STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215177	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Cherry Lane	9001 Cherry Lane Laurel, MD 20708

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive, person-centered care plan that specified the level of assistance a resident required for transfers/mobility for 1 (Resident #2) of 10 sampled residents. Findings included:An admission Record revealed the facility admitted Resident #2 on 08/19/2024. According to the admission Record, the resident had a medical history that included diagnoses of anoxic brain injury, epilepsy, and cardiomyopathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/2026, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #2 was dependent on staff for transfers. Resident #2's Care Plan Report included a focus area initiated 08/19/2024, that indicated the resident needed assistance with activities of daily living related to decreased mobility and acute intracranial processes. Interventions directed staff the resident was dependent on staff for mobility/locomotion on and off the unit. Resident #2's Physical Therapy (PT) Discharge Summary dated 04/05/2026, indicated the resident required a minimum of one person for transfers and was able to perform 75% or more of the activity but required weight-bearing assistance from one caregiver to complete. During an interview on 04/07/2026 at 8:37 AM, Resident #2 stated after the staff bathed them, two girls would come in with a lift and get them out of bed. During an interview on 04/07/2026 at 8:40 AM, Licensed Practical Nurse (LPN) #6 stated Resident #2 did not transfer on their own or get out of bed by themself. LPN #6 stated two persons assisted Resident #2 using the lift to transfer out of bed. During an interview on 04/08/2026 at 10:06 AM, Resident #2's Attending Physician stated Resident #2 would be discharged soon; however, the resident's family needed to come in for training on use of the lift. During an interview on 04/09/2026 at 10:05 AM, the MDS Coordinator stated Resident #2admitted to the facility using a mechanical lift, but the resident improved and some days the resident would not do as much, and the staff would use a mechanical lift. The MDS Coordinator stated the facility was behind updating residents' care plans. During an interview on 04/09/2026 at 2:30 PM, the Director of Nursing (DON) stated that when a resident completed rehabilitation, the Interdisciplinary Team (IDT) discussed falls, changes in the resident's condition, treatments, upcoming discharges, and therapy. The DON stated the Rehabilitation Director would inform the IDT if a resident was a one-person, two-person, required a lift for transfer, or used a wheelchair or walker during the morning meetings, and that information was communicated from the unit managers to the floor staff. During an interview on 04/10/2026 at 12:36 PM, the Rehabilitation Director stated that once a resident was completed with therapy, she communicated to nursing, dietary, and the social services team during the morning meetings. The Rehabilitation Director stated she did not have anything to do with the care plans or Kardex (a summary of a resident's care plan). The Rehabilitation Director stated she was unaware the staff were still using the mechanical lift as Resident #2's therapy discharge summary read the resident required maximal assistance of one person. During an interview on 04/13/2026 at 10:35 AM, Geriatric Nursing Assistant #16 stated Resident #2 had always been transferred by way of a mechanical lift. During a follow-up interview on 04/13/2026 at 1:32 PM, the DON stated she would expect care plans to be current and for revisions and updates to be done (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timely and accurately so that all staff would be aware of the expected care to be given to a resident. During an interview on 04/13/2026 at 1:47 PM, the Administrator stated communication was key, and the staff needed to communicate so that a residents' care plans were updated and revised timely.

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	215177	A. Building B. Wing	04/13/2026

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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 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 interview, record review, and facility policy review, the facility failed to ensure staff revised a resident's comprehensive person-centered care plan to reflect the resident's current transfer needs for 1 (Resident #6) of 10 sampled residents. Findings included: An admission Record revealed the facility admitted Resident #6 on 09/12/2025. According to the admission Record, the resident had a medical history that included diagnoses of spinal stenosis and wedge compression fracture of the first lumbar vertebra. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #6 required partial/moderate assistance for transfers Resident #6's Care Plan Report included a focus area initiated 09/13/2025, that indicated the resident needed assistance with activities of daily living related to spinal compression fracture and dementia. Interventions directed staff the resident was dependent on two staff with a mechanical lift for transfers. Resident #6's Physical Therapy (PT) Discharge Summary dated 12/24/2025, indicated the resident required a minimum of one person for transfers and was able to perform 75% or more of the activity but required weight-bearing assistance from one caregiver to complete.During an interview on 04/07/2026 at 1:36 PM, Resident #6's spouse stated the resident could stand with the assistance of staff and transfer out of bed.During an interview on 04/09/2026 at 10:05 AM, the MDS Coordinator stated the facility was behind updating residents' care plans.During an interview on 04/13/2026 at 11:09 AM, Geriatric Nursing Assistant #15 stated Resident #6 did not require a mechanical lift for transfer.During a follow-up interview on 04/13/2026 at 11:45 AM, the MDS Coordinator stated she did not know why Resident #6's care plan was not updated, as the Interdisciplinary Team discussed transfers in the morning meetings. During an interview on 04/13/2026 at 1:32 PM, the Director of Nursing stated she would expect care plans to be current and for revisions and updates to be done timely and accurately so that all staff would be aware of the expected care to be given to a resident. During an interview on 04/13/2026 at 1:47 PM, the Administrator stated communication was key, and the staff needed to communicate so that a residents' care plans were updated and revised timely.