STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interviews it was determined that the facility staff failed to supervise a cognately impaired resident who was at high risk for elopement as evidenced by the resident leaving the facility unattended without the staff's knowledge. This deficient practice was evidenced in 1(#40) of 1 resident investigations reviewed for elopement during the recertification survey.The BIMS (Brief Interview for Mental Status) assessment is a quick standardized cognitive screening tool used in long-term care facilities to gauge a resident's orientation, attention and memory recall through simple questions about the date and repeating three words. Scored from 0-15, it helps staff track changes in cognitive function, identify potential delirium or dementia, and determine if further specialized assessment is needed. Scores are categorized: 13-15 (intact), 8-12 (moderate impairment), 0-7 (severe impairment).The findings include:On 12/15/25 at 10:09 AM a review of the facility's investigation related to the elopement of Resident #40 revealed on the afternoon of 12/21/24 a visitor was in their truck in the parking lot of the facility and heard Resident #40 attempted to open the door to their vehicle. The visitor realized Resident #40 was a resident from the facility. He & his wife brought the resident back to the facility. Prior to the incident Resident #40 was residing on the Dementia Unit Choptank which was a locked unit. It was documented that the residents' Brief Interview for Mental Status (BIMS) score at the time of the incident was 5/15. On 12/15/25 at 10:40 AM a review of the Investigation Summary revealed the secured door leading out of the Dementia Unit (Choptank) malfunctioned and was not securely locking. The surveyor reviewed the Wandering/Elopement assessment completed on 05/12/23 when Resident #40 was admitted and revealed the resident was deemed a high risk to wander.On 12/15/25 at 1:18 PM during an interview with Regional Director of Maintenance #10 the surveyor asked when there is a maintenance issue that needs to be addressed, how does the staff communicate the problem to the maintenance department. Regional Director of Maintenance verbalized the staff puts a work order request in TELS. The surveyor asked what checks and balance system was in place to ensure that maintenance issues are addressed. He/she verbalized they go out and fix what needs to be fixed. On 12/15/25 at 2:11 PM during an interview with Regional Director of Maintenance #10 the surveyor asked for documentation to verify the door to the secured Dementia Unit, Choptank was repaired. The Regional Director of Maintenance #10 verbalized a work order was not completed for the door to be repaired on 12/21; when the resident got out of the facility, he/she came in and fixed the door. When he/she comes in on emergency calls he/she doesn't create a work order. The surveyor asked how they could verify if the door was repaired and what was wrong with the door. Regional Director of maintenance #10 verbalized the plate that grabs the mag lock would not close. The plate got stuck and it wouldn't move. He/she adjusted the plate and the speed of the closer. He/she kept adjusting it long enough for it to close. The Administrator reported he/she had the staff checking the doors every shift after the incident occurred for 4 days afterwards. On 12/16/25 at 9:18 AM a review of the Performance Improvement Plan (PIP) dated 01/03/25 indicated the door was repaired and the staff were instructed to check the doors every shift x 5 days then weekly by the maintenance department for three months. A note on 12/27/24 indicated every shift door checks were completed. In-service education was to be (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	provided to all staff to check the doors after entering and exiting the unit. A note on 12/26/24 indicated all staff were in-serviced on checking the door after entering and exiting the unit. The surveyor reviewed the documentation to verify the staff checked the doors every shift x 5 days as indicated on the PIP. The surveyor reviewed an invoice from the security company dated 02/26/25. A description of the services to be provided: Install 4 Single Door Mag locks with Bond Sensors, 2 Timer Modules, 2 Piezo Buzzer, 2 Audio/Visual Sirens, and 1 Power Supply. A note was written on the invoice that stated, replacement Choptank Buzzer, mag lock alarms with timer. The Administrator was made aware the invoice did not indicate a fee was paid for the services on the invoice. The Administrator provided an email from the security company indicating the work was started on 02/20/25 and completed on 02/26/25.On 12/16/25 at 11:14 AM the surveyor reviewed the days and times when there was no documentation to verify the staff checked the doors after the resident eloped. The Administrator confirmed the dates and times.On 12/17/25 at 9:01 AM during an interview with the Administrator the surveyor reported all the staff were not in-serviced concerning elopement and the surveyor confirmed the doors were not checked for 5 days as indicated on the PIP. The Administrator reported there was no further information about the training and the doors being checked. The surveyor reported that after reviewing all the documentation from the investigation, there is no documentation to support the door to the locked Dementia Unit Choptank was repaired prior to 02/26/25. The compliance date was determined to be 02/26/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, record review, and interviews with facility staff, it was determined that the facility failed to maintain food service equipment in a manner that ensures sanitary food service operations to prevent possible foodborne illness. This was evident during the initial tour of the kitchen.The findings include:Cross-contamination refers to the transference of harmful substances or pathogenic microorganisms to food by hands, food contact surfaces, sponges, cloth towels, or utensils that have not been properly cleaned after contacting raw food and then touching ready-to-eat foods. Cross-contamination may also arise from inadequate dishwashing procedures that fail to effectively wash, rinse, sanitize, and air-dry all food equipment.On 12/10/2025 at 7:45 AM, The surveyor conducted a kitchen tour with the Healthcare Services Group (HCSG) Regional Manager after calibrating stem thermometers in a cup of ice water, and the following non-compliance issues were identified:Front Entrance AreaHandwashing Facility Absence: A hand sink was missing near the ice machine and the drink station. Employees must walk across the kitchen to the walk-in cooler or warewashing areas for handwashing after each tasks such as donning hair/beard nets, serving ice, dispensing fountain sodas, and coffee/tea.Ice Machine Condition: The interior and exterior of the ice machine were unclean.Improper Ice Storage: The ice bucket and scoop were stored incorrectly on top of the ice machine.Mop Sink/Chemical Storage Area 4. Handwashing Facility Absence: A hand sink was not present in the mop sink/chemical storage area. 5. Clutter: The mop sink area was cluttered. 