STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215224	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Silver Spring	2501 Musgrove Road Silver Spring, MD 20904

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 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. Based on record review and interview, it was determined the facility failed to report allegations of abuse to the State Agency (SA) within the required timeframe. This was evident for 1 (#2) of 1 resident reviewed for an abuse allegation.The findings include:On 4/28/26 at 1:40 PM review of a grievance form dated as received on 4/15/26 at 4:30 PM revealed that Resident #2 reported to the facility an allegation of abuse. The form read that the resident reported on 4/14/26 around 8:30 PM that the assigned geriatric nursing assistant (GNA) came into their room to assist them to go to bed. When Resident #2 told the GNA s/he was not ready to go to bed, the GNA continued to urge him/her to go to bed and then threatened to slap the resident if they did not go to bed. The form was signed by Registered Nurse (RN) #7.A review of the facility's investigation file for the facility reported incident #298941 on 4/27/26 at 1:28 PM revealed on the initial report form that the facility was alleging they were not aware of the allegation of abuse until 4/17/26 at 2:30 PM. It was documented that the Ombudsman reported the allegation of abuse to the Nursing Home Administrator (NHA). The allegation read that Resident #2 alleged that an assigned GNA had hit him/her. However, on a witness statement form completed by RN #7 and the Assistant Director of Nursing (ADON) revealed that the resident's allegation was the same as the incident s/he reported to the facility on 4/15/26.An interview with the Activity Director #4 on 4/28/26 at 1:18 PM revealed Resident #2 reported the allegation of abuse on 4/15/26 during a resident council meeting. She stated that the resident informed the group that she was threatened by a staff member who stated she would slap him/her if she did not go to bed. She stated she left the meeting immediately and verbally reported it to the Nursing Home Administrator (NHA) and the she told the Assistant Director of Nursing (ADON).Surveyor was unable to interview the NHA because she was unavailable during the survey.An interview with the ADON on 4/28/26 at 1:32 PM revealed she was approached by the Activity Director on 4/15/26 about Resident #2's allegation of abuse. She stated she went to the NHA who told her to write it on a grievance form and start an investigation. She confirmed she had not reported it to the SA because they were just investigating it at that time. She stated that the resident alleged it occurred on 4/14/26 in the evening, however, she pointed out GNA #8 who had not been on duty that evening. When shown the schedule and that GNA #8 had not worked on 4/14/26, but had worked on 4/13/26, she stated she had not noticed that during the investigation. Furthermore, because the resident reported the wrong date, GNA #8 was allowed to continue to work on 4/15/26 and was assigned to Resident #2. When asked why the allegation was not reported as an allegation of abuse on 4/15/26, but was reported after the Ombudsman reported it to the NHA, she stated that she was not sure because it was the same allegation that they had already investigated on 4/15/26 and 4/16/26.The concerns were reviewed with Corporate Compliance Officer on 4/28/26 at 2:30 PM.Cross Reference: F610

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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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 interview, it was determined that the facility failed to ensure that a staff member was removed from the resident care area following an allegation of abuse to ensure the safety of all residents until an investigation was completed. This was evident for 1 (#2) of 1 resident reviewed for abuse allegation.The findings include:On 4/28/26 at 1:40 PM review of a grievance form dated as received on 4/15/26 at 4:30 PM revealed that Resident #2 reported to the facility an allegation of abuse. The form read that the resident reported on 4/14/26 around 8:30 PM that the assigned geriatric nursing assistant (GNA) came into their room to assist them to go to bed. When Resident #2 told the GNA s/he was not ready to go to bed, the GNA continued to urge him/her to go to bed and then threatened to slap the resident if they did not go to bed. The form was signed by Registered Nurse (RN) #7.An interview with the ADON on 4/28/26 at 1:32 PM revealed she was approached by the Activity Director on 4/15/26 about Resident #2's allegation of abuse. She stated that she and the evening shift supervisor RN #7 worked on an investigation that evening and into the next day (4/16/26). She reported that they asked the GNA who was assigned to the resident on 4/14/26 during the evening shift to come to the facility on 4/15/26. When the resident saw her, the resident stated that it was not her and pointed out GNA # 8 and see if that was who the resident was talking about. The Activity Director stated she went to the NHA who told her to write it on a grievance form and start an investigation. She confirmed she had not reported it to the SA because they were just investigating it at that time. She stated that the resident alleged it occurred on 4/14/26 in the evening, however, she pointed out GNA #8. The ADON reported she had not asked GNA #8 to leave the resident care area because she was not working on the day the resident alleged the incident happened. She was shown the schedules and that GNA #8 had not worked on 4/14/26, but had worked on 4/13/26, she stated she had not noticed that during the investigation. She agreed that the resident may not have had the right date but she had clearly identified the GNA #8 who threatened her. An interview with the Ombudsman on 4/28/26 at 11:43 AM revealed she had visited Resident #2 on 4/16/26 around 5:00 PM. The resident reported the allegation of abuse to her and when GNA #8 came in the room, the resident stated that it was her who had threatened the resident. A review of the facility's investigation file for the facility reported incident #298941 on 4/27/26 at 1:28 PM revealed a witness statement dated 4/17/26, that RN #7 wrote that Resident #2 had pointed out GNA #8 as the alleged perpetrator that day.A review of the time stamps for GNA #8 on 4/28/26 at 1:37 PM revealed she worked the evening shift 4/15/26 - 4/24/26. Even though the allegation was reported a second time to the NHA on 4/17/26 by the Ombudsman who reported to her that the resident identified GNA #8 as the alleged perpetrator.The surveyor was unable to interview the NHA because she was unavailable during the survey.The concerns were reviewed with Corporate Compliance Officer on 4/28/26 at 2:30 PM.Cross Reference: F609

