 6 (Resident #13, #23, #41, #133, #149, #171) out of 7 residents reviewed for respiratory care during the survey.Nasal cannula- a medical device used to provide supplemental oxygen therapy to people who have lower oxygen levels.An oxygen concentrator is a medical device that extracts oxygen from room air by filtering out or separating the nitrogen from the oxygen. The oxygen passes through a filter system and is then stored within the device for delivery based on the flow meter setting. The findings include:1.On 4/6/26 at 8:16 AM, the surveyor observed that Resident #13 had 4.5 liters/minute of oxygen being administered via nasal cannula. The nasal cannula was hooked directly to an oxygen concentrator machine in Resident #13's room. No date was labeled on the tubing. Additionally, a partially used humidification bottle (not attached to the oxygen tubing) was also not dated. The surveyor also noted that the nebulizer tubing that was placed in the top drawer of Resident 13's bedside table was not dated. On 4/7/16 at 7:55 AM, the surveyor reviewed Resident #13's oxygen orders. The review revealed that Resident #13 had orders for oxygen to be delivered at 3 liters/min via nasal cannula and for oxygen tubing to be changed weekly with instructions to label each component of oxygen equipment with date and initials. On 4/7/26 at 10:17 AM, the surveyor and Unit Manger (UM) #4 observed Resident #13's oxygen being administered at 5 liters/minute. UM #4 asked Resident #13 if he/she had adjusted the oxygen level. Resident #13 stated that the nurse adjusted the oxygen when he/she had difficulty breathing. It was noted that the oxygen tubing was now labeled. The surveyor asked UM #4 if Resident #13's oxygen level was adjusted should staff notify the providers and/or should the oxygen order be changed. UM # 4 confirmed that if the oxygen was adjusted outside of the orders, the providers should be notified and order adjusted if needed. She also confirmed that the oxygen components should have been dated on 4/6/26 observation. At the time of exit no additional documents were provided to indicate why the oxygen was being administered outside of the oxygen orders. 2.On 04/06/2026 at 8:17 AM, the surveyor noted that Resident #41, #133, #149 and #171's oxygen nasal cannulas were not labeled, and there was no Oxygen in Use signage on the doors. On 04/06/2026 at 8:25 AM, Licensed Practical Nurse (LPN) #1 verified that the above oxygen nasal cannulas were not labeled and signage was not displayed on the doors. LPN #1 stated staff should label new oxygen nasal cannulas every 72 hours and we should have the Oxygen in Use signage on the door (continued on next page)

