STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215199	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Braddock Heights	6012 Jefferson Boulevard Frederick, MD 21703

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation and interview, it was determined that the facility failed to ensure residents' call devices were in reach. This was evident for 1 resident (Resident #39) of 24 residents screened during the initial pool portion of the recertification survey.The findings include:Resident #39 was admitted to the facility for care due to a degenerative neurological condition which caused them to be dependent on others for personal care. On 1/14/26 at 8:53 AM an observation and interview was conducted in Resident #39's room as part of the initial tour and screening during the recertification survey. The resident was seated upright in bed. They were awake, alert and easily engaged in conversation. The resident said that they were unable to reposition themselves without assistance. They expressed several concerns which included a delay in call bell response times. The surveyor did not see the resident's call device near the resident and asked the resident where it was. The resident said they did not know. The surveyor then observed the resident's call device on top of the nightstand which was located at the foot end of the resident's bed. The resident said they could not reach it there and that staff must have left it there. The surveyor went into the hallway and approached a Geriatric Nurse Assistant (GNA), Staff #8 to assist Resident #39 with their call device and the GNA agreed and went into Resident #39's room.A review of Resident #39's Geriatric Nursing Assistant (GNA) Kardex (resident's care plan for GNA provided care) showed that it listed, in part, the following instructions: keep call light within reach at all times, resident is dependent for bed mobility, requires set up assist of 1 staff participation for eating.A review of Resident #39's care plan revealed a problem for risk for falls due to impaired mobility, weakness, ambulatory dysfunction. One of the interventions associated with this problem was: call light within reach when in bed.On 1/14/26 at 2:58 PM an interview was conducted with the Nursing Home Administrator (NHA) to review that Resident #39 did not have their call device within reach at 8:53 AM, and she acknowledged the deficiency.

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility 1) failed to report an allegation of abuse timely, and 2) failed to report an allegation of abuse. This was evident for one facility reported incident (#351278) of 8 facility reported incidents (FRIs) reviewed during the recertification survey, and one resident (Resident #22) of three residents reviewed for grievances.The findings include:1) Resident #12 had an allegation of abuse in early 2025. A facility reported incident, with Incident351278 was filed related to the allegation. A review of the facility's investigation packet was conducted on 1/21/26 at 11:17 AM. The review revealed the initial report was sent to OHCQ on 3/17/25 at 2:13 PM. Included in the investigation packet was the statement of physical therapy assistant (Staff #20) that indicated Resident #12 reported the allegation of abuse to her on 3/17/25 at 10 AM. This was 4 hours and 13 minutes before the facility had reported the allegation The Nursing Home Administrator (NHA) was interviewed on 1/21/26 at 3:07 PM. During the interview, she confirmed that she was the facility's abuse coordinator and had investigated Incident351278. The NHA also reported her process when an allegation is reported to her. Noting that her initial action was to report to corporate (vice president and regional staff) that she had a potential facility report, then she determines if the allegation was something that needed to be reported. The NHA stated, the clock starts as soon as someone (staff) is made aware. We have 2 hours. A review of the investigation packet related to incident351278 was conducted with the NHA on 1/21/26 at 3:28 PM. Then NHA confirmed that Resident #12 reported the allegation to Staff #20 on 3/17/25 at 10 AM. The NHA confirmed that she did not report it to OHCQ within the mandated timeframe. She explained that Staff #20 did not report the allegation to her but to the director of rehab, who then reported it to her, causing the delay. However, further review of the investigation packet indicated that Staff#20 directly reported the allegation to the NHA. The NHA also stated that Staff #20 was educated on reporting allegations of abuse immediately. 2). On 1/21/26 at 9:23 AM a review of medical records revealed that Resident #22 was a long term care resident who had diagnoses that included cerebral ischemia, unspecified dementia, and a cognitive communication deficit. A cognitive assessment performed on 11/25/25 indicated that the resident had severe cognitive impairment and was rarely/never understood. The resident was deemed by the facility's Medical Director to lack capacity for decision making as of 4/28/22. The Geriatric Nursing Assistant (GNA) Kardex, a document which described the type of care a resident required, indicated that the resident: 1) required total assist of 1 staff participation with personal hygiene and oral care, 2) required extensive assistance for turning and repositioning in bed, and 3) resident was unable to use call bell and staff should do frequent rounding. Resident #54 was Resident #22's roommate on 1/08/26. Resident #54 was assessed for cognition on 10/29/25 and 1/19/26 and found to be cognitively intact at both assessments. During an investigation of another resident's allegation of a recent loss of property, the NHA was asked to provide evidence of any grievances for January 2026. On 1/20/26 at 3:30 PM two grievance forms were provided. One of the forms was for Resident #22, and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that their roommate at the time, Resident #54, had reported that they observed a GNA (Staff #7) give abrupt care to Resident #22 on the morning of 1/08/26. The grievance form was filed by the facility's social worker (Staff #2). On 1/21/25 at 12:15 PM an interview was conducted with Resident #54 in their room. They no longer resided in the same room with Resident #22, but when asked, Resident #54 said they remembered the incident on 1/08/26. They were initially