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	03/27/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation and interview, it was determined facility dietary staff failed to maintain proper infection control procedures by using serving warming plates and cloches that had been wet nesting and were still wet with standing water when the residents' plates of food were placed in them. Wet nesting is a sanitation hazard occurring when recently washed, wet, or damp items (like plates, pots, or bowls) are stacked together. This practice restricts airflow, creating a dark, moist environment that promotes rapid bacterial growth and mold.During the survey observation of the lunch plating, it was observed that the warming plates and cloches that were being used were very wet with the warming plates having standing water in them. This was observed when the warming plates were being set on the warming charger and the water in the them began to boil with obvious bubbles. The surveyor discussed the wet nesting situation with Employee #31 who directed the kitchen staff to run the warming plates and cloches back through the dishwasher and allow them to air dry.

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of employee files and interviews with facility staff, it was determined that the facility failed to conduct required performance reviews of Geriatric Nursing Assistants (GNAs) at least once every 12 months. This was evident for 4 (GNA #17, #19, #20, #5) out of 5 GNAs' employee files reviewed during the Sufficient and Competent Nursing Staffing portion of the facility's recertification survey. The findings include:Performance reviews are to be completed for each GNA at least every 12 months to identify specific, in-service education based on the outcome of those individual performance reviews. On 3/24/26 at 10:02 AM the surveyor requested the complete employee files for GNA #17, GNA #18, GNA #19, GNA #20, and GNA #5. An interview was conducted with the Human Resources Director (HRD #21) on 3/24/26 at 10:50 AM. During the interview, she verified and confirmed that the employee files provided were the complete files and included all documents related to the employees except for their health files. On 3/24/26 at 10:54 AM review of GNA #17's employee file revealed she was hired on 2/8/18; however, failed to reveal a performance review from 2025.On 3/24/26 at 11:06 AM review of GNA #18's employee file revealed she was hired on 11/30/16; however, failed to reveal a performance review from 2025.On 3/24/26 at 11:14 AM review of GNA #19's employee file revealed she was hired on 3/11/25; however, failed to reveal a performance review from 2025.On 3/24/26 at 11:18 AM review of GNA #20's employee file revealed she was hired on 10/15/24; however, failed to reveal a performance review from 2025.On 3/24/26 at 11:23 AM review of GNA #5's employee file revealed she was hired on 1/14/15; however, failed to reveal a performance review from 2025.On 3/24/26 at 11:48 AM in an interview with the Assistant Director of Nursing /Staff Educator (ADONSE #8) when asked if performance reviews were conducted for the GNAs, she stated yes. When asked how often, she said, Every year. When asked who conducted them, she stated the supervisors, managers or Director of Nursing (DON). When asked where they were stored, she stated, I'm not sure, maybe with HRD #21 or the Director of Nursing.On 3/24/26 at 12:10 PM in an interview with ADONSE #8 she stated, I talked to HRD #21 and for the GNA performance evaluations, we're in the process of putting it together.On 3/25/26 at 9:05 AM in an interview with ADONSE #8, when asked about the GNA performance reviews, she stated, If they were not in the employee file then they were not completed, but we are going to get a process in place. On 3/26/26 at11:08 AM during an interview with ADONSE #8, she stated Performance reviews, we dropped the ball on that because of all the changes and changes in ownerships. The surveyor shared this was a concern and the ADONSE #8 acknowledged understanding of the concern.On 3/27/26 at 10:00 AM the Nursing Home Administrator (NHA) provided 11 GNA performance reviews that she said they had located. Review of the performance reviews revealed 1 GNA's [GNA #18] out of the 5 GNAs reviewed for Staffing was included. On 3/27/26 at 11:27 AM the NHA provided 9 additional GNA performance reviews; however, they were all from 2024. When asked where these reviews were located, she stated she had to let the previous Human Resources go because she was just stacking paperwork and not filing it. During the interview, she stated, The first stack was found in HRD #21's office and the second stack was found in the DON's office. Additionally, she stated that they were supposed to be in the employees' files. The surveyor shared the concern that only 1 of 5 GNAs reviewed had a performance review completed. The NHA acknowledged understanding of the concern.