6. Ventilation Verification: the mechanical exhaust ventilation operability could not be verified due to insufficient lighting by the mop sink area.Warewashing Area 7. Hand Sink Integrity: The hand sink and faucet were not securely fastened to the wall and sink basin. 8. Mechanical Dishwasher Condition: The interior and exterior of the high-temperature mechanical dishwasher were unclean, showing excessive accumulation of dust, dirt, debris, and food particles. (Final rinse temperature measured 173 F with a DishTemp thermometer). 9. Type 2 [NAME] Design: The Type 2 Local Exhaust Ventilation ([NAME]) for the high-temperature mechanical dishwasher was improperly designed and calibrated, failing to sufficiently remove heat, steam, and vapors. Steam was observed dissipating into the kitchen instead of being drawn into the [NAME] directly above the dishwasher. 10. Structural Cleanliness: Walls and floors underneath the equipment were soiled. 11. Sanitizer Concentration: The sanitizer level in the 3-compartment sink was measured above 400 ppm from the dispensing unit. 12. 3-Compartment Sink Faucet: The faucet at the 3-compartment sink was loose. 13. Sink Sealant Condition: The sealant around the edges of the 3-compartment sink was unclean and/or missing. 14. 3-Compartment Sink Drainage Failure: A dump test on the 3-compartment sink failed, with the drain line splashing gray water onto the kitchen floor. 15. Floor Condition: Pools of standing gray water were observed in cracked floor tiles around the 3-compartment floor sink.Food Preparation Area 16. Can Opener Cleanliness: The prep table-mounted commercial can opener was unclean. 17. Utensil Storage: Wall-mounted cooking utensils were improperly hung. All food contact surfaces and kitchen equipment must be smooth, non-porous, and easily cleanable and sanitized. 18. Prep Sink Drainage Failure: A dump test on the in-counter food prep sink failed, with drain lines discharging gray water directly onto the kitchen floor. 19. Bulk Food Storage Cleanliness: Bulk food bins stored beneath a food prep table were unclean. 20. Equipment Integrity: The food prep table legs were replaced with makeshift, painted wooden legs that are now bent and no longer perpendicular to the floor. 21. Storage Height: The bottom shelves of clean dish racks require elevation to 18 inches off the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	floor.Cooking AreaH 22. Hand Sink Integrity: The hand sink was not securely fastened to the wall. 23. Equipment Cleanliness: All cooking equipment beneath the Type 1 canopy hood was unclean, exhibiting excessive buildup of grease, dirt, dust, debris, and food particles. 24. Structural Cleanliness: Walls and floors underneath the cooking equipment were unclean. 25. Exhaust Obstruction: The overshelf over the 6-burner gas range obstructed the exhaust of grease, steam, odor, and latent vapors from the cookline. Excessive buildup of grease, dirt, and debris were observed beneath the overshelf. 26. Equipment Placement: The commercial convection oven and steamer protruded beyond the canopy hood overhang, allowing grease, steam, and latent vapors to escape into the kitchen. 27. Canopy Hood Condition/Documentation: The canopy hood baffles were unclean. Unable to verify the last hood service report or the date on the service plate during the survey. 28. Equipment Repair: The inoperable steam table must be repaired or replaced to prevent the harborage of dust, dirt, debris, bacteria, and pests. 29. Personal Items: Personal belongings were observed near the cookline. 30. Clean Storage Height: Clean sheet pans were stored under the in-counter prep sink, next to the drain line, less than 18 inches above the floor. 31. Equipment Repair and Cleanliness: The interior and exterior of the hot warming cabinet were unclean. The door gaskets of the unit were warped. Walk-in Refrigerator 32. Door Gaskets: The walk-in refrigerator door gaskets were unclean. 33. Threshold Plate: The threshold plate was loose and unstable. 34. Evaporator Coils: Ice buildup was observed behind the condensate fans around the evaporator coils. 35. Storage Practices: Milk crates were stored directly on the floor. 36. Shelving Cleanliness: Shelving units were unclean.Walk-in Freezer 37. Conditions of Walk-in freezer/Potential Cross-contamination: Walls, floor, ceiling, and shelving units were covered with excessive frost, ice buildup, and ice dam. Ice buildup was present inside open food boxes, excessive frost on ice cream cartons, icicles formed around the condensate fans reaching the bags of ice in the back corners of the unit, and on top of frozen sheet pans. All unopened/sealed food boxes delivered that morning were stored on the floors. A freezer truck was reserved to relocate the items. 38. Door Gaskets: Repair or replace torn walk-in freezer door gaskets.Throughout the Kitchen Area 39. Backflow Prevention: Backflow prevention devices must be provided on all water lines and/or replaced every three years. 40. Drainage Air Gap: Rusted floor sink grate covers must be removed, and an air gap equal to two times the diameter of the drainpipe must be provided on all drainpipes to prevent siphonage. 41. Cracked, Chipped, Pitted, and Unsealed Wood: Repair or replace broken floor tiles and cove base. Replace all cracked/chipped/pitted plate covers, food containers, and utensils. Seal porous materials with food-grade sealant to prevent/eliminate absorption and bacterial proliferation. 42. Wall and Ceiling Penetrations: Seal open penetrations on the walls and ceilings throughout the kitchen to prevent pests/insect infestations. 43. Odor Control and Cleanliness: All floor sinks, trench drains, drainpipes, p-traps, and drain hubs must be cleaned to eliminate foul odors.Food Storage Area 44. Structural Damage: Water damage was observed on the ceiling. 