reluctant to speak with the surveyor and stated that they feared retaliation from facility staff if they discussed the incident. They said they saw all of the interaction between Staff #7 and Resident #22 because Resident #22's privacy curtain was not pulled around Resident #22's bed at the time of the incident even though the GNA was providing care. Resident #54 described Staff #7 as an agency aide who when she entered the room was already not in a good mood, and who became more frustrated with Resident #22's inability to cooperate with her as she tried to dress the resident and assist them to get out of bed. Resident #54 described Resident #22 as easily agitated and who often said ouch when care was provided to them. Resident #54 stated that they observed Staff #7 grab the resident hard and heard Staff #7 speak angrily to Resident #22. Resident #54 went on to say that they observed Staff #7 sit Resident #22 up on the side of the bed, but when Staff #7 was unable to get the resident up, she proceeded to lay Resident #22 back down on the bed and used force to [NAME] the resident's legs onto the bed. Resident #54 said they were concerned about what they observed and so they told the facility social worker, Staff #2 about it later that same morning. Resident #54 added that it was Resident #22's normal routine to be out of bed early in the morning. An interview was conducted with Staff #2 on 1/21/26 and she was asked if she recalled the incident that Resident #54 brought to Staff #2's attention. Staff #2 explained that the concern was reviewed by the NHA who asked Resident #54 if they thought the incident was abuse, and the resident said no, so the incident was not reported to the state Office of Health Care Quality. Staff #2 further explained that Resident #22 was known to get agitated during physical care and transfers, and Staff #2 confirmed that Resident #54 had reported that they thought Staff #7 was frustrated, impatient, and in their opinion, not as gentle as she should have been when she cared for Resident #22 on the morning of 1/08/26. Further review of the grievance form revealed statements that the facility's investigation of the grievance included assessments of other residents, and that follow up included contact with Staff #7's employment agency to inform them that she was not allowed to return to the facility. On 1/21/26 at 3:47 PM an interview was conducted with the NHA regarding the grievance document dated 1/08/26 that alleged rough care was observed by Resident #54 to be provided to Resident #22 by a GNA, Staff #7. When asked if all allegations of abuse were supposed to be reported, she said yes, but that this incident was determined not to be abuse because Resident #54's description of the incident indicated Staff #7's actions were not intentional. She further explained that other residents were assessed for any signs of abuse and none was found. When asked if she interviewed Staff #7 she said an attempt was made but she was not able to be interviewed. When asked if other staff were interviewed she said yes, and that she had a soft file with that information. She also said she had a signed statement from Resident #54 who witnessed and reported the incident. The NHA was asked to provide any additional evidence to support her claim that the incident did not need to be reported to the state agency. The NHA returned later on 1/21/26 and provided copies of the facility's soft file on the incident. The documents provided were; an email between the employment agency and the NHA informing the agency (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that Staff #7 not return to work at the facility; a census of residents on the Skyline unit as of 1/07/26; a typed witness statement dated 1/12/26, signed by Resident #54, and co-signed by the NHA and Staff #2; a copy of the grievance form; ten typed resident witness statements which asked How was your care last night on 11-7 shift? that all had a handwritten comment [no] concerns. There were no staff witness statements and no resident physical assessments. On 1/21/26 at 4:15 PM the NHA was interviewed and asked why the incident was not reported as an allegation of abuse, the NHA said that the incident did not meet the definition of abuse and therefore it did not need to be reported.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to thoroughly investigate allegations of abuse. This was evident for 3 (#351276, #351281, and #2623047) of 8 facility reported incidents reviewed during the recertification survey.The findings include:1). On 1/14/26, during the entrance conference, the Nursing Home Administrator (NHA) was asked to provide the facility's investigation file for Incident #351276. The facility's abuse policy was also requested at that time. A review of the incident report which was received at the Office of Health Care Quality (OHCQ) on 2/23/25, revealed the following statement: resident alleged that staff member was rough when providing care. On 2/24/25, Resident [#40] told the 7a-7pm nurse that she was hit by the GNA [Geriatric Nursing Assistant] providing care to her on 7p-7a. On 1/21/26 at 3:06 PM an interview was conducted with the NHA to review the facility's process reportable incidents. The NHA said she was the abuse coordinator and responsible 24 hours per day, 7 days per week for operations of the facility and that she ensured the facility's compliance with regulations at all times. She described the overall process of an abuse investigation, which included obtaining witness statements from the alleged perpetrator, staff on duty at the time, and residents in the area and/or cared for by the alleged perpetrator. She explained that any resident who was incapable of giving a statement would have a physical assessment to check for any signs of abuse. She further explained that the alleged perpetrator would be suspended pending the investigation, and that if they were not available in person, she would call them to get their statement. If they needed education, that would be done prior to them returning to work once the investigation was completed. On 1/22/26 at 2:41 PM the facility's investigation file was reviewed. It lacked any staff witness statements, and no statement from the alleged perpetrator. There were no resident witness statements or resident assessments. There was no evidence of the alleged perpetrator's license, education, or work status in the file. There was one witness statement for Resident #40 that was handwritten and was in the form of questionnaire. The document was dated 2/23/25 and did not contain the name or signature of the interviewer. The file also lacked a copy of the both the initial and the final report to OHCQ. On 1/23/26 in an interview with the NHA and the Director of Nursing (DON), they were asked who wrote the resident's witness statement. They both said it was the former DON, that they recognized his handwriting, but they both confirmed that his name did not appear anywhere on the document. When asked if there were any staff witness statements for this investigation they did not have an answer. When asked if other residents were interviewed and assessed they said yes but did not provide any evidence. The NHA later produced a copy of the facility's final report to OHCQ, but no other information was provided by the end of the survey. 