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

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	215165	A. Building B. Wing	04/10/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/07/2026 at 7:38 AM, the Director of Nursing (DON) acknowledged the concern about unlabeled oxygen nasal cannulas and the missing oxygen signage. The DON stated staff were changing and dating the nasal cannulas and would post appropriate signage. 3.On 4/6/2026 at 1:27 PM the surveyor observed Resident #23 in bed with oxygen in use through nasal cannula tubing delivered by an oxygen concentrator. There was no oxygen signage on Resident #23's door or door frame indicating that oxygen was in use. The surveyor conducted a record review of Resident #23's medical record at 6:45 AM on 4/7/2026. Review of the medical record revealed that Resident #23 had an active physician order for oxygen 3 Liters/minute via nasal cannula. At 8:35 AM on 4/7/2026 the surveyor observed that Resident #23 continued to have oxygen in use, but there was no oxygen signage on the door or door frame. In an interview with the North Unit Nurse Manager at 8:45 AM on 4/7/2026 regarding oxygen usage, she stated that there should be signage on the Resident room doors indicating that oxygen was in use. The Unit Manager observed with the surveyor Resident #23 with oxygen in use with an oxygen concentrator and no oxygen signage on the Resident's door. Unit Manager stated that there should be a sign on the door and that it may have fallen off. The surveyor reviewed at 3:30 PM on 4/7/2026 the facility's Oxygen Concentrator policy dated 12/14/2022. The policy indicated the following 4. Use of Concentrator – h. place an oxygen warning sign on the Resident's door. The Licensed Nursing Home Administrator (LNHA) was notified of the findings at 4:45 PM on 4/8/2026.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interviews and record review, it was determined that the facility failed to provide the resident/resident representative with written notification of a new roommate. This was evident for 1(Resident#73) of 1 resident reviewed for roommate changes during the recertification survey.The findings include:During an interview on 04/06/26 at 10:44 AM Resident #73 reported that they were not informed in advance that he/she would receive a new roommate. On 04/08/26 at 7:00 AM a review of the clinical record revealed that Resident #73 received a new roommate on 02/04/26. Further review revealed no evidence that the facility notified the resident/resident representative prior to the new roommate's arrival on 02/04/26.During an interview on 04/08/26 at 11:00 AM Admissions Director stated that the Admissions Department was responsible for notification and that she verbally informed Resident #73 twenty-four hours prior to the new roommate's arrival. When asked if the resident/resident representative was given a written notice, the Admissions Director responded No.On 04/10/26 at 7:10 AM during an interview the Administrator was informed of the findings. The Administrator stated that he was aware of the surveyor's findings and that he informed the Admissions Director that a written notification should have been issued to the resident/resident representative.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and staff interview it was determined that the facility failed to ensure the personal privacy of a Resident. This finding was found to be evident in 1 (Resident #72) out of 1 Residents reviewed for urinary catheters. The findings include:Urinary Drainage Bag collects urine from a catheter designed to be kept below bladder level to prevent backflow and infections. Urinary drainage bags hang on the bedframe or wheelchair. At 12:34 PM on 4/6/2026 the surveyor observed Resident #72 in bed with a yellow substance in the urinary drainage bag hanging on the bed frame. On 4/7/2026 the surveyor observed Resident #72 at 8:30 AM in bed with the urinary drainage bag in view hanging on the bed frame.In an interview with the North Unit Nurse Manager at 8:45 AM on 4/7/2026 the surveyor conveyed that Resident #72 had a catheter and urinary drainage bag, but there was not a privacy bag on the urinary drainage bag. The Unit Manager accompanied the surveyor to Resident #72's room where Resident was observed in bed with the urinary drainage bag hanging on the bed frame without a privacy bag. The surveyor asked the Unit Manager what the expectation was for urinary drainage bags to be covered with a privacy bag, and the Unit Manager stated that the urinary drainage bag should be in a plastic blue bag that covered the urinary drainage bag. The Unit Manager acknowledged that the urinary drainage bag for Resident #72 was not covered with the blue privacy bag.At 9:15 AM on 4/7/2026 in a follow-up interview with the Unit Manager, the surveyor observed the plastic blue bags at the nursing station on North Nursing Unit, and the Unit Manager stated that these were the privacy bags that were used for covering the urinary drainage bags.The surveyor on 4/7/2026 at 12:30 PM reviewed the facility's policy for Catheter Care dated 1/26/2023. The policy indicated the following it is the policy of this facility to ensure that Residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use, and #2. Privacy bags will be available and catheter bags will be covered at all times and #3. Privacy bags will be changed out when soiled, with a catheter change or as needed.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 and updated to reflect changes in health status or care needs. The care plan includes problems, goals, interventions and evaluations.Additionally, the surveyor conducted a record review of Resident #72's medical record on 4/8/2026 at 7:15 AM. Review of the medical record revealed that Resident #72 had a care plan for a catheter with interventions to provide privacy and comfort and to provide privacy bag.The Licensed Nursing Home Administrator (LNHA) was notified of the findings at 4:45 PM on 4/8/2026.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews it was determined that the facility failed to maintain a safe, comfortable, homelike environment for Residents. This finding was found to be evident in 9 (Resident rooms/bathrooms N34 N39, N40, N42, N46, N50, N34, N62 and S72) out of 9 Resident rooms/bathrooms reviewed, and 1 (North Unit shower room) out of 1 shower rooms reviewed for physical environment during the recertification survey.The findings include: 1.On 4/6/26 at 9:58 AM, during the initial tour of the facility, the surveyor observed in room [ROOM NUMBER]-B that resident #8's wardrobe cabinet door was scraped up, about 4x10 inches to the side and that the 2nd draw from the bottom-up area measuring about 2x8 inches were all scraped off revealing the cream-colored wood inside. On bed 34-A's nightstand were also observed an area on top measuring about 2x4 inches that was scraped off. On the drawer top was another scrapped area measuring about 13 x1.5-inch. In the residents' bathroom, brown stains were observed all over the bottom side of the toilet seat. In the hallway opposite room [ROOM NUMBER] were 2 Geri Chairs, the green leather covering the handrest on both Geri chairs were all torn exposing the cream-colored foam underneath. On 4/7/26 at 2:30PM The Nursing Home Administrator (NHA) and the Maintenance Director was made aware of the conditions of the wardrobe, nightstand, toilet seat and the Geri Chairs. The NHA and Maintenance Director both said they placed an order for new wardrobes, and 10 nightstands have been placed to replace damaged ones. They were asked about the Geri Chairs and toilet seats. They said they were not ordered because they were not aware of the damage until the surveyor made them aware. They were asked to provide proof of the prior orders they placed. On 4/7/26 at 2:45 PM, the NHA brought a confirmation document dated 3/4/26 which showed that 10 overbed tables were ordered but not the wardrobes or nightstands. When asked about the wardrobes and nightstand, the NHA said they have placed the orders but was waiting for the order to be accepted/confirmed. He was asked to provide evidence that the wardrobe cabinet and nightstands were ordered. He brought another invoice that was not dated to indicate that an order was placed and said that he was still waiting for confirmation. He was made aware that this was still a concern. 2. At 8:05 on 4/6/2026 the surveyor toured the North Nursing Unit. Observation revealed that the following Resident rooms were not to be in good repair. Resident room N39 – sink counter cracked and splintered, bathroom door marred; Resident room N40 – doorframe cracked at bottom on both sides, bathroom door marred with large dried water spots on doorframe, crack of the wood frame on the mirror above the sink, crack on sink counter; Resident room N42 – bathroom door and wall marred, foot board of bed marred with chipped wood, cracked doorframes on both sides, cracked sink counter; Resident room N46 – bathroom door and bathroom wall marred; Resident room N50 – wall marred in room, baseboard loose next to bathroom, marred dresser, cracked sink counter. The surveyor reviewed these observations (doors, frames, sinks, baseboards, etc.) of concerns with the Maintenance Director at 3:45 PM on 4/7/2026. Additionally, the surveyor, Licensed Nursing Home Administrator (LNHA) and the Maintenance Director toured the North Nursing Unit at 3:55 PM and observed several of these areas that were not in good repair in the Resident rooms. LNHA and the Maintenance Director acknowledged these concerns. 3. On 4/6/26 at 9:34 AM, the surveyor interviewed Resident #7. During the interview Resident #7 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	relayed concerns with the vents in the bathrooms and shower rooms. Next the surveyor observed the bathroom in room [ROOM NUMBER]N and noted that the ceiling vent had dust accumulating over the top. On 4/7/26 at 12:04 AM, Resident #7 pointed to the ceiling vent in the North wing shower room. Again, the surveyor noted dust accumulating over the vent. On 4/8/26 at 12:56 AM, the surveyor showed the Nursing Home Administrator (NH) the dust accumulation on the vent in the bathroom in room [ROOM NUMBER]N as well as the North shower room. The NHA stated the concern would be addressed. 4. On 04/09/2026 at 8:10 AM, the surveyor observed a hole in the corner of room [ROOM NUMBER]. The hole was sealed with a yellow substance, resulting in an inadequate and incomplete repair. On 04/09/2026 at 2:30 PM, the Nursing Home Administrator (NHA) explained that the repair was a temporary fix for rodent entry and that other renovations were in progress. On 04/09/2026 at 2:31 PM, the NHA acknowledged the concern.