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the social services department failed to ensure that a resident received medically related social services. This was evident for 1 (#1) of 1 resident reviewed for discharge.The findings include:MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. On 4/23/26 at 12:44 PM a medical record review for Resident #1 was conducted. According to the progress notes, the resident had an initial care plan on 3/27/26 with a family member present and the note was authored by the Social Services Director. In the discharge planning section, the Social Services Director failed to document the resident's plans for discharge. The admission minimum data set (MDS) documented that the resident had no cognitive impairment and no impairment with communication. According to section GG, Resident #1 required staff assistance with most ADLs (activities of daily living such as toileting, dressing, bathing, personal hygiene) and was wheelchair bound.A note dated 4/14/26 from the Social Services Director Staff #2 stated the resident's insurance coverage was ending and the resident agreed to go home on 4/15/26. Then later that day Staff #2 wrote that the resident wanted to appeal the decision. On 4/16/26, the resident was visited by Nurse Practitioner (NP) #1 and she wrote the resident was admitted for generalized muscle weakness. The resident had mobility and ADL dysfunction and was at risk for functional impairment without pain control and physical and occupation therapy services. The attending physician wrote a note on 4/16/26, stating the resident was in extensive need of therapy and was not ready to be discharged to his/her home.On 4/23/26 at 12:08 PM an interview with Resident #1 revealed he/she asked to be transferred to another facility the same day of admission because he/she did not feel the facility was able to meet his/her needs. Resident #1 reported he/she spoke with the Social Services Director staff #5 regarding this transfer during the care plan meeting. When asked what Staff #5 had done after the request was made, Resident #1 stated that he did nothing and stated that the stress caused by the facility had affected his/her ability to heal.On 4/23/26 at 1:31 PM this was confirmed by the resident's family member who had attended the care plan meeting.An interview with the Social Services Director staff #5 on 4/27/26 at 10:22 AM revealed he had not completed the discharge planning section on the care plan note dated 3/27/26 because he stated the resident wanted to be transferred to another facility. When asked what he had done to assist the resident with the transfer to another facility, he stated that he had asked the Social Services Assistant to take care of it. Staff #5 confirmed he had not sent any referrals to attempt to find another facility per the resident's request.The Social Services Assistant staff #6 was interviewed on 4/27/26 at 11:30 AM. She reported she was on leave when the resident had a care plan meeting on 3/27/26 and had not returned until the following Saturday (April 4,2026). When asked if she was asked by the Social Services Director to assist Resident #1 with transferring to another facility, she reported she had not. She stated when she returned from her leave that she knew the resident had asked for be transferred but was not involved. She stated that the resident approached her in the hallway at the end of the day on 4/12/26 and stated he/she wanted to be transferred to another facility. Staff #6 stated that she did not want to discuss this information in the hallway and made arrangements with the resident to meet the following day. She provided evidence that she contacted another facility for a possible transfer. This was 18 days after the resident had requested the transfer and the resident had to request the transfer a second time. An interview with Resident #1 on 4/23/26 at 12:08 PM revealed he/she was being discharged that day but was concerned because Resident #1 was not able to walk yet. Resident #1 stated they asked to stay at the facility to receive more therapy so they could walk before going home. When asked if the facility had set up therapy services for him/her at home, (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 stated that they had not told him/her if they did.An interview with Resident #1's family member with the resident was present was conducted on 4/23/26 at 1:31 PM. The family member reported he was there to take the resident home. However, he voiced concerns about taking the resident home because s/he was unable to get around on their own. When asked what the home situation was like, they reported that the resident had to walk across about 4 feet of grass to the steps and then up 4 steps to the porch to enter the house. The house was one level inside except for a few steps to go to the laundry room. The resident was going to be home during the day alone. They reported the resident wanted to go home because the insurance was not going to cover services at the facility. They stated they were not aware of any in-home services that had been set up by the facility and were unaware that this was an option.On 4/27/26 at 9:00 AM a medical record review for Resident #1 revealed the resident had refused to discharge unless home health services had been set up. It was documented the resident was being charged private pay while staying at the facility. An interview with Physical Therapist (PT) #9 on 4/27/26 at 12:00 PM revealed Resident #1 had not met his/her therapy goals and was not able to discharge home safely without continued physical therapy