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record review, it was determined that the facility failed to implement appropriate infection control practices as evidenced by 1) failing to ensure oxygen tubing and humidification bottles were dated to indicate timely replacement, 2) not stocking enough Personal Protective Equipment (PPE) outside resident rooms, and 3) using appropriate infection control practice during urinary catheter maintenance. This was found to be evident for 9 (Residents #3, #9, #22, #116, #157, #158, #23, #30, and #155) of 47 residents investigated during the recertification survey. The findings include: PPE includes specialized clothing or gear, such as gloves, gowns, and masks, worn to create a physical barrier between a person and infectious materials. Contact Precautions require staff to wear a gown and gloves for every entry into a patient's room to prevent the spread of germs through direct or indirect touch. Enhanced Barrier Precautions (EBP) are a more targeted approach used in nursing homes, requiring gown and glove use only during high-contact care activities—like bathing, dressing, or wound care. A urinary catheter bag is a sterile container that collects urine from the bladder via a flexible tube. The catheter bag should never touch the floor to prevent contamination and the risk of infection. 1) On 03/23/2026 at 8:03 AM, observation revealed Resident #157 with oxygen tubing and a humidification bottle that were not dated. At 8:11 AM, Resident #22 was observed with undated oxygen tubing and humidification bottle. At 8:29 AM, Resident #9 was observed with undated oxygen tubing and humidification bottle. At 8:42 AM, Resident #116 was observed with undated oxygen tubing and humidification bottle. On 03/26/2026 at 12:16 PM, the surveyor requested the facility policy regarding oxygen tubing and humidification bottles, including the frequency of changes. The Assistant Director of Nursing (ADON) stated they would check to clarify. At this time, the surveyor shared the information about the four residents that were observed without dates on the oxygen tubing or humidification bottles. At 12:25 PM, the facility policy was provided, which indicated that humidification bottles are to be changed every 72 hours. The absence of dates on the oxygen tubing and humidification bottles prevented verification that the equipment was changed in accordance with facility policy. 2) On 3/23/2026 at 8:51 AM, multiple rooms on the 1st floor unit were observed to have contact or EBP signs attached to doors outside of resident rooms. On 3/23/2026 at 8:51 AM, Registered Nurse (RN) #12 stated during an interview that PPE should be located outside of resident rooms in carts if they are on EBP or contact precautions. The following was observed on 3/23/2026: At 8:54 AM, contact precaution sign observed on Resident #3's door, PPE cart outside room did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have gloves or gowns stocked, no PPE observed inside resident room. At 8:59 AM, EBP sign observed on Resident #158's door, PPE cart outside room did not have gloves or gowns stocked, no PPE observed inside resident room. At 9:05 AM, EBP sign observed on Resident #23's door, PPE cart outside room did not have gloves stocked, no PPE observed inside resident room. At 9:06 AM, EBP sign observed on Resident #30's door, PPE cart outside room did not have gowns stocked, no PPE observed inside resident room. At 9:07 AM, contact precaution sign observed on Resident #155's door, no PPE cart was observed outside of room, no PPE was observed inside resident room. On 3/23/2026 at 9:40 AM, previously mentioned PPE carts were observed to be fully stocked. On 3/23/2026 at 10:41 AM, a PPE cart was observed outside of Resident #155's room. On 3/24/2026 at 10:33 AM, concerns were addressed with the ADON. The ADON stated it's the facility's expectation the PPE carts are stocked with the necessary supplies and that it is the night shift supervisor's responsibility to ensure the carts are stocked and outside resident rooms. 3) On 3/23/2026 at 8:54 AM, Resident #3's catheter drainage bag was observed hanging from their bed but touching the floor. This again was observed at 10:07 AM. On 3/24/2026 at 10:30 AM, Resident #3's catheter drainage bag was observed not hung from their bed and laying directly on the floor. The ADON observed the catheter drainage bag with surveyor on 3/24/2026 at 10:33 AM. The ADON stated it's the facility's expectation that the drainage bag is not on the floor and stated they would immediately switch out the bag with a new one and ensure it was hung properly from the bed frame.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on review of the medical record and pertinent documentation and interviews with facility staff, it was determined that the facility failed to transmit MDS assessments within 14 days of completion of the assessment. This was evident for 1 (Resident #53) of 1 residents reviewed for resident assessment. The findings include:The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's functional, medical, psychosocial, and cognitive status. It is administered to all residents at admission, quarterly, annually, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident. Each resident assessment must be encoded within 7 days and transmitted to the Centers for Medicare and Medicaid (CMS) System within 14 days of when an assessment is completed.On 3/27/2026 at 12:00 PM in an interview with the MDS Coordinator (MDSC #33) when asked if she had transmitted any data for Resident #53 in the last 120 days, she stated she would go check. On 3/27/2026 at 12:27 PM in an interview with MDSC #33, she provided a document referencing Resident #53's February 2026 MDS that had documented at the bottom, Message: Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (A0050 equals 1) assessment. When asked if this MDS was submitted late, she pointed to the document and stated, That's what it says. The surveyor shared this as a concern and MDSC #33 acknowledged understanding of the concern. The surveyor requested a copy of the resident's Final Validation Report verifying the exact date the MDS was transmitted. On 3/27/2026 at 12:43 PM in an interview with MDSC #33, she provided a copy of the Final Validation Report which showed the Target Date as 2/13/26 and the Submission Date/Time as 3/19/26 11:54 AM. When asked why it was submitted late, she stated her supervisor submits the MDSs.On 3/27/2026 at 1:03 PM in an interview with the Regional MDS (RMDS #34) when asked why Resident #53's February 2026 MDS was submitted late she stated, I can't remember what happened. During the interview, RMDS #34 verified and confirmed that it was submitted late. The surveyor shared this as a concern and RMDS #34 acknowledged understanding.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review, and facility staff interview, it was determined that the facility staff failed to develop and initiate comprehensive person-centered care plans for residents residing in the facility. This was evident for 2 (#33, #47) of 33 residents reviewed during the recertification survey. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. On 03/26/2026 at 11:25 AM, during a review of the medical record for Resident #47, it was determined that the resident's dental issues were not addressed in their care plan. The contract dental service had been seeing the resident, had identified the resident's dental issues and were working to resolve them by replacing the resident's dentures. The dental services had documented what had been done and what needed to be done but the care plan did not reflect this issue. On 03/27/2026 at 12:18 PM, during a review of the medical record it was discovered that though Resident #33 had been diagnosed by their primary provider with Chronic Kidney Disease (CKD), Stage 3, this diagnosis had not been addressed in the resident's care plan. There was no mention of CKD in either the initial care plan or the current care. The resident's CKD had also been identified by the providers at the acute care hospital during 2 emergency room visits in the last 8 months.On 3/27/2026 at 2:20 PM, during an interview with Employee #8 it was requested that they review the care plans for Residents #33 and #47 to verify that the elements identified during the survey were missing. Employee #8 verified that the residents' care plans were missing the identified elements and stated the care plans would be updated.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, medical record review, and interviews, it was determined that the facility failed to follow provider orders. This was found to be evident in 1 (Resident #3) of 47 residents reviewed during the recertification survey.The findings include:A midline intravenous (IV) or midline catheter is a thin, flexible tube inserted into a vein in the upper arm that provides longer-term access than a standard IV, typically lasting up to four weeks. The sterile dressing must be changed regularly-usually once a week-to protect the insertion site from bacteria, moisture, and debris that could cause a serious infection.On 3/23/2026 at 10:07 AM, Resident #3 was observed to have a midline IV in their left arm. The dressing covering the IV site was dated 3/17/2026.On 3/26/2026 at 1:00 PM, Resident #3's midline IV dressing was observed and was dated 3/17/2026.On 3/27/2026 at 9:10 AM, Resident #3's medical record was reviewed which revealed an active order placed by the nursing facility provider dated 3/18/2026 that stated, Change midline insertion site dressing, every evening shift every Thu Label with Initials, Date and Time AND as needed Label with Initials, Date and Time.On 3/27/2026 at 9:43 AM, Resident #3's Treatment Administration Record (TAR) was reviewed. It was documented in the TAR that the order for dressing change was performed on 3/19/2026 and 3/26/2026 by facility staff.On 3/27/2026 at 11:06 AM, Resident #3's midline IV was observed and the dressing was dated 3/17/2026.On 3/27/2026 at 11:11 AM, Registered Nurse (RN) Supervisor #32 observed the midline dressing with surveyor and confirmed it was dated 3/17/2026. RN #32 also reviewed Resident #3's TAR with surveyor and confirmed that it was documented that the dressing was changed on 3/19/2026 and 3/26/2026. RN #32 stated that it's the facility's expectation that orders checked off as performed in the TAR are completed.On 3/27/2026 at 11:25 AM, surveyor concern about the lack of dressing changes and incorrect documentation was addressed with the Nursing Home Administrator.