45. Equipment Storage: Mixer attachments were stored improperly.Unit Ice Chest and 5-gallon Water Dispenser 46. Non-Commercial Equipment and Sanitation: Two push carts holding a non-commercial grade ice chest and 5-gallon water dispenser were in front of the kitchen double doors. The surveyor asked the HCSG Regional Manager to open the ice chest lid and verified standing water with floating black, unknown particles. In addition, the bottom shelves of the push carts were heavily soiled, potentially from juice spillage from the 5-gallon water dispenser. The surveyor could not verify the location in the kitchen where the ice chest coolers and water dispenser were washed, rinsed, sanitized, and air-dried.At 9:23 AM, the Regional Maintenance Director, Maintenance Director, HCSG Regional Director, and the Administrator toured the kitchen to go over the list of findings listed above. At 11:10 AM, the surveyor observed the HCSG Regional Manager discarding open boxes of biscuits, pizza dough, health shakes, pie shells, pancakes, and frozen pie. The walk-in freezer floor was very slippery with layers of ice buildup on the floor. The walk-in freezer conditions were noted to be hazardous for employees to remove additional contaminated food items safely. All sealed and unopened boxes were to be removed upon the freezer truck's arrival. The surveyor requested to be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	present when the freezer was shut off, and ice buildup have been melted to witness the discard of the remaining contaminated food items from the unit. Cross reference to F880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations and interviews with facility staff, it was determined that the facility failed to maintain clean and effective ventilation systems, thereby impeding proper airflow throughout the premises. This was evident in 13 out of 16 ventilation systems reviewed during the annual survey.The findings include:Local Exhaust Ventilation ([NAME]) systems are designed/engineered to capture and remove contaminants such as excessive heat, steam, condensation, vapor, smoke, and fumes. This is achieved by calibrating the total pressure, which is determined by the sum of the static pressure exiting and entering the system, minus the velocity pressure entering the system. In addition, the fan speed, pressure, and power must be adjusted to account for the specific gravity of the contaminant being captured and removed by the [NAME] system, considering the specific size and air changes of the room.Type 1 hood systems are designed and installed primarily over cooking equipment to exhaust grease, heat, steam, condensation, vapor, smoke and fumes from the kitchen. Type 2 hood systems are designed and installed primarily over high-temperature mechanical dishwashers and other commercial kitchen equipment that produce excessive steam, condensation, and vapor.On 12/10/2025 at 8:20 AM, the surveyor utilized a smoke stick to assess the laminar airflow of the [NAME] systems in the kitchen, and the following deficiencies were noted:The Type 2 hood situated above the high-temperature mechanical dishwasher was found to be inadequately designed and calibrated, resulting in insufficient removal of heat, steam, and vapors. Steam was observed dissipating into the kitchen rather than being effectively captured by the [NAME] directly above the dishwasher.The Type 1 canopy hood serving the commercial convection oven and steamer was positioned such that the appliance protruded beyond the canopy hood's overhang. This configuration allowed grease, steam, heat, condensation, and latent vapors [NAME] out into the kitchen.On 12/17/2025, at 2:25 PM, the Regional Maintenance Director assisted the surveyor in the physical verification of the following ventilation systems' functionality by placing a sheet of tissue paper on the exhaust fan covers:Dirty laundry room - inoperableClean laundry room - inoperableChoptank janitor's closet - inoperableSoiled utility closet - inoperableSpa Room - sufficientroom [ROOM NUMBER] bathroom - inoperableBathroom in E hallway - sufficientroom [ROOM NUMBER] bathroom - sufficientB-wing soiled utility room - inoperableB-wing janitor's closet - inoperableroom [ROOM NUMBER] bathroom - insufficientroom [ROOM NUMBER] bathroom - inoperableroom [ROOM NUMBER] bathroom - inoperableOxygen tank storage room - positive pressureAt 3:55 PM, the surveyor presented the findings to the Administrator, who confirmed that the Regional Maintenance Director had also shared the information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observations and interview it was determined that the facility staff failed to ensure residents had access to their calls bells if assistance was needed. This deficient practice was evidenced in 7 (#10, #28, #44, #59, #72, #83, & #85) out of 36 residents who resided on Choptank during the recertification survey.The findings include:On 12/10/25 at 7:44 am during observation rounds the surveyor observed multiple residents on the unit Choptank who did not have access to their call bells. At 7:46 am the surveyor observed Resident # 44 call bell on top of the fall mat next to the bed. At 7:53 am the surveyor observed Resident #85 & Resident #28 call bells on the floor. At 7:55 am the surveyor observed Resident #10 call bell hanging off the side of the bed. At 8:04 am the surveyor was unable to locate Resident #72 call bell. Geriatric Nursing Assistant #15 found the resident's call bell inside the top drawer of the bedside table. At 8:11 am the surveyor observed Resident #59 call bell on the floor near the head of the bed close to the wheel and Resident #83 call bell was clipped to the privacy curtain. On 12/16/25 at 3:00 pm the surveyor reported there were several residents who did not have access to their call bell during observation rounds. The Director of Nursing verbalized whenever the staff goes into a residents room the staff is to ensure the residents have their call bell.On 12/17/25 at 10:57 am during an interview with Registered Nurse Unit Manager #15 the surveyor asked how they ensure the residents have their call bells. He/she verbalized that the staff should ensure the residents have their call bells as much as possible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility staff failed to provide a clean homelike environment as evidenced by soiled and unlined waste baskets and stained wash sinks in residents' rooms. This deficient practice was observed on the Unit Choptank during the recertification survey.The findings include:On 12/10/25 at 7:50 am while in room [ROOM NUMBER] the surveyor observed stains in the sinks of the resident's bathroom. At 7:56 am while in room [ROOM NUMBER] the surveyor observed a soiled unlined waster basket next to a resident's wheelchair. At 7:58 am while in room [ROOM NUMBER] the surveyor observed pink stains in the sink, a soiled unlined waste basket, and stains on the bathroom floor. At 8:04 am the surveyor observed a soiled unlined waste basket in room [ROOM NUMBER]. At 8:06 am the waste basket in room [ROOM NUMBER] was soiled and unlined. At 8:11 am the waste basket in room [ROOM NUMBER] near bed B was soiled and unlined. On 12/17/25 at 11:32 am the surveyor informed EVS Director #30 the environmental concerns observed during observation rounds. EVS Director #30 verbalized doing rounds the previous day and there were multiple trash cans that didn't have bags, and the situation was rectified. Rounds are usually done 2-3 times daily. The trash cans will be cleaned when they do their rounds. They leave waste bags in the linen closet for the staff to use when they are not present. The commodes and sinks are cleaned while they are in the building.