services.An interview on 4/27/26 at 10:22 AM with the Social Services Director Staff #5 revealed he was not at the facility on 4/23/26 and had not set up home health services or therapy services for the resident. He stated that he referred this to the Social Services Assistant Staff #6. He confirmed that he provided oversight for Staff #6, however had not ensured that everything was in place for Resident #1 prior to the discharge date . During an interview with the Social Services Assistant Staff #6 on 4/27/26 at 11:30 AM, she provided a utilization review sent to the facility by the insurance company. On that paperwork dated 4/17/26, it noted the resident was eligible for home health and in-home therapy services. When asked if she had set up those services for the planned discharge on [DATE], she stated that she had notified a home health provider on 4/23/26 around 12 noon. However, the evidence she provided showed she had not sent a request until 4/23/26 at 3:26 PM which was during the discharge meeting with the resident. She reported she was unaware she could set up the services prior to the discharge date . She reported that the resident was not discharged because they were unable to find a home health provider that accepted the resident's insurance although there was a list of providers on the utilization review paperwork she presented during the interview.An interview with the Ombudsman on 4/28/26 at 11:46 AM revealed that Resident #1's family member called her on 4/24/26 and put her on speaker during a discharge meeting. She stated that until she asked for social services to be present, they had not been at the meeting. She confirmed that the facility had not secured home health and therapy services for Resident #1's discharge home. She stated she informed them that the home health provider they were trying to secure was not listed on the utilization review dated 4/17/26.The Nursing Home Administrator (NHA) was not available during the survey. The concerns were reviewed with the Corporate Compliance Officer on 4/28/26 at 2:30 PM and she acknowledged the concerns.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to provide their residents with rehabilitation services based on their plan of care as required. This was evident for 1 (#1) of 1 resident reviewed for rehabilitation services. The findings include: 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. MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. On 4/23/26 at 12:44 PM a medical record review for Resident #1 was conducted. A review of the resident's care plan revealed on 3/25/26 a focus for rehabilitation (rehab) services was initiated on 3/25/26 with a goal to improve current level of function with therapy services. There was an intervention to provide therapy services as per the physician's orders. The admission minimum data set (MDS) documented that the resident had no cognitive impairment and no impairment with communication. According to section GG, the resident required staff assistance with most ADLs (activities of daily living such as toileting, dressing, bathing, personal hygiene) and was wheelchair bound.A note dated 4/14/26 from the Social Services Director Staff #2 stated the resident's insurance coverage was ending and the resident agreed to go home on 4/15/26. Then later that day Staff #2 wrote that the resident wanted to appeal the decision. On 4/16/26, the resident was visited by Nurse Practitioner (NP) #1 and she wrote the resident was admitted for generalized muscle weakness. The resident had mobility and ADL dysfunction and was at risk for functional impairment without pain control and physical and occupation therapy services. The attending physician wrote a note on 4/16/26, stating the resident was in extensive need of therapy and was not ready to be discharged to his/her home. A review of therapy notes for the resident revealed s/he had not had therapy since 4/16/26.An interview with Resident #1 on 4/23/26 at 12:08 PM revealed s/he was scheduled to go home that day. The resident reported s/he had concerns about going home because they felt they needed more therapy to be safe at home and had appealed the insurance decision to send them home. The resident reported that they were granted an extended stay, but had not received any more therapy since 4/16/26.The Social Services Director Staff #5 was interviewed on 4/27/26 at 10:22 AM and confirmed that the resident was supposed to discharge on [DATE], but had been granted additional days and then the resident appealed that decision and was granted to stay until 4/22/26. Physical Therapist (PT) #9 was interviewed on 4/27/26 at 12:00 PM and she reported that Resident #1 had participated in therapy but had not reached his/her goals. She stated that the resident needed to improve his/her navigation of steps before going home. PT #9 reported that even though the resident had been approved for services until 4/23/26 sometimes the insurance would stop the services. An interview with the Rehab Director #10 on 4/27/26 at 12:12 PM confirmed that Resident #1 had not had services since 4/16/26 and that she was aware the resident had been appealing the insurance decision to discharge. She stated that when the resident was extended it was for custodial reasons based on abnormal labs which was why she had not extended the resident's therapy services. However, she wanted to look at some paperwork and get back to the surveyor. On 4/27/26 at 12:40 PM Rehab Director #10 came back and reported Resident #1 had met his/her therapy goals for skilled nursing services and so the insurance company felt the resident could continue therapy services at home. When asked why they had not continued to provide therapy through the appeal processes she stated it was back and forth with this resident and she was not sure what was going on with the discharge. She reported that the resident would experience a physical decline without therapy services for 11 days and that they were going to start services again until the resident was discharged . The surveyor was unable to interview the Nursing Home Administrator because she was unavailable. The concerns were reviewed with the Corporate Compliance Officer on 4/28/26 at 2:30 PM and she acknowledged the concerns.