2.) On 1/15/26 at 11:07 AM, the surveyor reviewed Resident #67's medical record and the facility investigation file related to Facility Reported Incident (FRI) #351281. Record review confirmed Resident #67 was admitted on [DATE] and discharged on 5/19/25. Medical record review identified a provider note dated 4/21/25 at 3:11 PM documenting the resident reported a concern of physical assault that occurred the prior weekend and stated a staff member (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	struck his left arm purposefully and handled him too aggressively. The provider documented no obvious signs of physical trauma at the time of assessment. On 1/20/26 at 2:08 PM, during a review of the facility investigation file, the surveyor identified an unsigned and unnamed statement dated 4/17/25 which described the resident's report of events, and included an allegation that staff slapped the resident's hand away while interacting with the resident's urinal and that another staff member was present in the room. On 1/20/26 at 2:17 PM, the surveyor reviewed a document in the investigation file, signed by the Nursing Home Administrator (NHA), that indicated that Staff #15 was suspended pending investigation and reflected a summary of an interview with Staff #15, in which Staff #15 stated the contact with the resident's hand was accidental and not intentional. The investigation file also included an education acknowledgment titled Abuse, Neglect + Customer Service Training, dated 04/18/2025, signed by Staff #15. On 1/20/26 at 2:30 PM, further review of the investigation file revealed that it included a signed statement from Staff #14, dated 4/17/25, stating that Staff #15 emptied the urinal for Resident # 67 and that Staff #14 did not hear a slap while in the room. However, the investigation file did not contain a signed statement from Staff #15 regarding the incident, and the file did not contain documentation that Staff #15 was requested to provide a signed statement or declined or was unavailable to do so. On 1/22/26 at 9:19 AM, the surveyor reviewed an internal corporate email dated 12/22/25 at 10:55 AM included in a separate facility FRI file. The email, from a regional nursing representative to facility leadership, instructed that investigative statements should be conducted as interviews using direct questions; the data collected should be factual; interviews should include residents present at the time of the incident and staff; and the final self-report should be supported by documentation to approval. On 1/21/26 at 3:30 PM, the surveyor interviewed the NHA regarding whether signed statements existed from staff identified as alleged perpetrators in FRI #351281 and FRI #2623047. On 1/21/26 at 3:36 PM, the NHA stated the facility did not have a signed statement from Staff #15. On 1/23/26 at 12:30 PM, by the end of the survey, the facility did not provide a signed statement from Staff #15 nor documentation that Staff #15 was requested to provide a signed statement and declined or was unavailable. 3.) On 1/21/26 at 2:10 PM, the surveyor reviewed the facility investigation file for FRI #2623047. The initial report submitted to the Office of Health Care Quality (OHCQ) on 9/20/25 at 6:00 PM documented that the [NAME] County Sheriff's Office was contacted. The report did not identify an officer and did not provide a report number or other objective documentation that supported the contact. The facility's investigation documentation included questionnaires which reflected resident and staff interviews. The investigation file lacked documentation that identified witnesses to the alleged incident. Additionally, within the investigation record, the section that identified law enforcement notification was listed as [NAME] County Sheriff's Office but was blank for the date and time of contact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/26 at 2:56 PM, the surveyor reviewed the facility's follow-up report dated 9/26/25 at 4:00 PM, which stated that Resident #18 was unable to communicate, a skin assessment was completed with no new areas noted, and residents were interviewed or assessed as applicable. The follow-up report also stated the alleged perpetrator was unaware of the incident due to lack of a specific date/time. The facility's documentation reflected Staff #18 was suspended pending investigation. On 1/21/26 at 3:30 PM, the surveyor asked the NHA whether a signed statement from Staff #18 regarding the investigation existed. On 1/21/2026 at 3:36 PM, the NHA stated the facility did not have a signed statement from Staff #18. On 1/21/26 at 3:36 PM, the surveyor also asked the NHA to provide evidence supporting that the incident was reported to the [NAME] County Sheriff's Office as documented in reports to OHCQ for FRI #351281 and FRI #2623047. The NHA stated these notifications were likely phone calls and that a police report number was not always provided. On 1/23/26 at 12:30 PM, by the end of the survey, the facility did not provide objective supporting documentation to verify law enforcement notification, such as the date/time of contact, the name/badge/identifier of the person contacted, a report number, or other documentation supporting the contact as documented in the reports to OHCQ. In addition, the facility did not provide a signed statement from Staff #18 or documentation of an attempt to obtain a signed statement and the outcome (refusal/unavailability).