

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on administrative record review and staff interviews, it was determined that the facility staff failed to ensure that a resident was free of verbal abuse while in the care of a Geriatric Nursing Assistant (GNA). This was evident for 1 (#7) of 4 residents reviewed for abuse. The findings include: Verbal abuse is defined as the willful use of oral, written, or gestured language that includes disparaging, derogatory, or threatening terms to residents or their families, or within their hearing distance, regardless of the resident's age, ability to comprehend, or disability. On 1/15/26 at 9:54 AM, a review of the facility's investigation for facility reported incident #354455 revealed the facility had substantiated verbal abuse based on resident and staff interviews. The facility's investigation revealed on 6/19/25, approximately 6:30 PM, there was a verbal argument between Staff #4, Geriatric Nursing Assistant (GNA) and Resident #7 and foul language was exchanged between them. As a result of the facility's investigation, Staff #4, was terminated for his/her actions and reported to the Maryland Board of Nursing (MBON). The above findings were discussed with the Director of Nurses on 1/15/25 at 9:25 AM. The DON acknowledged the concerns and stated that the incident with he GNA was reported to the MBON for verbal abuse. At that time, the DON stated Resident #7 had a history of berating behaviors towards staff, and had tormented Staff #4 who reacted.</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on administrative record review and staff interviews, it was determined that the facility staff failed to immediately report allegations of abuse to the facility administration and the state agency. This was evident for 1 (#7) of 4 residents reviewed for abuse. The findings include: On 1/15/26 at 9:54 AM, a review of the facility's investigation documentation for facility reported incident, #354455, which alleged a verbal altercation with profane words exchanged between Staff #4, GNA and Resident #7 occurred on 6/19/25 at approximately 6:30 PM and was witnessed by Staff #2, GNA. Following the altercation, Staff #4, GNA did not report his/her altercation with Resident #7 to the administration, and Staff #2, GNA failed to notify the facility's administration of the witnessed verbal altercation. Following the incident, In a resident interview statement, on 6/19/25, Staff #1, Licensed Practical Nurse (LPN), Unit Manager (UM) documented Resident #7 requested to speak to a manager. When Staff #1, LPN, UM, accompanied by Staff #14, LPN, Shift Supervisor, went to speak with Resident #7, the resident reported alleged abuse by Staff #4, GNA. Staff #1, LPN, UM further documented that the complaint was taken to the NHA at approximately 7:15 PM. The facility's initial self-report documented that the administrator was notified of the incident on 6/19/25 at approximately 7:30 PM The GNA's failure to notify the administration of the witnessed altercation between Resident #7 and Staff #4, delayed the facility's reporting to the state agency. The altercation was documented as occurring on 6/10/25 at approximately 6:30 PM and the facility's initial self-report was sent to the State Survey Agency, which is The Office of Health Care Quality (OHCQ), on 6/19/25 at 9:20 PM, which was greater than 2 hours after the alleged abuse was witnessed by Staff #1, GNA. On 1/21/26 at 3:08 PM, during an interview, the above concerns were discussed with the Director of Nurses (DON). The DON acknowledged the concerns and indicated that during the altercation, Staff #2 heard the resident berate the GNA, and heard raised voices, but; s/he didn't understand the foul language and what was being said.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and resident and staff interviews it was determined the facility staff failed to conduct a thorough investigation of an allegation of abuse. This was evident for 1 (#5) of 5 residents reviewed for Abuse. The findings include: Facility reported incident #2675137 and Resident #5's medical record were reviewed concurrently on 1/20/26 at 9:15 AM. The facility's report revealed that Resident #5's family member called the facility on 11/21/25 at 9:25 AM and reported the resident told them a nurse threw urine in his/her face. The facility reported the incident to the state agency and conducted an investigation. The facility's investigation documentation included an Abuse Allegation Incident Report dated 11/21/25 11:00 (it did not indicate AM or PM) by Staff #1 the Sugarloaf Unit Manager. The report included Nursing Description: Resident alleging GNA intentionally threw urine in [his/her] face after [s/he] threw a full urinal bottle towards him/her. A written statement dated 11/21/25 7:27 PM was signed by Staff #5 an agency GNA (Geriatric Nursing Assistant) assigned to provide care for Resident #5 during the 11 pm - 7 am shift on 11/20/25. The statement revealed that when GNA #5 responded to Resident #5's call bell, the resident indicated s/he needed to urinate, was incapable of holding a urinal himself and asked her to hold it. She indicated that when she realized she forgot to put on gloves she attempted to place the resident's hand on the urinal, the resident snapped his/her arm back aggressively, causing Staff #5 to drop the urinal. Staff #5 indicated the resident began to yell at her, so she started walking out of the room. The resident threw the urinal at her and urine splashed all on me. She indicated she grabbed a glove, picked up the urinal and put it on the bed and left the room. There was no documentation to indicate that Staff #5 was asked about throwing urine onto Resident #5's face. Resident #5's medical record revealed a General Nurses Note dated 11/21/25 10:41 AM by the Director of Nursing in which she documented that she and a police officer met with Resident #5 regarding the incident. The note