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment sufficient to minimize or eliminate the risk of cross-contamination as evidenced by residents who shared a bathroom personal items were not labeled and failed to implement proper hand hygiene practices to help prevent the spread of pathogenic diseases. This was evident in 13 areas within the facility that were assessed during the recertification survey. The findings include: Infection control practices include indications for the use of gloves, masks, and other personal protective equipment (PPE); methods for hand hygiene; procedures for vascular access and dressing changes; and protocols for cleaning and disinfecting equipment and the environment following spills and splashes of blood or effluent. Infection control measures include implementation of care, handling, cleaning, storage, and disposal of equipment, supplies, biohazardous waste and including proper ventilation. Hand hygiene refers to a general term that includes hand washing with soap and water, antiseptic handwash, and the use of alcohol-based hand rub (ABHR). 1). On 12/10/25 at 7:44 am during observation rounds on the unit Choptank, the surveyor observed the residents personal care items in their bathrooms were not labeled. The residents who reside in room [ROOM NUMBER] personal care items in the bathroom were not labeled. At 7:53 am while in room [ROOM NUMBER] the surveyor observed the residents' personal care items in the bathroom were not labeled. At 7:58 am the surveyor observed the residents in room [ROOM NUMBER] personal care items in the bathroom were not labeled. At 8:03 am while in room [ROOM NUMBER] the surveyor observed the residents' personal care items in the bathroom were not labeled. At 8:11 am the surveyor observed the residents in room [ROOM NUMBER] personal care items in the bathroom were not labeled. On 12/17/25 at 10:59 am the surveyor reported several residents had personal care items that were not labeled in a shared bathroom. The Director of Nursing verbalized the staff were made aware to label the residents' personal care items. 2). 1) On 12/10/2025 at 7:30 AM, the surveyor observed that employees, after donning a hairnet, were required to walk across the kitchen near the walk-in coolers and/or the hand washing area, in order to wash their hands. This indicated the absence of a readily accessible handwashing sink near the front entrance. At 7:45 AM, the surveyor asked the Healthcare Services Group (HCSG) Regional Manager for the location where employees would perform hand hygiene after putting on a hair net, or prior to dispensing ice from the ice machine and/or serving beverages at the drink station near the front entrance doors. The HCSG Regional Manager confirmed the lack of a hand sink by the kitchen entrance doors, noting that the two available hand sinks are situated near the walk-in coolers and the hand-washing area on the opposite side of the kitchen. 2) On 12/10/2025 at 8:55 AM, the surveyor observed two push carts containing a non-commercial grade ice chest and a 5-gallon water dispenser positioned in front of the kitchen double doors. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor requested the HCSG Regional Manager to open the ice chest lid and verified the presence of standing melted ice water containing floating black, unidentified particles. The surveyor was unable to verify the location within the kitchen where the ice chests and water dispensers were washed, rinsed, sanitized, and air-dried. At 1:35 PM, the surveyor confirmed that the ice/water station was situated in front of the nurses' stations. However, no open sinks were located nearby for nursing staff to properly wash their hands with soap and water before dispensing ice to residents. 3) On 12/10/2025 at 1:40 PM, the surveyor noted that the over-the-toilet commodes in rooms [ROOM NUMBERS] exhibited rusted and damaged components. These parts included bolts holding the handles to the frames that could potentially contact residents' hands, as well as components at the front of the frame. The rust on these bolts and joints made these areas difficult to sanitize effectively between uses. On 12/11/2025 at 10:08 AM, the surveyor observed a rusted commode within the resident restroom in room [ROOM NUMBER]. At 1:10 PM, the surveyor provided the Director of Nursing (DON) with room numbers and photographic evidence of the rusted, chipped, and/or cracked commodes. 4) On 12/11/2025 at 10:34 AM, the surveyor conducted an interview with Resident #8 and observed a full portable urinal placed on top of the bedside dresser drawer, situated in front of a box of Riz crackers. At 11:19 AM, the surveyor asked the Assistant Director of Nursing (ADON) whether the placement of the full urinal by the resident's bedside dresser conformed to the facility's standard practice. The ADON confirmed that this placement did not adhere to the proper standard procedures for handling a full portable urinal. 