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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 staff and Resident interviews and surveyor record reviews it was determined that the facility failed to provide notification to the Ombudsman of Residents that transferred to the hospital. This finding was found to be evident in 2 (Resident #10 and #72) out of 2 Residents reviewed for discharge process.The findings include:At 6:10 AM on 4/8/2026 the surveyor conducted a record review of Resident #10's medical record. Review of the medical record revealed that Resident #10 transferred to the hospital on the following dates 7/20/2025, 9/3/2025, 9/20/2025, 10/5/2025, 10/11/2025 and 3/25/2026 over the past year. Further review of the medical record revealed that there was no documentation located that the Ombudsman was notified of Resident #10's transfers to the hospital.In an interview with the Social Services Director at 8:26 AM on 4/8/2026 the surveyor asked what the process was for notification to the Ombudsman of Resident transfers to the hospital. SSD stated that the Social Services Department sends an email to the Ombudsman monthly with a list of Residents who transferred/discharged to the hospital the previous month. The surveyor requested a copy of emails sent to the Ombudsman for Resident #10's transfers for July 2025, September 2025, October 2025 and March 2026. The SSD stated that she would follow up.At 9:45 AM on 4/8/2026 the SSD provided the surveyor with Ombudsman notification emails for Resident #10's transfers to the hospital for 7/20/2025 and 3/25/2026. At 10:40 AM the SSD stated that she was unable to locate the Ombudsman notification emails for the September 2025 and October 2025 transfers to the hospital for Resident #10. At 11:00 AM the SSD stated that she had contacted the IT Department for assistance in locating the emails as she was unable to locate the emails to the Ombudsman for the 9/3/2025, 9/20/2025, 10/5/2025 and 10/11/2025 transfers to the hospital for Resident #10.On 4/8/2026 at 6:55 AM the surveyor conducted a record review of Resident #72's medical record. Review of the medical record revealed that Resident #72 transferred to the hospital over the past year on 3/19/2025, 5/22/2025, 9/17/2025, 3/6/2026 and 3/31/2026. Further review of Resident #72's medical record revealed that there was no documentation found that the Ombudsman was notified of the transfers to the hospital.In an interview with the Social Services Director at 8:26 AM on 4/8/2026 the surveyor asked what the process was for notification to the Ombudsman of Resident transfers to the hospital. SSD stated that the Social Services Department sends an email to the Ombudsman monthly with a list of Residents who transferred/discharged to the hospital the previous month. The surveyor requested a copy of emails sent to the Ombudsman for Resident #72's transfers for March 2025, May 2025, September 2025 and March 2026. The SSD stated that she would follow up.At 9:45 AM on 4/8/2026 the SSD provided the surveyor with Ombudsman notification emails for Resident #72's transfers to the hospital for 3/19/2025, 5/22/2025, 3/6/2026 and 3/31/2026. At 10:40 AM the SSD stated that she was unable to locate the Ombudsman notification email for the September 2025 transfer to the hospital. At 11:00 AM the SSD stated that she had contacted the IT Department for assistance in locating the email as she was unable to locate the email to the Ombudsman for the 9/17/2025 transfer to the hospital for Resident #72.At the time of exit with the Licensed Nursing Home Administrator (LNHA) at 4:45 PM on 4/8/2026 no additional documentation was provided by the facility to indicate that the Ombudsman was notified of these hospital transfers.