revealed the resident indicated that they couldn't hold the urinal due to only having one hand to hold it. That Resident #5 asked Staff #5 to hold the urinal but she wouldn't hold it right. The note included that the resident stated She told me I could go and the urine got me wet, so I threw the urinal at the wall. She picked it up and shook it at me. There was urine still in it and it hit my face. The facility's Follow-Up Investigation Report revealed the Steps Taken to Investigate the Allegation: Resident #5 stated GNA was holding urinal in place and dropped it in [his/her] lap spilling urine on [him/her]. [S/he] then threw urinal containing urine at GNA. It also reflected the nursing supervisor stated GNA reported urine had accidentally spilled on Resident #5 when she prompted Resident #5 to hold the urinal. GNA then reported that Resident #5 threw the urinal at her, the urinal hit the wall splashing urine on her, wall and ceiling. The GNA denied intentionally pouring urine on Resident #5. It did not reflect that the facility addressed the allegation that the GNA caused urine to splash onto Resident #5's face from the urinal. An interview was conducted with Resident #5 on 1/20/26 at 1:11 PM. When asked, s/he indicated remembering the incident very well. That s/he called for assistance to use the urinal. S/he felt the urinal wasn't positioned properly, would spill back onto him/her, and protested. Resident #5 indicated the GNA stated repeatedly it'll be okay and continued to hold the resident's wrist. The resident indicated that when s/he pulled his/her wrist away from GNA #5 the GNA poured the urinal onto him/her, gesturing toward his/her lap area. When asked if it was accidental s/he reported feeling that it was intentional. Resident #5 indicated, as the GNA was going out of the room the resident threw the urinal, stating I didn't throw it at her, I threw it at the wall, the urinal bounced off the wall and landed upright on the floor. S/he stated the GNA picked it up and flicked it at him/her causing urine to splash his/her face. Resident #5 confirmed that the same information was provided during an interview with the Director of Nursing</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and the Police. A statement dated 12/1/25 by the Director of Nursing stated This writer and unit manager spoke with resident about conclusion of investigation r/t (related to) allegation that GNA intentionally poured urine on resident. Informed resident that investigation finds were inconclusive. The Investigation Conclusion in the final report indicated the facility determined the allegation was inconclusive, it indicated the GNA reported accidentally spilling urine on Resident #5. Resident #5 reported s/he was upset that urine had spilled on him/her and admitted to throwing urinal containing urine at GNA. There was no evidence that the facility investigated the allegation that Staff #5 threw urine in Resident #5's face as reported by the resident's family member and Resident #5. These findings were reviewed with the Director of Nursing on 1/21/26 at 3:00 PM.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on medical record review, review of pertinent documents, and staff interviews, it was determined that the facility failed to provide the appropriate care for activities of daily living to residents for a resident who was dependent on staff for showers and bathing. This was evident for 1 (#) of 5 residents reviewed for quality of care. The findings include:ADLs are activities that people perform every day such as, getting dressed, taking showers or baths, cooking, and eating. On 1/16/26 at 11:11 AM, a review of complaint #2663151 which was received at the state office on 10/31/25, alleged while Resident #8's hygiene was poor prior to being discharged home from the facility and days the resident never got cleaned up A review of associated complaint #2663151, received at the state office on 11/7/25, alleged while at the facility, Resident #8, who was bedbound, incontinent and dependent on staff for care, was often left soiled for extended periods of time without assistance. Review of Resident #8's electronic medical record (EMR) revealed Resident #8 was admitted to the facility in mid-July 2025, for rehab following an acute hospitalization with diagnosis which included deep vein thrombosis (blood clot) bilateral lower limbs, s/p Inferior Vena Cava (IVC) filter placement, unstable T9 (9th thoracic vertebra) fracture, back pain and weakness, and discharged to home at the end of October 2025. Review of Resident #8's admission assessment with an assessment reference date (ARD) of 7/23/25 documented the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident was cognitively intact. The assessment documented Resident #8 required extensive assistance with 1-person physical assist for dressing, toileting, and personal hygiene and the resident was totally dependent on staff for bathing, with 1 person physical assist. Review of Resident #8's care plans, revealed a care plan, Resident #8 has an ADL Self Care Performance Deficit r/t deconditioning, weakness and recent hospitalization, with the goal, Resident #8 will improve current level of function with the intervention of rehab services x 90 days, with interventions that included, Resident #8, requires max assist of 1 with bathing, initiated on 7/17/25. Review of the Resident #8's Geriatric Nursing Assistant (GNA) task documentation, for August, September, and October 2025, printed from the electronic medical record (EMR) revealed Documentation Survey Report Forms that included the intervention/task, Bathing that was followed by space for the GNA to document the resident's bathing self-performance, bathing support provided, whether a bath or shower was given, and the resident's ability to bath themselves. Review of Resident #8's September 2025 Documentation Survey Report intervention/task for Showers schedule per preference, Tuesday