5) On 12/16/2025 at 7:46 AM, the surveyor observed Staff #21 and Staff #23 encountering difficulty while pushing two carts, which contained exposed plates, dome plate covers, and milk, in addition to one steam table, out of the kitchen double doors and the unit double doors. At 7:51 AM, after setting up the steam table and two push carts in the B-wing hallway, the surveyor asked the dietary service employees where they would wash their hands with soap and water after touching high-contact surfaces during the transport of the food carts and prior to serving food to the residents. Staff #21 and Staff #23 responded that they do not wash their hands before donning and after doffing gloves to serve food. Then further explained that they were not permitted to have a bottle of ABHR. 6) On 12/16/2025 at 8:00 AM, the surveyor noted wet nesting on top of the dome plate covers stacked on one of the push carts, which caused by improper warewashing procedures. The surveyor observed Geriatric Nursing Assistants (GNAs) shaking moisture from the dome plate covers before placing them on plates or placing the covers directly onto the plates to serve residents, potentially causing cross-contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) On 12/16/2025 at 8:38 AM, Resident #6 approached the steam table in a wheelchair and informed Staff #21 and Staff #23 that the green beans from the previous evening's dinner were very delicious. Resident #6 also expressed disappointment regarding being denied second servings while grasping the white cutting board on the steam table for assistance in the hallway. The surveyor advised Resident #6 not to touch the steam table due to potential heat hazards. At 8:39 AM, the surveyor did not observe dietary service employees sanitizing the cutting board. Then when asked, the dietary service employees confirmed that similar situations had occurred previously where residents would approach the hot steam table, and exposed food carts. At 8:40 AM, the surveyor observed dietary service employees touching a keypad and then touching double doors to enter the Choptank unit. Therefore, the surveyor instructed the dietary service employees to properly wash their hands with soap and water in the bathroom while keeping the door open to avoid contact with the doorknob. 8) On 12/16/2025 at 8:43 AM, the surveyor observed and confirmed with Staff #15 that no residents seated at the dining room tables had performed hand hygiene. 9) On 12/17/2025 at 1:12 PM, the surveyor observed Staff #21 wearing a winter scarf around her neck while working in the kitchen. The surveyor asked the HCSG Regional Manager to increase the kitchen thermostat, as wearing street clothes were prohibited while working in the kitchen. The Regional Nursing Home Administrator confirmed that the thermostat was set to 53 degrees Fahrenheit in the kitchen. 10) On 12/17/2025 at 1:17 PM, the surveyor toured the laundry room with the Environmental Services (EVS) Director and the Administrator. The following instances of non-compliance were observed: Soiled Laundry Room Damaged surfaces: The drywalls situated behind the two laundry washers, the mop sink, and the two-basin utility sink (which had been converted into a hand sink) were significantly damaged. The floors and cove base exhibited cracks, chips, and tears. Unsanitary sink: The hand washing sink was heavily stained, and the water faucet and turning knobs were soiled with an excessive accumulation of dirt, dust, and debris. Unclean mop sink: The mop sink was unclean and heavily stained. Soiled chemical storage: The chemical storage dunnage racks were heavily soiled with an excessive buildup of cleaning solutions, dust, dirt, and debris. Improper storage: Cleaning supplies, including mops and mop buckets, were improperly stored between the two commercial washing machines. Mechanical ventilation: The mechanical ventilation system was noisy, with stains observed around the vent cover on the ceiling. Clean Laundry Room (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ventilation/ Open window: The ventilation system was inoperable; thus, a window was open to facilitate air circulation within the room. Stained floor: Stained floor tiles were observed adjacent to the dryer unit. Lack of hand hygiene: Laundry must be processed and handled in a manner that prevents the spread of infections. 11) On 12/17/ 2025 at 2:25 PM, the surveyor observed an oxygen tube remaining attached to an oxygen cylinder while assessing the oxygen storage room with the Region Maintenance Director. The Regional Maintenance Director confirmed that the oxygen tubing was attached to the full oxygen cylinder. 12) On 12/18/2025 at 9:00 AM, the surveyor observed Staff #24 wearing a mask positioned under her chin in the kitchen before promptly pulling it up to cover her nose. She then approached the surveyor without performing hand hygiene with soap and water. The surveyor asked Staff #24 about the purpose of wearing a mask in the kitchen. She stated that four additional employees from the Healthcare Service Group were required to wear masks due to declining the influenza vaccine based on allergies or personal reasons. 13) On 12/18/2025 at 9:20 AM, the surveyor requested the EVS Director to provide the policy and procedures for cleaning/disinfecting soiled IV poles and to identify the storage location for clean IV poles. The EVS Director stated that soiled poles are stored in the utility closets, and once cleaned, the IV poles are placed in front of the Central Supply Room doors, adjacent to the kitchen. The surveyor requested access to the Central Supply Room, but the EVS Director did not possess the room key. At 9:45 AM, the surveyor interviewed Staff #37, Medical Records Coordinator, who is also responsible for the Central Supply Room, regarding the three IV poles stored in the room. One of the IV poles exhibited dirt/spills on the bottom, and all three poles were uncovered. Staff #37 stated that the IV poles are placed in front of the room doors, and she places them back in the locked Central Supply Room without receiving confirmation from EVS that they have been cleaned and disinfected. At 11:32 AM, the surveyor conducted an interview with the Infection Preventionist (IP) to communicate the findings. The IP confirmed that the infection control issues have been shared by the staff throughout the survey period.