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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	215199	A. Building B. Wing	01/23/2026

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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 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, (continued on next page)

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	215199	A. Building B. Wing	01/23/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and 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 (continued on next page)

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	215199	A. Building B. Wing	01/23/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agency 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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	215199	A. Building B. Wing	01/23/2026

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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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	215199	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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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	215199	A. Building B. Wing	01/23/2026

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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).

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	215199	A. Building B. Wing	01/23/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to communicate a resident's comprehensive care plan goals to the receiving healthcare institution to ensure safe and effective transition of care. This was evident for 1 (Resident #64) of 1 resident reviewed for hospitalization.The findings include:Record review on 1/16/26 at 11:06 AM for Resident #64 noted that s/he had resided in the facility since November 2025. The continued review included a nurse's note dated 12/21/25 indicating that Resident #64 had a change in condition and that the attending physician ordered Resident #64 transferred to the emergency room for evaluation and treatment.Further review included a change in condition/concurrent review form dated 12/21/25 for Resident #64. The form noted that the Resident's representative was not present at the time of transfer to the hospital. The form also had a check mark in a boxed area before each item to indicate which document was printed and sent with the Resident to the receiving acute care provider. The first item, care plan goals, did not have a check mark.However, the following items were checked: 2) face sheet; 3) current medication list or current MAR (Medication Administration Record); 4) change in condition progress note (if completed); 5) Advance Directives (Durable Power of Attorney for Health Care, Living Will); 6) Advance Care Orders (MOLST-Medical Orders for Life-Sustaining Treatment); 7) Printed Vaccination Record; 8) Most Recent History and Physical; 9) Recent Hospital Discharge Summary; 10) Relevant Lab Results (from the last 1-3 months); 11) Relevant X-rays and other diagnostic test results; 12) Recent MD/NP/PA progress notes; 13) Transfer Form.In an interview on 1/20/26 at 3:53 PM, the director of nursing (DON) reviewed Resident #64's change in condition form dated 12/21/25 and stated that the lack of a check mark for care plan goals indicated that the Resident's care plan goals were not included in the paperwork staff sent to the hospital with the Resident upon transfer on 12/21/25.The interview lacked evidence that Resident #64's comprehensive goals were communicated to the receiving facility at the time of transfer to the hospital on [DATE].

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	215199	A. Building B. Wing	01/23/2026

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, it was determined that the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory timeframes to facilitate appropriate care planning and maintain current, accurate assessment records. This was evident for 2 (Resident #43 and #52) of 3 residents reviewed for activities and 1 (Resident #55) of 4 residents reviewed for Resident assessment.The findings include:The MDS is a federally mandated assessment tool that nursing home staff use to gather information about each Resident's strengths and needs. The information collected informs resident care planning decisions. The admission MDS is a comprehensive assessment for new Residents and, under certain circumstances, returning Residents. It must be completed by the end of day 14, with the date of admission to the facility as day 1.The last day of the observation period is the Assessment Reference Date (ARD). It marks the end of the observation period and serves as a common reference point for all team members participating in the assessment. 1) Record review on 1/14/26 at 10:13 AM showed that Resident #43 was admitted to the facility on [DATE].A continued review included an admission MDS assessment for Resident #43, dated 12/22/25, which was due on 12/30/25.However, further review showed that Resident #43's admission MDS was completed and signed in section V0200B2 on 1/6/26, 21 days after admission, making it 7 days late.During an interview on 1/21/26 at 12:33 PM, staff #3, an MDS Coordinator, confirmed that Resident #43's admission MDS assessment was completed 7 days late. 2) A review on 1/14/26 at 10:01 AM of Resident #52's admission MDS assessment with ARD 12/18/25 revealed that Resident #52 was admitted to the facility on [DATE]. A continued review of the MDS assessment showed that it was due on 12/25/25. However, it was completed and signed in sections Z0500B and V0200B2 on 1/6/26, 26 days after Resident #52's admission to the facility and 12 days late. In an interview on 1/21/26 at 12:20 PM, Staff #3 confirmed that Resident #52's admission MDS was completed late.3) A record review conducted on 1/20/26 at 10:14 AM for Resident #55 included an admission MDS assessment with an ARD of 12/24/25. The review showed that the Resident was admitted to the facility on [DATE], so the admission MDS assessment was due on 12/31/25.However, a continued review showed that Resident #55's admission assessment was completed and signed in section V0200B2 on 1/6/26, 20 days after the Resident's admission to the facility, making it 6 days late. During an interview on 1/21/26 at 12:25 PM, staff #3 checked the completion date for Resident #55's admission MDS and reported that it was completed late.