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	215165	A. Building B. Wing	04/10/2026

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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 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. (continued on next page)

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	215165	A. Building B. Wing	04/10/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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	215165	A. Building B. Wing	04/10/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observations, clinical record review and interviews, it was determined that the facility failed to provide an activities program to meet the needs and interests of a resident. This was evident for 1 (Resident #14) of 1 resident reviewed for activities during the recertification survey.The findings include:Resident #14 diagnoses included Cognitive Communication Deficit, Other Schizoaffective Disorders and Encounter for Palliative Care. The resident was admitted to Hospice in November 2025.Several observations by the surveyor on 04/06/26 and 04/07/26 revealed Resident #14 lying in bed with no form of activity being provided in his/her room.A review of the resident's clinical record on 04/08/26 at 6:21 AM revealed a care plan was initiated on 06/17/25 and revised on 03/25/26 with the following: Focus: (Resident) has some group setting interest as indicated during (his/her) activity evaluation. Resident is verbally able to make (his/her) needs known. Goal: (Resident) will have the opportunity to enjoy activities of choice through the next review date.Intervention: Staff to invite to all activities, regardless of previous attendance. Staff to provide 1:1 room visits as desired/available.Further review of the clinical records failed to reveal evidence of Activities being provided to meet the resident's needs. Also, there was no documentation to indicate that the resident had refused to participate in Activities.On 04/08/26 at 7:45 AM in an interview, the Director of Activities stated that she had been employed by the facility for 2 weeks and was unaware of documentation to indicate Activities were offered to Resident #14 during the past 6 months. She suggested that the surveyor interview the Activities Aide.On 04/08/26 at 10:06 AM the surveyor interviewed Activities Aide #31 who stated that Resident #14 attended group activities before he/she transitioned to hospice care. However, since the transition a few months ago, the resident was not invited to Activities and 1:1 Activities were not provided in his/her room.During an interview on 04/10/26 at 7:05 AM the Administrator was made aware of the surveyor's concerns.