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on record review and interview it was determined that the facility staff failed to assure residents whose funds are being managed by the facility have ready and reasonable access to their funds. This deficient practice has the potential to affect 58 of the 93 resident whose accounts are being managed by the facility when the recertification survey was conducted.The findings are:On 12/17/25 at 2:27 pm during an interview with Business Office Manager # 25 the surveyor asked to explain how a resident is allowed access to their funds. Business Office manager #25 verbalized they come up front and tell the receptionist or him/her they want a certain amount of cash. They have a cash box and if the money is in the cash box, the resident can have it. If not they will try to get the money by the next day. When a resident receives money, they have to sign for it. After hours and the weekend, they can get $5 or $10.On 12/17/25 at 3:00 pm the surveyor informed Business Office Manager #25 the residents are supposed to have access to their account at any time and they should be able to access up to $100 immediately ($50 Medicaid) and over $100 within three days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews it was determined that the facility staff failed to complete through investigations for allegations of abuse. This deficient practice was evidenced in 2 (#38 & #59) of 5 investigations reviewed for a through investigation during the recertification survey.The findings include:1) On 12/18/25 at 1:29 pm a review of the investigation related to an allegation of abuse concerning Resident #59 revealed twenty-one different staff worked on the unit from 03/01/25 - 03/02/25 when the alleged incident may have occurred. There were no statements from all the staff who worked when the alleged incident may have occurred. On 12/18/25 at 2:25 pm during an interview with the Administrator the surveyor asked how they determine who needs to be interviewed when they need to complete an investigation. The staff were told to write their name and title on statements. The Administration verbalized they usually get the staffing sheets to see who worked and interview the staff. 2) On 12/18/25 at 3:08 pm a review of the investigation concerning an allegation of abuse concerning Resident #38. A review of the statements from the staff indicated all the staff who worked during the time the bruise was discovered were not interviewed. A review of the staffing sheets and statements revealed all the staff who worked during the time the bruise was found on the resident were not interviewed. A CMA, GNA, and a female staff were not interviewed but worked on the unit during the time of the alleged incident. On 12/18/25 at 3:37 pm the Administrator confirmed that a GNA and dining room attendant were not interviewed, and the surveyor reported all the staff who worked during the time the bruise was discovered were not interviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on medical record review and staff interview it was determined the facility failed to notify the resident/resident representative in writing of the bed hold policy when the resident was transferred/discharged from the facility to an acute care facility. This was evident for 1 (resident # 2) of 3 residents reviewed that were transferred to an acute care facility. The findings include: Review of the medical records for Resident #2 on 12/15/2025 at 3:52 PM revealed on 8/24/2025 the resident was sent to an acute care facility for a change in his/her medical condition. Further review of the medical record failed to produce written evidence that the resident and /or the resident representative were given written notice of the bed hold policy. During an interview with the Administrator about Resident #2, on 12/16/2025 at 10:43 AM, she stated that she mailed the bed hold policy to the resident's representative. However, the Administrator was unable to produce written evidence that the resident/ resident representative was given/received written notice of the bed hold policy. The Administrator stated that she understood that not having written proof that the resident/representative was notified of the bed hold policy was an issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility staff failed to initiate a person-centered care plan for a resident who was high risk for wandering, required assistance with oral hygiene, and a resident who frequently refused ADL care. This deficient practice was evidenced in 2 (#11 & #40) of 11 resident records reviewed for person centered care plans during the recertification survey.The findings include:1) On 12/10/25 at 12:47 pm during observation rounds the surveyor noticed Resident #40 had several missing teeth and the remaining teeth were discolored and decayed. On 12/12/25 at 9:31 am during an interview with the RN Unit Manager of Choptank #15 the surveyor asked how the facility ensures the residents receive dental care. He/she verbalized they don't ask if the residents had recent vision, dental, or audiology care when they are admitted . Routine dental assessments are done quarterly; he/she gets them enrolled into Health Drive. They usually don't care plan for all services for Health Drive. The surveyor received a copy of Resident #40 dental assessment that was provided on 11/13/25 by Health Drive. A review of the assessment revealed Resident #40 could not perform oral hygiene independently. On 12/12/25 at 10:23 am during an interview with the Director of Nursing (DON) he/she verbalized RN Unit Manager of Choptank #1 oversees Health Drive and the ADL care plan for Resident #40 indicated the GNA sets the resident up for teeth brushing. The surveyor reported setting the resident up for teeth brushing and brushing his/her teeth was not the same. The care plan was not patient specific and did not indicate the staff brushed Resident #40 teeth. The Health Drive form said the resident could not perform oral hygiene independently. On 12/15/25 at 11:53 am a review of Resident #40 care plans; the resident had a care plan for wandering/elopement that was initiated on 12/21/24, but the care plan was not person centered. A review of the elopement assessment dated [DATE] when the resident was admitted to the facility revealed the resident was deemed high risk for wandering/elopement. A person-centered care plan was not initiated when the resident was deemed high risk for wandering/elopement. 2) On 12/16/25 at 7:46 am reviewing the Task section in PCC to see if there is documentation to verify Resident #11 received showers. Per PCC the resident was scheduled to receive a shower on Wednesday & Saturday during the 3 pm-11pm shift. It was documented that the resident had a shower on 12/03/25 at 8:41 pm and 12/10/25 at 8:56 pm. It was documented he/she did not have a shower on 12/06 and 12/13. A review of the progress notes, there was no documentation to indicate why he/she did not receive a shower. During an interview with the DON on 12/16/25 at 11:45 am, he/she verbalized the resident refused showers. The surveyor asked for a copy of the care plan for the resident refusing ADL care. Prior to the end of the survey, the surveyor did not receive the requested care plan for resident #11 refusing ADL care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical record review and interview it was determined that the facility staff failed to adhere to professional nursing standards as evidenced by the nursing staff failure to document why a resident did not