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	215199	A. Building B. Wing	01/23/2026

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, it was determined that the facility failed to complete Quarterly Minimum Data Set (MDS) assessments for residents within the required regulatory timeframes to facilitate appropriate care planning and maintain current assessment records. This was evident for 1 (Resident #7) of 3 residents reviewed for Resident assessments and for 1 (Resident #27) of 3 residents reviewed for Nutrition.The findings include:The Minimum Data Set (MDS) assessment is a federally mandated tool used by nursing home staff to gather information about each resident's strengths and needs. The information collected informs residents' care planning decisions. The Quarterly assessment must be completed within 92 days of the MDS Completion Date of the last OBRA assessment. It must also be completed no later than 14 days after the ARD (ARD + 14 days).The last day of the observation period is the Assessment Reference Date (ARD). This date serves as a common reference point for all team members involved in the assessment. 1) Record review conducted for Resident #7 showed that s/he had resided at the facility since 2013. The continued review included the latest Quarterly MDS assessment, dated 10/12/25, for Resident #7. The MDS assessment was to be completed on 10/26/25.However, the review showed that Resident 7's Quarterly MDS was completed and signed in section Z0500B on 11/3/25, 22 days after the ARD and eight days late.In an interview on 1/21/26, staff #3, an MDS Coordinator, confirmed that Resident #7's quarterly MDS assessment dated [DATE] was completed late. 2) A review of Resident #27's record contained a prior MDS assessment dated [DATE] which was completed on 6/13/25. The resident's next MDS assessment was scheduled for 8/25/25 and was to be completed on 9/8/25.However, a subsequent review showed that Resident #27's Quarterly MDS assessment, dated 8/25/25, was completed and signed in section Z0500B on 9/19/25, 25 days after the ARD and 11 days late.During an interview on 1/21/26 at 12:16 PM, staff #3 confirmed that Resident #27's MDS assessment dated [DATE] was completed late.

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to accurately code residents' Minimum Data Set (MDS) assessments correctly. This was evident for one (Resident #43) of one resident reviewed for communication and sensory, one (Resident #52) of 3 residents reviewed for Activities, and one (Resident #8), of 2 residents reviewed for dental care during the recertification survey.The findings include:The Resident Assessment Instrument (RAI) delineates the process that long term care facilities follow to screen residents, assess resident strengths and needs, plan for resident care delivery, and evaluate the residents progress and needs on an ongoing basis by returning to additional, periodic screening, assessment and planning throughout a resident admission. The RAI process is the basis for the accurate assessment of each resident. The Minimum Data Set (MDS) assessments are an integral part of the RAI and include completion of standardized assessment questions. There are comprehensive MDS assessments and periodic non-comprehensive MDS assessments which facilities conduct to maintain an accurate understanding of each resident's most current needs and strengths, and to ensure care planning remains current and effective. An Assessment Reference Date (ARD) is the date that shows the end of the look back (observation) period. This date is used to base responses to all MDS coding items during the MDS assessment. 1) On 1/14/26 at 10:12 AM, Resident #43 reported to the surveyor during an interview that s/he had difficulty hearing. Staff #21, a geriatric nurse aide (GNA), was present and assisted in placing the Resident's hearing aids in both ears. A record review for Resident #43 on 1/16/26 at 4:23 PM included an Admit/Readmit Screener dated 12/17/25 for Resident #43, which indicated that the Resident used hearing aids in both ears. A continued review included an admission Activity assessment dated [DATE], which noted that Resident #43 had impaired hearing. Further review of Resident #43's admission MDS assessment dated [DATE] showed that section B documented the Resident's hearing as adequate, with no use of hearing aids. During an interview on 1/16/26 at 5:17 PM, staff #22, a GNA, confirmed that Resident #43 was hard of hearing and required hearing aids in both ears to communicate. In an interview on 1/21/26 at 11:21 AM with staff #3, an MDS Coordinator, she stated that Resident 43's admission MDS was recorded in error. She said she would correct the MDS after the surveyor's intervention. 2) An observation of Resident #52 on 1/16/26 at 2:19 PM showed that the Resident had no natural lower teeth. The Resident stated at that time that s/he was wearing full upper dentures. During a subsequent observation on 1/21/26 at 11:14 AM with staff #3, she asked Resident #52 whether he/she used dentures. The Resident responded that he/she wore full upper dentures and had no natural bottom teeth. A review of Resident #52's record included an Admit/Readmit Screener dated 12/12/25, which noted (continued on next page)

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	215199	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the Resident had full upper dentures. A continued review included an admission MDS assessment for Resident #52, completed on 1/6/26, which answered NO to the statement No natural teeth or tooth fragment(s) (edentulous) in section L, indicating that the Resident had natural teeth. An interview on 1/21/26 at 12:20 PM with staff #3 confirmed that Resident #52's admission MDS assessment did not reflect his/her use of dentures or edentulous (toothless) oral status. In a subsequent interview on 1/22/26 at 8:33 AM, staff #3 handed the surveyor a completed, corrected MDS assessment for Resident #52 and said, I corrected it after the surveyor's intervention. 3). On 1/15/26 at 10:41 AM Resident #8 was observed and interviewed in their room. They were observed to be without any natural teeth in their mouth and when asked, they said they expected to receive their new dentures on 12/30/25, but they had not received them yet. The resident said they had to cut up their food into tiny bits in order to eat. They expressed distress that they still did not have their dentures. On 1/16/26 at 11:17 AM an interview was conducted with the Director of Nursing (DON) regarding Resident #8's dentures. The DON said there was documentation that the dentist came to check the fit of the dentures and took them back to be adjusted. She further explained that the dentures would be brought back on 1/21/26, the next time the dental practitioner was scheduled to be in the building. A review of Resident #8's electronic record revealed dental notes that indicated the resident had their remaining natural teeth extracted on 5/23/25 at the facility. Additional dental notes dated 6/24/25 and 9/16/25 in the resident's record indicated dental provider follow up and that dental impressions were made for complete upper and lower dentures. A dental note dated 9/30/25 indicated upper and lower wax impressions were fitted and adjusted. On 1/20/26 at 2:19 PM a record review of Resident #8's annual MDS, with an ARD date of 10/04/25 was reviewed for accuracy. The review of Section L - Oral/Dental status revealed that it was coded to indicate that the resident was not edentulous (without teeth). It also was coded to indicate that the resident had no problem chewing. On 1/21/26 at 11:42 AM an interview was conducted with the facility's MDS nurse (Staff #3). When asked how she performed assessments she said she did record reviews, except for pain assessments which were done in person. When Staff #3 was shown Section L of the MDS assessment with the ARD of 10/04/25, she said she did not do that one, that the person who completed that assessment worked at another facility. Staff #3 reviewed the coding for Section L and confirmed that it was coded incorrectly and said she would make the correction. On 1/22/2026 at 2:02 PM the DON brought the corrected copy of the 10/04/25 MDS Section L that indicated Resident #8 was edentulous.