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	215165	A. Building B. Wing	04/10/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to ensure a follow-up assessment was completed in accordance with professional standards of practice. This was evident for 1 (Resident #168) of 1 residents reviewed for skin/head-to-toe assessments. The findings include:On 04/06/26 at 1:30 PM, the surveyor interviewed the resident's surrogate. The surrogate expressed that the areas of concern included an undocumented incident involving a rodent in the resident's bed on 03/19/26 and the facility's adherence to required skin checks and monitoring protocols. The surrogate provided the surveyor with hospice notes that stated the resident had a scratch/skin tear on his/her lower extremities. According to the notes, the resident was asked how the wounds occurred and he/she stated It feels like something bit me. The facility believed the resident was confused and that the accuracy of the resident's statements could not be relied upon.On 04/08/26 at 3:00 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #18. LPN #18 stated that he/she was present the day of the incident and he/she completed a skin/head-to-toe assessment for the resident on 03/19/26. On 04/08/26 at 3:12 PM, the surveyor conducted a record review. The resident had weekly skin evaluations documented for the following dates: 02/19/26- Right top ankle outer.02/24/26- No concerns.03/03/26- No concerns.03/10/26- No concerns.03/17/26- No concerns.03/24/26- No concerns.03/30/26- Scab on right top ankle. 03/31/26- No concerns.On 04/08/26 at 3:35 PM, the surveyor sought clarification from LPN #18 regarding Resident #168's weekly skin evaluations. LPN #18 confirmed that there was a wound on the resident's right leg that he/she made note of on 02/19/26 and 03/30/26. The surveyor asked LPN #18 why a skin/head-to-toe assessment had not been documented on 03/19/26, the date of the rodent incident. LPN #18 stated that he/she completed a skin/head-to-toe-assessment but forgot to document it in the EHR. On 04/08/26 at 4:48 PM, the surveyor interviewed the Nursing Home Administrator (NHA). The NHA stated that the physician was notified about the rodent in Resident #168's bed. According to the NHA, the physician's recommendation was for a nurse to perform a head-to-toe assessment. The NHA stated that the assessment was completed when the incident occurred and he would provide a copy to the surveyor. However, the facility was unable to produce a skin/head-to-toe assessment dated [DATE]. Instead, the surveyor received an assessment dated [DATE], one month prior. On 04/08/26 at 5:00 PM, the Director of Nursing acknowledged the concerns.

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	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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation and interview, it was determined that the facility failed to administer enteral feeding consistent with professional standards of practice. This was found to be evident for 1 (#74) out of 1 Resident observed for enteral feeding during the recertification survey.The findings include:Enteral feeding (tube feeding) delivers liquid nutrition directly into the stomach or small intestine, used when oral intake is unsafe or inadequate.On 04/06/2026 at 9:13 AM, the surveyor observed tube feeding infusing with no date on tubing or bottle. Licensed Practical Nurse (LPN) #1 verified the missing date on the tube feeding bottle and tubing and stated it should be dated when hung. On 04/07/2026 at 7:38 AM, the Director of Nursing acknowledged the concern about the missing date on Resident #74's enteral feeding.

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	215165	A. Building B. Wing	04/10/2026

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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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	215165	A. Building B. Wing	04/10/2026

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Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interviews it was determined that the facility failed to have a process in place that ensured a Resident's medication irregularity reports were reviewed by the primary care physician and the actions taken based on the recommendations were being documented. This was found evident of 1 (Resident #13) of 5 Residents reviewed for medication regimen review.The findings include:Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The MRR also involves collaborating with other members of the Inter Disciplinary Team (IDT), including the resident, their family, and/or resident representative.On 4/7/26 at 8:59 AM, the surveyor reviewed Resident #13's MMR's along with Resident #13's medication orders. The review revealed that on 11/25/25 a MMR report recommended adding instructions to Resident #13's Advair inhaler order to include, rinse after use, in order to help avoid thrush from developing. The provider signed the recommendation form; however, the added instructions were not completed. This same recommendation was written again on 1/21/26 with the provider again signing the recommendations. The order was finally updated with the rinse instructions on 3/19/26.An additional MMR report dated 12/16/25 recommended a gradual dose reduction of alprazolam from 0.5mg three times a day to 0.25mg three times a day. The provider signed the form and checks agreed, however, the order was re-written on 12/22/25 with the same dosage and the rationale for continuing and not reducing was not noted until the psychological note written on 2/11/26.On 2/23/26 a MMR report recommended that metoclopramide 5mg, written to be given every 6 hours for nausea, be reassessed for continued therapy and/or to be considered for a gradual dose reduction or discontinuation. This medication was discontinued on 4/6/26. On 4/8/26 at 12:18 PM, the surveyor conducted an interview with the Assistant Director of Nursing (ADON). During the interview the ADON stated that he was in charge of reviewing the MMR reports and pursuing the provider's review. The surveyor reviewed the concerns some of the recommendations agreed on by the providers were not acted upon until re-reviewed, such as the case with the Advair instructions. The surveyor also reviewed the concern that the provider agreed to a gradual dose reduction with alprazolam, however, the medication was never decreased. And the metoclopramide recommendation was not addressed until 42 days later. The ADON stated he would look into the concerns.