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with facility staff, it was determined that the facility failed to ensure monthly Medication Regimen Reviews were completed by a provider and to respond to and address recommendations made by consulting pharmacists in a timely manner. This was evident for 1 (Resident #29) of 5 residents reviewed for unnecessary medications during the facility's recertification survey.The findings include:The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. On 3/24/26 at 12:54 PM review of Resident #29's medical record revealed the 1/8/26 and 2/8/26 MRR documented as See [pharmacist's] report. On 3/24/2026 1:37 PM in an interview with the Assistant Director of Nursing (ADON) when asked the facility's MRR process, she stated, The pharmacist emails it to us and we fix whatever they need us to fix. We give it to the Nurse Practitioner (NP #14) who addresses them all. Some of the MRRs say for the attending and those we give to the Medical Director. During the interview when asked who received the report, she stated, The Medical Director, Attending Physician, Director of Nursing, ADON, Administrator, and Unit Managers (UMs). Everyone gets the email, but I print the recommendations. After I print the recommendations, I hand them all to the NP [#14] and she addresses them and hands them back to me. When asked if the expectation was for the provider to check one of the three boxes (agree, disagree or other) and sign and date it, she stated, yes. When asked who was responsible for discontinuing and/or creating new orders based off the recommendations, she stated, Some of them she [NP #14] makes the changes in PCC (the facility's electronic medical record) and some of them she does not. For the ones she did not address, I give them to the UMs in the morning meeting, and they make the changes in PCC and then they either put them in the MRR binder or give them back to me and I put them in the binder. When asked when the MRRs were to be completed, she stated before the next month's review.On 3/24/2026 at 1:48 PM the surveyor requested the 1/8/26 and 2/9/26 MRR for Resident #29. On 3/25/26 at 8:52 AM the ADON provided the 1/8/26 MRR to the surveyor. When asked where the 2/9/26 MRR was she said she would check.On 3/25/26 at 8:53 AM review of the MRR revealed a recommendation to discontinue the resident's melatonin. The provider had checked agree and signed and dated the MRR; however, the date was 3/3/26 almost 2 months after the pharmacist made the recommendation.On 3/25/26 at 9:00 AM the ADON provided Resident #29's 2/9/26 MRR. Review of the recommendation revealed it was the same recommendation from 1/8/26. In an interview with the ADON she stated, It was the same as the 1/8/26 MRR and they were both missed. During the interview she stated, I was on vacation. During a dual observation, the surveyor pointed out that the [DATE] MRR was not addressed until 3/3/26 and that the 2/9/26 MRR was not addressed at all with no signature, date, or checked box. When asked who the signature was on the 1/8/26 MRR, she stated it was NP #14's. The surveyor shared these were concerns and the ADON verified and acknowledged understanding of the concerns. On 3/25/26 at 9:47 AM review of the facility's policy titled Addressing Medication Regimen Review Irregularities revealed, It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event. Further review of the policy revealed, The facility will utilize a systematic approach for reviewing each resident's medication regimen which preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. Continued review revealed, The pharmacist must (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report any irregularities to the attending physician, the facility's medical director and Director of Nursing, and the reports must be acted upon. Furthermore, the policy stated, If the pharmacist should identify a non-urgent recommendation the physician shall address the recommendation and the response shall be documented in the resident's medical record or on a form designated by the facility prior to the next scheduled review.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews of facility staff it was determined the facility failed to ensure an effective pest control program as flying gnats were observed throughout the first floor of the building. This was found to be evident during the survey. The findings include: During an environmental tour of the first floor unit on 03/23/2026 at 9:47 AM, the surveyor observed a plethora of gnats flying around in the hallway. The surveyor observed a more concentrated amount of flies upon entrance into room [ROOM NUMBER], in comparison to those noted in the hallway. During an interview with one the residents in room [ROOM NUMBER] the surveyor observed more than 20 gnats resting on the resident's right side of the bed and on the resident's privacy curtain. When asked by the surveyor, the resident stated that the flies are always in the room. However, the resident neither confirmed or denied reporting this issue to facility staff. On 3/23/2026 at 10:30 AM the Director of Environmental Services and the surveyor toured the first hallway on the first floor and also room [ROOM NUMBER] together. The Director of Environmental Services confirmed the presence of the gnats and stated that he will coordinate with nursing and environmental staff to take immediate action to clean the room and remove the gnats (when the residents are out of the room).