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
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and observations, it was determined that the facility failed to develop and implement comprehensive, resident-centered care plans. This was evident in 1 (Resident #43) of 1 resident reviewed for communication and sensory, and 1 (Resident #52) of 3 residents reviewed for ActivitiesThe findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information about each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need.A care plan is a guide that addresses each Resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the Resident's care. Staff utilize care plans to provide resident-centered care that includes support, services, and resources to address residents' needs.1) During an interview with Resident #43 on 1/14/26 at 10:12 AM, s/he reported difficulty hearing. A record review on 1/16/26 at 4:23 PM of Resident #43's Admit/Readmit Screener, dated 12/17/25, indicated that the resident used hearing aids in both ears. The review also included an admission Activity assessment dated [DATE], which noted that Resident #43 had impaired hearing. However, the review failed to show that Resident 43's hearing difficulty and use of hearing aids were addressed in his/her care plan.In an interview on 1/21/26 at 12:00 PM, staff #3, an MDS coordinator, reviewed the resident's care plan and confirmed that it did not address the resident's hearing impairment or his/her use of hearing aids.During an interview on 1/22/26 at 7:40 AM, the director of nursing (DON) reported that Resident #43's care plan had been revised to include his/her hearing difficulty and use of hearing aids. 2) An observation of Resident #52 on 1/16/26 at 2:19 PM showed that the Resident had no natural lower teeth. The Resident stated at that time that s/he was wearing full upper dentures. A subsequent observation on 1/21/26 at 11:14 AM with staff #3 showed that Resident #52 had no natural bottom teeth. Record review completed for Resident #52 on 1/20/26 at 10:28 AM included an admission assessment dated [DATE], which noted that the resident had full upper dentures.In an interview with staff #3 on 1/21/26 at 12:20 PM, she confirmed that Resident #52's care plan did not reflect his/her dental status.During a subsequent interview on 1/22/26 at 7:44 AM, the DON stated that Resident #52's care plan had been updated to reflect his/her dental status and use of dentures following the surveyor's intervention.

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

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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 record reviews and interviews, it was determined that the facility failed to 1) revise care plans, and 2) conduct care plan meetings after the completion of the comprehensive and/or quarterly assessments. This was evident for two residents (Resident #5, #8) of 2 residents reviewed for dental care, and one resident (Resident #62) of 2 residents reviewed for care planning.The findings include: A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. The Resident Assessment Instrument (RAI) delineates the process that long term care facilities follow to screen residents, assess resident strengths and needs, plan for resident care delivery, and evaluate the residents progress and needs on an ongoing basis by returning to additional, periodic screening, assessment and planning throughout a resident admission. The RAI process is the basis for the accurate assessment of each resident. The Minimum Data Set (MDS) assessments are an integral part of the RAI and include completion of standardized assessment questions. There are comprehensive MDS assessments and periodic non-comprehensive MDS assessments which facilities conduct to maintain an accurate understanding of each resident's most current needs and strengths, and to ensure care planning remains current and effective. An Assessment Reference Date (ARD) is the date that shows the end of the look back (observation) period. This date is used to base responses to all MDS coding items during the MDS assessment. 1.a). On 1/14/26 at 11:31 AM an observation and interview was conducted with Resident #5 in their room. They said they had a broken tooth, their back left molar, and that it happened in November 2025. They also said it was painful and that every time they ate, they bit their tongue. A review of Resident #5' medical records revealed a progress note dated 12/11/25 and written by Licensed Practical Nurse (LPN) Staff #16, that read Resident was seen by the Dentist on 12/9 for broken tooth. Resident was referred to Orthodontics for excretion [extraction]. Pending date for excretion [extraction]. MD [Medical Doctor] made aware. PRN [as needed] medications were up to date by MD. On 1/15/26 at 2:39 PM a review of Resident #5's care plan failed to reveal any problem listed for the resident's broken tooth. On 1/16/26 at 9:48 AM an interview was conducted with the MDS nurse (Staff #3) to review the resident's MDS assessments and care plan. When asked if Resident #5's care plan should contain a problem for their broken tooth, Staff #3 said yes. When asked the process for care plan revision, Staff #3 said usually the Assistant Director of Nursing (ADON) would update the care plan. On 1/16/26 at 11:08 AM an interview was conducted with the Director of Nursing (DON) and Resident #5's care plan was reviewed. The DON said there was nothing on the care plan about the resident's broken tooth, but it should have been. She confirmed the deficiency. 1.b). On 1/15/26 at 10:41 AM Resident #8 was observed and interviewed in their room. They were (continued on next page)