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	215165	A. Building B. Wing	04/10/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Number of residents sampled: Number of residents cited: Based on record review and staff interviews, it was determined that the facility failed to ensure that each resident's medication regimen was free from unnecessary medications. This was evident for 1 (Resident #4) of 5 residents reviewed for unnecessary medication during the annual survey.The findings include:On 4/7/26 at 11:47 AM, Review of Resident #4's medication orders reveal that resident has two medications that were ordered for pain management. The first order was for Tylenol to be given when the pain level is at 1-5. The second order is for Oxycodone HCl Oral Tablet 20 MG (Oxycodone HCl) Give 1 tablet by mouth every 8 hours as needed for Pain 6-10 Further review of the March 2026 medication administration records (MAR) revealed that on 3/6, 3/7, 3/28 and 3/29, Resident #4 was given oxycodone a narcotic medication use to control high level pain when their pain levels were between 4-5.In an interview with Staff # 4, a unit manager, she was asked about pain levels and what they signify. She stated that pain levels of 1-5 mean the resident is in low to moderate pain and pain levels of 6-10 means the resident is in severe pain. Staff #4 was asked if the resident's pain medications should be given when they are off the recommended parameters. She explained that if the resident has a high pain level and was given medication meant for a low pain level, then that medication will not be effective. Also, if the resident voiced a low pain threshold and is given medication meant for a higher pain level, the resident can be over medicated.On 4/8/26 at 12:43 PM the Director of Nursing (DON) was made aware of the concerns, she agreed and said she will follow up.

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	215165	A. Building B. Wing	04/10/2026

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Autumn Lake Healthcare at Bradford Oaks	7520 Surratts Road Clinton, MD 20735

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with staff, it was determined that the facility failed to store medication in a locked compartment. This was found evident on 2 of 2 random observations.The findings include:On 4/7/26 at 6:31 AM, the surveyor observed the East hallway and noted a medication cart that was unlocked and unattended next to room [ROOM NUMBER] and across from room [ROOM NUMBER]. The surveyor noted the top drawer consisted of stock medications in bottles, the 2nd drawer contained medication and vials, the 3rd drawer contained additional medication, noting Narcan, and the 4th drawer contained supplies.At 6:34 AM, the surveyor asked a staff member, who had just come out of a resident's room, who was in charge of the medication cart and was told Registered Nurse (RN) #14. The surveyor then interviewed RN #14. During the interview RN #14 stated that she had just given pain medication to a resident and must have forgotten to lock the cart. She confirmed that the medication cart was supposed to be locked when left unattended.On 4/7/26 6:38 AM, the surveyor observed two medication carts next to each other on the North hallway between room [ROOM NUMBER] and 39, again both unlocked and unattended.The first cart had stock medication in the first drawer, blister packs of medications in the 2nd, additional stock medications in the third. The second cart had stock medications in the first drawer, blister packs of medications in the 2nd, and glucometers and insulin pens in the 3rd.On 6:40 AM, the surveyor conducted an interview with Licensed Practical Nurse (LPN) #15. During the interview LPN #15 stated that she was responsible for both carts but had recently been pulled away from the medication carts. She confirmed that both carts should have been locked when unattended.On 4/7/26 at 7:18 AM, the surveyor informed the Nursing Home Administration (NHA) of the observations.

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	215165	A. Building B. Wing	04/10/2026