receive their enteral nutrition. This deficient practice was evidenced in 1 (#10) of 1 resident record reviewed for enteral nutrition during the recertification survey.The Maryland Nurse Practice Act guide and governs nursing practice in the state of Maryland. Registered Nurses, Licensed Practical Nurses, and certificate holders are expected to practice within the established regulations defined by the Nurse Practice Act. According to 10.27.10.02 B (3) (c) (i) The LPN contributes to the nursing assessment by recording data in a manner which is complete, timely, and accurate.The findings include:On 12/17/25 at 9:59 am a review of Resident #10 enteral nutrition order was dated 11/30/25 at 12:47 pm read Enteral Feed Order two times a day for dysphagia Jevity 1.5 at 55 ml hour x 20 hours (Total Volume 1100ml). Up at 5:00 pm, down at 1:00 pm: total volume for 24hrs 1100 ml. The volume of tube feeding the resident received was documented on 12/2, 12/3, and 12/4 was zero. 12/10 had an x in the column and a 9 which indicated see note. There was not a note in Point Click Care (PCC) from the nurse indicating why the resident did not receive their feeding. On 12/11/25 at 9:11 am while the surveyor was in Resident #10 room the TF was not infusing for at least 10 minutes. Licensed Practical Nurse (LPN) #17 went into the room and verbalized the pump was beeping. LPN #17 attempted to restart the tube feeding pump but there was a lot of air in the tubing. He/she verbalized they would get another bag to restart the tube feeding. At least 30-45 minutes passed without the resident receiving their enteral nutrition. On 12/17/25 at 10:57 am during an interview with Registered Nurse Unit Manager #15 the surveyor reported after reviewing Resident #10 treatment administration record, several nurses documented the resident did not receive their enteral nutrition and there was no documentation to indicate why. RN Unit Manager #15 verbalized if the resident did not receive their nutrition, the physician should have been notified and a note should have been written.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of Geriatric Nursing Assistant, (GNA) personnel files and staff interview, it was determined that the facility staff failed to conduct yearly performance reviews at least every 12 months on 1 out of 2 GNA files reviewed during the recertification survey.The findings include: On 12/18/2025 at 10:13 AM Staff #8, GNA record review revealed that their 12-month performance review was last completed 5/17/2024. On 12/18/2025 at 10:30 AM the Director of Nursing (DON) was interviewed and asked if they had any more documentation related to Staff #8, GNA's 12-month performance evaluation. The DON stated they do not have Staff #8's performance evaluation for 2025. The DON verbalized understanding that GNA's performance evaluation should be done annually.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Number of residents sampled: Number of residents cited: Based on review of medical records and interview with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 1of 5 residents (Residents #4) reviewed during the investigation phase of the survey for unnecessary medications. The findings include: On 12/15/2025 at 11:40 AM Resident #4's Medical Management Review (MMR) and the Medication Administration Record (MAR) were reviewed. The MMR had 2 recommendations for Resident #4. The first recommendation was addressed by Staff # 32, Physician Assistant (PA) as evidence by the written order, signature and date on the MMR. However, the second recommendation by the consulting pharmacist was not addressed. The consulting pharmacist stated that Resident #4 has an order for Midodrine 5mg three times a day for hypotension, low blood pressure (BP). Midodrine should be administered no later than 6pm (3-4 hours before bedtime) to avoid supine hypertension, high BP. Currently evening administration is at 9:00 PM. Please review the administration times for Midodrine for Resident #4 and consider changing the time so that the evening dose is not given past 6:00 PM. Review of the MAR revealed that Resident #4 is still receiving Midodrine 5mg three times a day at 9:00AM, 1:00PM and 9:00PM. The date the consulting pharmacist gave the recommendation was 11/7/2025 and today's date is 12/15/2025. On 12/16/2025 at 12:45 PM Staff #32, PA was interviewed and asked if this was her signature on the MMR dated 11/7/2025 for Resident #4 and they confirmed that yes this is my signature. Staff #32 was then asked if a note had been written with a rational stating why the pharmacy recommendations from the MMR were not addressed. Staff #30 stated that the order was missed, stating that the first recommendation was addressed but not the second recommendation for Midodrine. Staff #32 acknowledged that the second recommendation should have been addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Number of residents sampled: Number of residents cited: Based on observations, record review, and interviews, it was determined that the facility failed to ensure that resident meals were palatable, sufficiently portioned, and the foods were maintained outside of the food danger zone. This was evident for 2 (Resident #82 and Resident #5) of 2 residents interviewed and 2 of 2 foodservice operation days observed during the annual survey. The findings include: The Food Danger Zone means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. On 12/11/2025 at 1:15 PM, a telephone interview with Resident #82's Power of Attorney (POA) revealed that the resident was not receiving adequate food portions. On 12/11/2025 at 1:37 PM, Resident #5 voiced complaints regarding the taste and texture of the food. The resident further explained that the roast beef served for dinner on 12/10/2025 was tough, resembling rubber, and could not be cut with a butter knife. On 12/16/2025 at 9:15 AM, the surveyor observed Staff #21 requesting Staff #23 to retrieve an additional batch of scrambled eggs with cheese from the kitchen while scraping the bottom of the food pan in front of the Choptank unit. Staff #23 informed Staff #21 that the AM [NAME] had placed an additional sheet pan of scrambled eggs in the steam table. However, Staff #21 pointed out that the scrambled eggs in the steam table were without cheese. Residents who had previously ordered scrambled eggs with cheese had been served without the cheese. On 12/17/2025 at 1:05 PM, both the surveyor and the Healthcare Services Group (HCSG) Regional Manager took internal food temperatures of the last test plate at the Choptank unit. The internal food temperatures