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	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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed to be without any natural teeth in their mouth and when asked, they said they expected to receive their dentures, which had already been made, on 12/30/25 but they were still waiting. The resident said they had to cut up their food into tiny bits in order to eat. They expressed distress that they still did not have their dentures. On 1/16/26 at 11:17 AM an interview was conducted with the DON regarding Resident #8's dentures. The DON said there was documentation that the dentist came to check the fit of the dentures and took them back to be adjusted. She further explained that the dentures will be brought back on 1/21/26, the next time the dental practitioner is scheduled to be in the building. A review of Resident #8's electronic record revealed dental notes that indicated the resident had their remaining natural teeth extracted on 5/23/25 at the facility. Additional dental notes dated 6/24/25 and 9/16/25 in the resident's record indicated dental provider follow up and that dental impressions were made for complete upper and lower dentures. A dental note dated 9/30/25 indicated upper and lower wax impressions were fitted and adjusted. On 1/20/26 at 2:51 PM a record review of Resident #8's current active care plan failed to reveal a problem for the resident's status as edentulous, nor any indication that the resident was in the process of obtaining a full set of dentures. On 1/21/26 at 11:42 AM an interview was conducted with the MDS nurse (Staff #3). Resident #8's documentation in the electronic record was reviewed. The dental note of 5/23/25, when the resident's teeth were extracted, was found in the Miscellaneous scanned documents section of the record. The resident's care plan was then reviewed together, and the Staff #3 said there was no care plan entry for the resident's lack of teeth. When asked how resident care plans were updated, Staff #3 stated that the ADON or the DON updated care plans. On 1/23/26 at 10:56 AM an interview was conducted with the DON, Nursing Home Administrator (NHA), and regional nurse (Staff #9) to review survey deficiencies. No further information was provided by the end of the survey. 2) Resident #62 was admitted into the facility in mid-2025. An interview with the resident was conducted on 1/14/26 at 10:29 AM. Care planning was discussed with the resident and was asked if the facility held care plan meetings on a regular basis and/or whenever there was a change in his/her care or status. The resident stated, I don't know, I don't think so. A review of Resident #62's progress notes for care plan meetings was conducted on 1/15/26 at 12:29 PM. The review revealed the last 3 care plan meetings were held on 5/16/25, 8/5/25, and 12/16/25. All of which the residents attended. Further review of Resident #62's electronic health record was conducted on 1/15/26 at 12:35 PM. The review revealed the resident's assessments tab and indicated the following:ˆ admission assessment with an assessment reference date (ARD) of 5/8/25ˆ Quarterly assessment with an ARD of 8/8/25ˆ Quarterly assessment with an ARD of 9/17/25ˆ Quarterly assessment with an ARD of 12/18/25 The Social Services Director (Staff #2) was interviewed on 1/20/26 at 8:57 AM. During the interview, Staff #2 explained her process in scheduling care plan meetings. Noting that they are generally scheduled on Tuesdays and Thursdays but can be other days if the resident and/or responsible party (continued on next page)