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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. Number of residents sampled: Number of residents cited: F812, F 584 and F757F812Based on observation and staff interviews, it was determined that the facility failed to store, prepare, distribute, and serve food in a manner that prevents foodborne illness to the residents. This was evident during the annual survey and has the potential to affect most residents in the facility.The findings includeOn 4/6/26 at 7:53 AM an Initial tour of the kitchen was conducted accompanied by Staff #27 a temporary certified dietary manager (CDM). In the walk-in refrigerator, there were about 60 dessert bowls with no dates on them left on the roll-in refrigerator tray racks containing cinnamon apples and pears. Two cucumbers covered with white moldlike substances were in a Ziplock bag on the fridge shelf. Staff #27 stated that the desserts in the bowls should have been dated and that the cucumbers were bad. She proceeded to toss them out.Further observation of the general kitchen prep area revealed sections of white patches on the kitchen floor, the floor was not moped, areas with brown stains were visible all over with trash debris. Kitchen staff were busy dishing out breakfast to serve residents. On the floor of the dry storage area were observed patches of brown, red and dark stains. The surveyor also noted by the dish washing machine dirty dishes waiting to be washed, the floor had brown stains and trash debris. The whole kitchen floor was not clean or sanitary.In an interview with staff #27 and Staff #26 the CDMs on 4/6/26 at 8:05AM. They were asked why the whole kitchen area and floor was unclean and why they were prepping and serving food in such an environment. Staff #26 stated that the white stains on the kitchen floor were because of the buffing that was done the previous night. She stated that they would mop and clean up the kitchen area after serving breakfast and that they were short staffed.Further review of the service line checklist log used to record food temperature prior to serving was done on 4/6/26 at 8:19 AM. Review revealed that the temperature log was not completed on 4/1/26 for breakfast and lunch, and on 4/3/26 for lunch. This was brought to the attention of Staff #26. She stated that they probably forgot to record it in the logbook.On 4/6/26 at 2:56 PM the Director of nursing (DON) and the Nursing home Administrator (NHA) were made aware of the concern, they stated they will follow up.On 4/7/26 at 8:22 AM A second visit to the kitchen also revealed about 8 trays that were drying on the tray racks by the dish washing machine. Four of the eight trays were cracked at the edges, Staff #26 was made aware and she said she would toss them out, that they have more trays in stock. She was made aware that this was also a concern.

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	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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interviews it was determined that the facility staff failed to maintain infection prevention and control practices. This finding was found to be evident on 1 (North Nursing Unit) out of 3 nursing units reviewed for physical environment during the annual recertification survey.The findings include:The surveyor toured the North Nursing Unit at 8:05 AM on 4/6/2026.During the tour, the surveyor observed at 10:00 AM on 4/6/2026 the clean linen cart uncovered outside of room [ROOM NUMBER]. The clean linen cart had 3 shelves full of linen (bed sheets, towels, washcloths) and a blue plastic cover that was resting on top of the clean linen cart. In an interview with staff nurse #21 at 10:35 AM on 4/6/2026 the surveyor asked what the expectation was for the clean linen cart to be covered, and he/she stated that the clean linen cart should be covered with the cover. Staff nurse #21 proceeded to cover the clean linen cart with the attached blue plastic cover.The North Unit Nurse Manager was notified on 4/7/2026 at 8:45 AM of the concern with the clean linen cart not covered.The Licensed Nursing Home Administrator (LNHA) was notified at 4:45 PM on 4/8/2026 of the finding.

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	215165	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation and staff interviews, it was determined the facility failed to provide individual closet space for a resident. This was evident for Resident # 20 during the annual re-certification survey.The findings include:On 4/6/2026 at 8:56 AM: During the initial observation of Resident #20's room, two stand-alone closets were noted on Resident #20's side of the room, positioned behind the dividing curtain. Resident #20 repeatedly attempted to close the closet door near their bed and nodded yes when asked if the open door was bothering them. Both closets contained shirts and pants. When Resident #20 was asked if the clothes were theirs, Resident #62, the roommate, stated that all the clothes in both closets belonged to them. On 4/6/2026 at 9:06 AM: Staff #17, a Licensed Practical Nurse (LPN), was questioned about the two closets on Resident #20's side of the room and whose clothes were inside, to which Staff #17 replied, I am not sure. Resident #62 reiterated, both closets are mine and all the clothes in both closets are mine as I stated before. Resident #62's Brief Interview for Mental Status (BIMS) score on 1/12/2026 was 15. To confirm ownership, a red and black shirt and a grey sweatshirt with the [NAME] Redskins log were removed from the closets on Resident #20's side of the room, and Resident #62 confirmed both items were theirs, as well as all other clothes in the closets. On 4/6/2026 at 9:45 AM Staff 16, Unit Manager (UM) was shown the situation and acknowledged the issue of Resident #62's clothes occupying Resident #20's closet space. Staff #16, UM called Maintenance to move one stand-alone closet to Resident #62's side of the room and to remove Resident #62's clothing from the closet positioned by Resident #20's bed.

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	215165	A. Building B. Wing	04/10/2026

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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.