recorded were as follows:Sliced roast pork sandwich on the test plate: 97 degrees F.Sliced roast pork in the steam table pan: 121 degrees F.Mashed potatoes on the test plate: 117 degrees F.Mixed vegetables on the test plate: 112 degrees F.Apple sauce on the pushcart (individually pre-portioned the previous night and stored in the walk-in refrigerator): 57 degrees F.On 12/19/2025 at 2:45 PM, the surveyor also shared the final test tray temperatures to the Regional Nursing Home Administrator and the HCSG Regional Training Manager. Cross reference to F880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Number of residents sampled: Number of residents cited: Based on the QAPI process and interview it was determined that the facility staff were unable to report what individuals are legally responsible to establish and implement policies regarding the management and operations of the facility. The findings include: On 12/19/25 at 9:14 am during an interview with the Administrator the surveyor asked questions about the governing body, the Administrator verbalized not knowing what the surveyor was speaking of. The Administrator verbalized they have corporate leadership that comes to the facility, but she was uncertain who was legally responsible for the building and the leadership.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Number of residents sampled: Number of residents cited: Based on observations, record review, and interviews, it was determined that the facility failed to maintain essential equipment in proper operating condition. This was evident for 4 of 4 pieces of equipment reviewed during the annual survey.The findings include:All essential kitchen equipment, including but not limited to walk-in coolers, steam tables, dishwashers, ovens, stoves, and warming cabinets, must be maintained in safe operating conditions in accordance with the manufacturer's specifications and remain accessible throughout kitchen operations.On 12/10/2025 at 7:40 AM, the surveyor observed an inoperable steam table located in front of the cookline. The Healthcare Service Group (HCSG) District Manager confirmed the steam table was nonfunctional.At 7:55 AM, the surveyor observed that the Type 2 ventilation system above the high-temperature mechanical dishwasher was insufficiently removing steam from the unit. The steam escaped from the sides of the dishwasher and dissipated throughout the kitchen area.At 8:20 AM, the surveyor observed that the walk-in freezer walls, floor, ceiling, and food shelving units were covered in excessive ice, frost, an ice dam, and icicles. Food boxes, ice cream/frosting tubs, food pans, and bags of ice were similarly covered due to the unit's malfunction.At 9:20 AM, the surveyor reevaluated the Type 2 ventilation over the high-temperature mechanical dishwasher by lighting a smoke stick directly below the unit. The smoke was drawn halfway toward the Type 2 ventilation opening before gradually pulling vertically into the kitchen rather than being drawn horizontally into the unit.The Administrator, Regional Maintenance Director, Maintenance Director, and the HCSG District Manager have witnessed the observations listed above.On 12/11/2025 at 8:30 AM, the surveyor conducted a follow-up on the walk-in freezer with the HCSG Regional Operational Manager. The surveyor physically verified that the unopened food boxes delivered on the morning of 12/10/2025 had been relocated to the refrigerated truck parked by the rear entrance doors. The food items were physically verified to be free from potential cross-contamination originating from the ice and frost buildup within the walk-in freezer.At 9:10 AM, the HCSG Regional Operation Manager stated that the steam table at the cookline was functional and/or potentially repairable. On 12/12/2025 at 10:39 AM, the surveyor provided the Regional Nursing Home Administrator with a copy of the Maryland Department of Health (MDH) Ventilation Criteria for Food Establishments. The MDH Criteria is intended to help ensure that ventilation systems effectively and safely remove grease vapors, smoke, heat, steam, fumes, and obnoxious odors produced during food processing activities to promote a sanitary and well-ventilated environment.At 11:30 AM, the surveyor requested a written plan and procedures detailing how to safely transport open food boxes from the food truck to the kitchen to prevent potential cross-contamination from outside elements such as snow, sleet, or rain.At 1:40 PM, the surveyor observed that the steam table at the cookline remained turned off and inoperable. The HCSG District Manager confirmed that the unit was nonfunctional. Cross reference to F812

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215221	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Chesapeake Woods	525 Glenburn Avenue Cambridge, MD 21613

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, record review, and interviews with facility staff, it was determined that the facility failed to ensure a call bell system was accessible to residents. This was evident for 1 (Resident #8) of 1 resident's and 1of 1 restroom call bell systems reviewed during the annual survey.The findings include:On 12/11/2025 at 10:34 AM, the surveyor conducted an interview with Resident #8, who was seated in a wheelchair at the foot of the bed. Following the interview, the surveyor asked Resident #8 to press the call bell for assistance due to reported pain and discomfort. The resident was unable to access the call bell, which was positioned behind the wheelchair. The resident confirmed this was the designated location for the call bell each morning when seated in the wheelchair.At 11:19 AM, the surveyor once again reported to the nurses' station that Resident #8 was experiencing discomfort and requested repositioning from the wheelchair. The Assistant Director of Nursing (ADON) arrived at the room to reassess the resident and discuss the issues with the surveyor.On 12/16/2025 at 1:40 PM, the surveyor informed the Director of Nursing (DON) and the ADON of the necessity of personally calling for assistance for Resident #8. The surveyor documented the time elapsed while waiting at the resident's door to measure the staff's response time to address the resident's needs, given the inaccessibility of the call bell.On 12/17/2025 at 2:25 PM, the surveyor conducted a walk-through with the Regional Maintenance Director and noted that a restroom call bell cord in room [ROOM NUMBER] was too short to be reached by a resident on the floor. The Regional Maintenance Director agreed to extend the restroom call bell cord.