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	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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requests it. Staff #2 also explained the interval of care plan meetings was around 3 months and related to a resident's quarterly assessments. Staff #2 was asked if she would schedule a care plan meeting whenever a significant change assessment was completed and/or another quarterly assessment but less than 3 months from the last one. Staff #2 indicated that she did not know if a care plan meeting was necessary for significant change assessments, and that she would not schedule a care plan meeting for quarterly assessments completed less than 3 months from the prior quarterly assessment. Staff #2 stated, When I was hired, I was told I would be getting the schedule from the resident assessment coordinator to schedule the meetings. Resident #62's medical record was reviewed with Staff #2 on 1/20/26 at 9:08 AM. Staff #2 confirmed the care plan meeting dates and quarterly assessments listed above. Staff #2 was asked if she scheduled a care plan meeting after the completion of the 9/17/25 quarterly assessment. She answered, No, unless they told me specifically. Staff #2 reviewed communication between her and the resident assessment coordinator (Staff #3) and was not able to find documentation to indicate she was instructed to schedule a care plan meeting. The Resident assessment coordinator (Staff #3) was interviewed on 1/20/26 at 9:33 AM. During the interview, she reported that she sends Staff #2 a list of residents that will be due for their quarterly assessments, including the ARD dates, about 15 days in advance for the next month indicating that these residents need to be scheduled for care plan meetings. Staff #3 explained that if a resident had a significant change or any change that would require a new assessment to be completed, they would not be part of the list because it is prepared in advance (usually on the 15th of each month) and is not part of the scheduled assessments (quarterly and annual assessments). In an interview with the Nursing Home Administrator, Regional Director of Nursing, and the Director of Nursing on 1/23/26 at 10:46 AM, the findings were reviewed and the concern was discussed that Resident #62 did not have a care plan meeting after the 9/17/25 quarterly assessment was completed. All 3 staff verbalized understanding and acknowledged the concern.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, it was determined that the facility failed to provide an ongoing program of activities that met residents' needs and preferences. This was evident for 2 (Resident #43 and #52) out of 3 residents reviewed for activities.The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. A care plan is a guide that addresses each resident's unique needs. It is used to plan, assess, and evaluate the effectiveness of the resident's care.1) During an initial tour of the Roosevelt Nursing Unit on 1/14/26 at 10:13 AM, Resident #43 was observed lying in bed, was not involved in any activity, and his/her television was turned off. A subsequent observation on 1/15/26 at 11:32 AM showed that Resident #43 was lying in bed with the television off, and no activity program was in progress. A review of Resident #43's record on 1/20/26 at 8:59 AM showed that s/he had an altered mental status with a history of Dementia.Continued review included Resident #43's admission MDS assessment dated [DATE], which noted in section F- Activity preferences that it was very important to him/her to keep up with the news, have books, newspapers, and magazines to read, and be around animals, such as pets.Further review included Resident #43's care plan for Activities initiated on 12/18/25 and revised on 1/9/26. The care plan focus stated Activities with a goal that Resident #43 Will have the opportunity to enjoy activities of choice through the next review date and the interventions stated, Staff to assist resident in locomotion to activities as desired, Staff to provide 1:1 room visits as desired/available, Staff to provide a monthly calendar.Resident #43's Activity care plan was not person-centered and failed to reflect his/her activity preferences identified on his/her admission MDS assessment. A subsequent review on 1/20/26 at 11:10 AM of Resident #43's Activity logs for December 18, 2025, to January 16, 2026, was completed. The activities programs provided to Resident #43 were as follows: 19 Coffee Social (resident unavailable), 4 Television, 5 Exercise (resident unavailable), 1 Cocktail Hour (resident unavailable), 1 one-on-one visit, 1 family visit, 2 Bingo (resident unavailable), 1 Ball Toss (resident unavailable), 1 movie social, 2 Music (resident unavailable), and 1 social Media/Cell phone (resident unavailable). The review failed to show that Resident #43 engaged in activities, such as keeping up with the news, reading books, newspapers, and magazines, and being around animals, such as pets, which were previously documented as his/her activity preferences on his/her admission MDS assessment. In an interview on 1/20/26 at 1:02 PM, staff #19, the Activity Director, reported that Resident #43 was unavailable for most activities because s/he was receiving therapy exercises most of the time. Staff #19 was asked why the schedule was not adjusted to meet residents' needs, and she acknowledged the concern. Staff #19 confirmed that Resident #43's Activity care plan was not personalized. She added that, in the future, she would provide an activity program based on residents' preferences and interests, which would also be reflected in their care plans. 2) On 1/14/26 at 10:01 AM, Resident #52 was observed lying in bed with no activity and the TV off. A subsequent observation on 1/16/26 at 2:19 PM noted Resident #52 lying in bed, with the TV off and no activity program in progress. A review of Resident #52's admission Activity assessment dated [DATE] showed that it was very important for him/her to listen to music he/she likes and to go outside to get fresh air when the weather was good.A continued review of Resident #52's activity logs for December 15, 2025, to January 20, 2026, was completed. The review showed the following activity programs were offered to Resident #52: 26 Coffee Social (the resident was not available), 5 TV, 4 Bingo (the resident was unavailable), 1 Cocktail Hour (the resident was unavailable), 1 Ball Toss (the resident was unavailable), 1 in-room visit, 2 Music (the resident was unavailable), 1 one-on-one visit, 1 in-room visit, and 7 Exercise (the resident was unavailable).During an interview on 1/20/26 at 1:23 PM, staff #19 reviewed Resident #52's activity logs and reported that the resident was unavailable for most activities due to a (continued on next page)

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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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scheduling conflict with therapy. Staff #19 confirmed that the resident's Activity preferences identified during the admission Activity assessment were not reflected in the Activities logged as provided to him/her.

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interviews and record review, it was determined that the facility failed to 1) effectively manage residents' pain, and 2) ensure pain management was provided to residents according to professional standards of practice. These was evident for 2 (Resident #43, #2) of 3 residents reviewed for pain management during the recertification survey.The findings include:1). A pain scale ranges from 0 to 10, with 0 indicating no pain and 10 representing the worst pain. It is used to assess the level of pain a patient is experiencing and to guide treatment. Non-pharmacological pain management is an intervention that does not involve medications. In an interview on 1/14/26 at 10:16 AM, Resident #43 reported back pain and said s/he received Tylenol for it, but it was not always helpful. In a subsequent interview on 1/15/26 at 11:45 AM, Resident #43's representative reported that the resident had constant back pain and had been taking Tylenol, which was ineffective at times. She added that she had just asked the staff for more medication before this interview. Record review for Resident #43 on 1/21/26 at 8:59 AM included an attending provider's note dated 12/22/25 stating that Resident #43 had back pain due to a lumbar compression fracture. Continued review showed an attending provider's order dated 12/17/25 for Resident #43 to receive Tylenol 650 mg every 6 hours as needed for pain. The review also included an attending provider's order, initiated on 12/17/25, to attempt Non-Pharmacological Interventions (NPIs) before administering any pain medication as needed to Resident #43 (NPIs are interventions without medication, such as a warm beverage, repositioning, or soft music). Further review showed an attending provider's order for Resident #43 to receive oxycodone 5 mg every 8 hours as needed for severe low back pain. A review of Resident #43's medication administration records (MARs) from December 17, 2025, to January 20, 2026, showed that Resident #43 received pain medication on the following dates and at the following pain levels: 12/18/25 (pain level 5), 12/20/25 (pain level 3), 12/21/25 (pain level 3), 12/22/25 (pain level 3), 12/30/25 (pain level 5), 12/31/25 (pain level 7), 1/5/26 (pain level 7), 1/10/26 (pain level 9), 1/12/26 (pain level 6). However, the review failed to document a record of Resident #43's pain assessment before administering the medication, including the specific pain locations, pain type, and non-pharmacological interventions implemented. The review also noted that after administering the pain medicine, Resident #43 continued to experience pain at a level of two on 1/5/26, 1/10/26, 1/12/26, and 1/20/26. However, the review failed to show what the staff did to manage Resident #43's pain at those levels after administering the pain medicine. During an interview on 1/22/26 at 7:55 AM, the director of nursing (DON) stated that it was unrealistic to expect Resident #43 to be fully relieved of pain after pain medication was administered. However, the interview did not provide evidence of an assessment of Resident #43's pain management goals. The DON said she would interview Resident #43 to determine his/her acceptable level of pain after (continued on next page)