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, it was determined that the facility failed to ensure an effective pest control program. This was evident for 1 (Resident #168) out of 1 residents reviewed for pests during the recertification survey. The findings include: On 04/06/26 at 10:00 AM, the surveyor observed a rodent bait box and hole that was sealed with a yellow substance in the resident's room during the initial tour. On 04/06/26 at 1:30 PM, the surveyor interviewed the resident's surrogate. The surrogate stated that he/she had concerns about rodent activity in the resident's room due to two known sightings in the facility that the hospice staff documented during their visits. The surrogate provided the surveyor with documentation which consisted of a medical social services clinical note, a hospice aide visit note, a hospice nursing clinical note and a copy of an email that he/she sent to the ombudsman regarding pests. On 01/20/26, the medical social services clinical note stated that a large fat rodent was observed running in the resident's room during a visit. The social worker relayed their findings to the facility nurse who stated they would contact the maintenance department. The hospice aide visit note from 03/19/26 reported that when the hospice aide set the resident up to begin bathing him/her, the aide pulled the covers down and discovered a rodent in bed on the resident's right side. The aide notified their supervisor of the incident and then informed the resident's nurse and facility caregiver, who entered the resident's room and verified the presence of a rodent in the resident's bed. It was noted that the facility staff called maintenance and maintenance killed the rodent. The hospice nursing clinical note from 03/19/26 reported that the resident had a scratch/skin tear noted on his/her lower extremities. When the resident was asked how it occurred the resident told the caregiver It feels like something bit me. The Hospice Clinical Manager reported that there was a rodent in the resident's bed and they were informed that it was killed. According to the hospice nursing clinical note, the facility reported that the resident was confused and could not rely on the accuracy of the resident's statements. The surrogate reported that the facility did not share the incident with the family, they were rather informed by the hospice staff. When the surrogate questioned the facility's practice and protocol about how the facility handled the situation, the facility told him/her that residents are checked on and repositioned every two hours. Lastly, the surrogate was informed that skin/head-to-toe assessments were completed when the rodent was discovered in the resident's bed. On 04/08/26 at 3:00 PM, the surveyor interviewed LPN #18 regarding the rodent that was in the resident's bed. LPN #18 confirmed that he/she performed a skin/head-to-toe assessment on the resident on 03/19/2026. LPN #18 also added that skin evaluations are performed when residents get showered.On 04/08/26 at 3:12 PM, the surveyor performed a record review. According to the Electronic Health Record (EHR), the resident had scheduled weekly skin evaluations documented but the surveyor did not find evidence that LPN #18 completed documentation for a skin and head-to-toe assessments on 03/19/26. On 04/08/26 at 4:48 PM, the surveyor interviewed the Administrator. The Administrator was asked to explain the facility's protocol for responding to incidents such as the rodent found in a resident's bed and to describe the actions taken on 03/19/26. The Administrator stated that the facility responded by: - Treating the event like an environmental issue. The facility looked for points of entry and sealed them off. The Administrator stated there were entry ways outside and he sealed an opening in the resident's window. - Notifying Pest Control (All State Environmental Services) of the incident and scheduling service although they treat the facility every Wednesday. - Notified the physician and followed recommendations such having a nurse perform a skin/head-to-toe assessment on 03/19/26. - Removed everything from the resident's room for the facility to complete a thorough clean.On 04/09/26 at 8:20 AM, the surveyor performed a record review that consisted of pest logs and invoices. Pest Log: - 02/16/26: Staff observed a mouse on the East unit, treatment applied in room [ROOM NUMBER]. - 03/19/26: Staff observed mice on the East unit, the entire unit was treated. - 03/27/26: Staff observed mice on the East unit in room [ROOM (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NUMBER], treatment applied to 72B. - 04/05/26: Staff observed a mouse on the East unit-72B. Pest Invoices from All State Environmental Services (General comments/instructions): - 02/18/26: Followed up in the laundry room for mice with no bait acceptance noted. Followed up for mice in room [ROOM NUMBER], with no activity observed. A general treatment was applied throughout the kitchen, nursing stations, soiled linen rooms, and laundry area. - 03/30/26: Mice in the 72 east wing, report sent via email. - 04/05/26: Met with maintenance for service. Inspected and treated room [ROOM NUMBER] for mice activity, no activity seen. Treated the dining room, nurse stations, kitchen, dry food storage, pantries, and lobby. Observed droppings during the service.On 04/09/26 at 5:58 PM, the Nursing Home Administrator acknowledged the concern.