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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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the surveyor's intervention. 2) Resident #2 was admitted into the facility in late-2023 with diagnoses that include but not limited to lower back pain and absence of right leg below the knee. A review of Resident #2's medical orders was conducted on 1/16/26 at 8:42 AM. The review revealed a narcotic pain medication order to be administered on an as needed (PRN) basis with a start date of 12/1/25, and non-pharmacological interventions (NPI) to be attempted prior to administering any PRN pain medication, with numbers 1 through 6 that corresponded with the different interventions where #6 indicated resident refused, had a start date of 6/5/25. On 1/16/26 at 9:49 AM, Resident #2's electronic medication administration record (eMAR) for December 2025 was reviewed. The order for the PRN narcotic pain medication had spaces to indicate the pain score and another space to indicate time of administration and effectiveness of the medication. The review revealed that the PRN narcotic pain medication was administered on December 1, 2, 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 22, 26, 27, and 30th. However, the pain score was not documented. The order for NPI's had a space to document the corresponding number of intervention and another space to indicate time of administration/attempt and effectiveness of the intervention. The review revealed that the NPI's were administered/attempted on December 1, 2, 6, 7, 8, 11, 12, 15, 26, and 30th. All NPI's were documented as 6 (resident refused NPI). A review of Resident #2's progress notes related to the administration of the PRN narcotic pain medication and NPI's for December 2025 was conducted on 1/16/26 at 11:08 AM. The review revealed the following concerns:- On 12/1/25, the nurse did not indicate a pain score.- On 12/2/25, the nurse did not indicate a pain score and location of the pain.- On 12/4/25, the nurse did not indicate a pain score, location, and NPI provided/attempted.- On 12/5/25, the nurse did not indicate a pain score and NPI provided/attempted.- On 12/6/25, the nurse did not indicate a pain score and location of the pain.- On 12/7/25, the nurse did not indicate a pain score and location of the pain.- On 12/8/25, the nurse did not indicate the pain score and location of the pain.- On 12/11/25, the nurse did not indicate a pain score and location of the pain.- On 12/12/25, the nurse did not indicate a pain score and location of the pain.- On 12/13/25, the nurse did not indicate a pain score, location, and NPI provided/attempted.- On 12/14/25, the nurse did not indicate a pain score, location, and NPI provided/attempted.- On 12/15/25, the nurse did not indicate a pain score and location of the pain.- On 12/16/25, the nurse did not indicate a pain score, location, and NPI provided/attempted.- On 12/22/25, the nurse did not indicate NPI provided/attempted.- On 12/26/25, the nurse did not indicate a pain score and location of the pain.- On 12/27/25, the nurse did not indicate a pain score, location, and NPI provided/attempted.- On 12/30/25, the nurse did not indicate a pain score and location of the pain. The Director of Nursing (DON) was interviewed on the process of pain management on 1/16/26 at 3 PM. During the interview, she explained her expectations from nursing staff when a resident reports pain. Noting that the assessment for pain includes the location, intensity, quality, and duration of the pain. The DON reported that when residents report pain, she expects the nursing staff to provide and/or attempt NPI's first before administering the prn pain medications and to document them in the resident's medical record. She added, all documentation should be seen in the resident's progress notes. (continued on next page)

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	215199	A. Building B. Wing	01/23/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the concerns listed above was discussed with the DON on 1/16/26 at 3:06 PM. The DON indicated that she would review Resident #2's medical record and report back to the surveyor. On 1/20/26 at 10:12 AM, the DON confirmed the concerns listed above and reported that she was not able to find further documentation. The concern that the facility failed to provide pain management to Resident #2 according to professional standards of practice was discussed with the DON and she verbalized understanding and acknowledged the concern.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on record review and interview, it was determined that the facility failed to ensure that residents were cared for by licensed Geriatric Nursing Assistants (GNAs). This was evident for 1 GNA (Staff #10) of 5 GNA licenses reviewed during the staffing investigation portion of the recertification survey.The findings include:On 1/20/26 at 9:53 AM a review of the facility's staff list was conducted. From that list, 5 Geriatric Nursing Assistants (GNAs) names were randomly selected to review for evidence of licensure, and the facility was asked to provide copies of their licenses.A review of the licenses revealed that Staff #10's GNA license was issued on 6/05/25, but the staff list indicated that he was hired on 8/07/24.On 1/22/26 at 3:43 PM an interview was conducted with the Director of Human Resources (Staff #17) to review that Staff #10's GNA license was effective 10 months after his hire date at the facility. She was asked to provide evidence of the employee's status changes such as hire date and position status changes, and evidence of hours worked 4 months past his hire date.Staff #10 and the Nursing Home Administrator (NHA) returned with documents that showed that Staff #10 was hired on 8/07/24, worked as a Certified Nursing Assistant from 8/07/24 until 2/17/25 when his status was changed to GNA. Staff #17 showed a screen shot that indicated Staff #10 passed his GNA Skills test on 2/14/25, and that is why his status was changed to a GNA. However, there was no evidence that Staff #10 passed the written portion of the GNA test, and both Staff #17 and the NHA confirm that Staff #10's GNA license was issued on 6/05/25. They provided a calendar that showed days Staff #10 worked in December 2024, January 2025, and February 2025. They confirmed that Staff #10 worked as a GNA at the facility after the 4 month allowed window for GNA certification.No further evidence was provided by the end of the survey.

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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 observation and staff interview, the facility failed to ensure that resident medication storage areas and medical supplies were properly stored, free from expired items, and maintained in a sanitary and organized manner within 2 of 2 medication storage areas observed during the annual recertification survey. The findings include: On [DATE] at 12:30 PM, the surveyor observed the medication storage room on the Skyline unit. During the observation, the surveyor identified expired medical supplies stored in the medication storage area, including:(2) Medline suction/connection tubing, expired [DATE](1)Medline Gastrostomy Tube, 3-port, expired [DATE]On [DATE] at 12:55 PM, the surveyor reviewed the findings with Staff #3 and Staff #4 at the nurses' station on the Skyline unit.On [DATE] at 1:00 PM, the surveyor observed the medication storage room on the Roosevelt unit. Staff #5 provided access to the storage area. Upon entry, the surveyor observed that the counter space was cluttered, and the handwashing sink contained two large bags labeled Pharmacy Returns. The surveyor further observed a large tote/personal belongings bag and a lunch box on the counter. Staff #5 stated, These things are mine, and exited the medication storage room.During the observation, the surveyor identified expired and improperly stored medical supplies on the Roosevelt unit, including:(2) 1-liter Aspira Drainage Kits, expired [DATE](1) Opti-Neb Small Volume Nebulizer, expired 12/2017(1) [NAME] Sterile Urinary Drainage Bag with privacy cover; packaging torn open with privacy cover removed and the drainage bag replaced into the packaging(1) [NAME] RCI Adult Non-Rebreather Mask, expired [DATE](1) Amsino Sterile Silicone-Coated Latex Foley Catheter, 16 Fr, expired [DATE](1) Amsino Sterile Silicone-Coated Latex Foley Catheter, 16 Fr, expired [DATE](2) Medline Sterile Silicone-Coated Latex Foley Catheters, 14 Fr, expired [DATE](1) Medline Sterile Silicone-Coated Latex Foley Catheter, 18 Fr, expired [DATE]On [DATE] at 1:10 PM, the surveyor requested that Staff #5 ask the Director of Nursing (DON) to come to the unit for dual observation. On [DATE], at 1:15 PM, upon arrival, the DON instructed Staff #5 to remove personal items from the medication storage room, stating, Staff are provided with a locker for storage of personal items - and we should not be storing the pharmacy returns in the handwashing sink.When asked by the surveyor who is responsible for medication room audits and oversight of medication storage conditions, the DON stated, We have a rotation of managers who are assigned parts of the facility - and it is evident this room has not been reviewed.When asked if the observed conditions were typical, the DON stated, Staff should never store personal items in the medication storage room, and we should never have expired supplies.

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	215199	A. Building B. Wing	01/23/2026

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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. Based on observations and record review, it was determined that the facility failed to store food in accordance with professional standards. This was evident in 1 of 2 observations of the facility's kitchen during the recertification survey.The findings include:An initial tour of the facility's kitchen with the dietary manager on 1/14/26 at 8:15 AM revealed the following:- An observation of leftover prepared pear fruit in a container with no label indicating the date it was prepared or the use-by date in the reach-in refrigerator.-An observation of boiled eggs labeled with a use-by date of 1/13/26 in the reach-in refrigerator. Staff indicated they should have been discarded.-An observation of leftover plates of cinnamon brown sugar blondie, labeled with a use-by date of 1/12/26, stored in the walk-in refrigerator. Staff indicated they should have been disposed of.A review of the facility's Food storage policy on 1/16/26 at 5:32 PM, stated that all foods will be stored wrapped, or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.However, earlier observations of the walk-in refrigerator and reach-in refrigerators found leftovers that were unlabeled and undated, and past their use-by dates.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, it was determined that the facility failed to ensure that staff accurately documented in a resident's medical record. This was evident in one (Resident #69) of three residents reviewed for infection control.The findings include:An initial observation was made on 1/14/26 at approximately 10:10 AM of Resident #69 seated on the resident's bed, speaking with staff #2, a social worker, who was also seated in a chair by the resident's bedside.During a subsequent observation on 1/14/26 at 11:24 AM, signage on Resident #69's door read, Special droplet/contact precautions in addition to standard precautions; only essential personnel should enter this room. The observation also noted a small cart of personal protective equipment (PPE) in front of Resident #69's room.Staff #11, a registered nurse, was interviewed on 1/14/26 at 11:24 AM and reported that Resident #69 had tested positive for COVID-19 on 1/12/26, prior to admission to the facility on 1/13/26. However, the facility did not have that information in the resident's hospital discharge record until the surveyor's initial observation of Resident #69, so the resident was not placed in isolation during that observation.On another observation on 1/14/26 at 11:43 AM, the signage for special contact/droplet precautions on Resident #69's door and the PPE cart had been removed. Staff #11 was present and questioned and reported that Resident #69 did not require isolation per her supervisor.A record review for Resident #69 included a hospital discharge summary indicating that the resident initially tested positive for COVID-19 on 1/3/26. The resident was retested on [DATE], found to be positive for COVID-19, and admitted to the facility on [DATE].The review also included an attending provider's order for Resident #69, initiated on 1/13/26 and discontinued on 1/14/26. The order stated, Quarantine: Covid-19 protocol- mask and gloves ppe with patient care. Encourage resident to self -isolate in room. If resident comes out of room, apply mask to resident in common resident used area every shift for 10 Days. Covid-19 protocol- normal dishware, mask and gloves with resident interaction, resident encouraged to use mask when out of resident's room. Further review of Resident #69's Treatment administration record (TAR) for January 2026 revealed that Staff #13, a registered nurse, and Staff #11 documented on 11/13/26 and 11/14/26 that the resident was in isolation.However, in an earlier interview, staff #11 reported that the facility received information about Resident #69's positive COVID-19 results only after the surveyor's initial observation of Resident #69 on 1/14/26. Further review identified another physician's order for Resident #69, initiated on 1/14/26, which stated, Maintain Special CONTACT/DROPLET precautions every day shift for COVID-19 Positive Diagnosis until 1/23/2026. All meals, therapy, and nursing services are completed in the resident's room. A review of Resident #69's January 2026 TAR revealed that nurses continued to document that Resident #69 was on droplet isolation until 1/15/26, including Staff #11, who had earlier reported that the resident did not require isolation.In an interview on 1/15/26 at 1:26 PM, staff #4, an infection prevention nurse, stated that upon reviewing the resident's record on 1/14/26, she placed the resident in isolation. However, she reviewed the chart again that same day and realized that Resident #69 had been over 10 days since her first test was positive and did not require isolation, so she removed the isolation signage on 1/14/26. During an interview on 1/23/26 at 8:47 AM, the director of nursing reported that Resident #69 did not require isolation. However, the facility's electronic health record was experiencing issues and automatically populating isolation orders for new residents upon admission, so nurses usually had to review and delete them. Resident #69's isolation orders were missed.

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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. Based on observations, record reviews, and interviews, it was determined that the facility failed to ensure all staff donned appropriate personal protective equipment (PPE) for enhanced barrier precautions. This was evident for 1 (Resident #62) of 3 residents reviewed for pressure ulcers. The findings include:Enhanced Barrier Precautions (EBP) - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).Resident #62 had been residing in the facility since mid-2025. During an interview with the resident on 1/14/26 at 10:24 AM, s/he reported having a wound in the sacral area and indicated that staff would wear gloves and masks when providing his/her care but would often skip wearing the gowns.While still in the interview with Resident #62, a Certified Nursing Assistant (Staff #8) introduced himself and indicated that he needed to provide incontinence care to the resident on 1/14/26 at 10:32 AM. The resident and the surveyor agreed that the interview would be postponed until Staff #8 could finish his task. Staff #8 was observed wearing a mask and a pair of gloves. The surveyor stepped outside the resident's room and waited while Staff #8 pulled the privacy curtain and proceeded to provide care to the resident. While outside Resident #62's room on 1/14/26 at 10:40 AM, the surveyor observed an EBP sign and storage for PPE with supplies in it. On 1/14/26 at 10:50 AM, Staff #8 opened the privacy curtain and stepped out of Resident #62's room, still only wearing a mask and a pair of gloves, holding a clear plastic bag (contents appeared to be soiled diaper, wipes, and disposable absorbent pads) and indicated that he needed to discard it in the dirty utility room and will be right back. Upon return of Staff #8 on 1/14/26 at 10:52 AM, he confirmed that the resident was on EBP. The concern was discussed that he was providing incontinence care with incomplete PPEs. Staff #8 confirmed that he only had a mask and a pair of gloves on. The Infection Preventionist Nurse (Staff #4) was interviewed on 1/15/26 at 1:26 PM. During the interview, she reported that she was already aware of Staff #8 not wearing the appropriate PPE while providing incontinence care to a resident on EBP. She also reported that she did review education with Staff #8 on EBP and other levels of precautions. Staff #4 acknowledged the concern.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observations and interviews, it was determined that the facility failed to ensure full visual privacy was provided to residents residing in semi-private rooms. This was evident for 1 (Resident #12) of 1 resident reviewed for privacy. The findings include:While Resident #12 was being interviewed on 1/15/26 at 9:10 AM, it was observed that the ceiling suspended curtain that moved around the resident's bed was not long enough to provide full visual privacy. Approximately 2 feet of opening was observed when the curtain was fully extended, in combination with the roommate's curtain. On 1/20/26 at 12:34 PM, the Director of Nursing (DON) was invited to inspect Resident #12's room with the surveyor. During the inspection, the DON confirmed that the ceiling suspended curtain left an approximate 2 feet opening when fully extended and stated, That's a privacy issue.On 1/23/26 at 10:46 AM, the concern with the ceiling suspended curtain not providing full visual privacy was discussed with the Nursing Home Administrator (NHA), Regional Director of Nursing (RDON), and the DON. The DON indicated that the facility had previously done an audit on all the privacy curtains. However, the NHA explained that the purpose of the audit was to find out how many curtains the facility had so that they can purchase another set, to make it easy to replace when a curtain gets soiled. All 3 staff acknowledged the concern.