and Friday, day revealed documentation indicating Resident failed to receive a shower on 7 (9/2, 9/5, 9/9/ 9/12, 9/16, 9/19, 9/26) of 9 scheduled shower days in September, and the resident refused a shower on 4 (9/9, 9/12, 9/16, 9/19) on 4 of those days. Review of Resident #8's October 2025 Documentation Survey Report intervention/task for Showers schedule per preference, Tuesday and Friday, day revealed documentation indicating Resident #8 failed to receive a shower on 4 (10/3, 10/10, 10/14, 10/17) of 5 shower days in October 2025. Review of Resident #8's August 2025 Treatment Administration Record (TAR) revealed a 7/17/25 order for showers every dayshift, every Tue., Fri., was discontinued on 8/26/25 and documented Resident #8 did not receive a shower on 2 (8/5, 8/22) and of 8 shower days. A 8/26/25 order for showers twice weekly on Tuesday and Friday, day shift; document all refusals with a progress note documented Resident #8 refused a shower on 8/28/25. Review of Resident #8's progress notes revealed on 8/22/25 at 9:26 AM, in an eMAR, Medication Administration Note, the nurse documented Resident #8 refused a shower and progress notes were found to indicate why the resident had not received a shower on 8/5/25 and 8/28/25. Review of Resident #8's September 2025 TAR revealed a 8/26/25 order for showers twice weekly on Tuesday and Friday, day shift; document all refusals with a progress note that documented</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #8 refused a shower on 8 (9/2, 9/9, 9/12, 9/16, 9/19, 9/23, 9/28, 9/30) of 9 shower days in September. Review of Resident #8's progress notes revealed there were no progress notes written to indicate why the resident had refused his/her showers in September. Review of Resident #8's October 2025 TAR revealed an 8/26/25 order for showers twice weekly on Tuesday and Friday, day shift, document all refusals with a progress note that documented Resident #8 did not receive a shower on 3 (10/3, 10/17, 10/21) of 7 shower days and had refused the showers on 10/3//25 and 10/17/25. Review of Resident #8's progress notes revealed in an eMAR, Medication Administration Note, on 10/21/25 at 2:25 PM, the nurse documented Resident #8 refused a shower. No progress notes were found to indicate Resident #8 had refused a shower on 10/3//25 and 10/17/25. Review of the medical record revealed the facility staff failed to follow the physician's order by failing to document in a progress note when Resident #8 refused a shower, and no documentation was found in the medical record to indicate the physician had been notified of the residents frequent refusal of showers. Continued review of Resident #8's medical record found no documentation to indicate why Resident #8 refused showers. The facility failed to update the resident's ADL care plan to reflect his/her frequent refusal of showers with a measurable goal and interventions to address the resident's bathing needs and preferences. In addition, no documentation found in the medical record to indicate the resident's representative was made aware of Resident #8's frequent refusal of showers. On 1/21/26 at 3:10 PM, the DON was made aware of the concerns. The DON responded, stating Resident #8 never or rarely took a shower, and thought this was documented in the medical record, and the DON would check her notes. No other documentation was provided to the surveyor by the time of exit on 1/23/26/</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, record review, and interviews, it was determined that the facility staff failed to implement the use of a gait belt resulting in avoidable falls. This was evident for 1 (#14) of 6 residents reviewed for a complaint. The findings include: Hemiparesis is weakness on one side of the body and hemiplegia is paralysis that affects only one side of the body. A gait belt (transfer belt) is a safety device used to stabilize, guide, or support a patient during mobility. On 1/22/26 at 9:43 AM, a review of complaint #2716523 was conducted. The complaint alleged that while at the facility recovering from a stroke, Resident #14 had three falls (10/24/25, 11/6/25, 11/27/25) in the presence of a staff member who failed to put a gait belt on the resident. On 1/22/25 at 10:30 AM, a review of Resident #14's electronic medical record (EMR) was conducted. The medical record documented Resident #14 was admitted to the facility in mid-October 2025 following an acute hospitalization with diagnosis which included hemiplegia and hemiparesis following cerebral infarction (stroke), affecting right dominant side, generalized muscle weakness, difficulty in walking, aphasia (language disorder resulting from brain injury), anxiety, and unspecified pain following cerebral infarction. Review of Resident #14's admission documented the resident was cognitively intact. Functional Abilities documented the resident required substantial/maximal assistance to roll left and right, sit to lying and sit to stand, transfer from one surface to another and to walk 10 feet. Fall History documented the resident had a fall in the last month prior to admission. Review of Resident #14's care plans revealed an ADL care plan, initiated on 10/15/25 had the intervention [Resident #14] requires mod (moderate) assist of 1 with transfers and gait belt that was initiated on 10/15/25, which was prior to the resident's fall on 10/24/25. On 10/24/25 at 10:30 PM, in a review, the nurse documented Resident #14 had a witnessed fall in the bathroom with the GNA (geriatric nursing assistant) while transferring from wheelchair to toilet. The resident was assisted off the floor by the nurse and the GNA, finished toileting, and placed in bed for final examination. A Fall Assessment was not completed following the fall. The nurse wrote that the resident was admitted for right sided weakness of both upper and lower extremities. On 10/25/25 at 12:42 PM, in a care plan note, the nurse documented Resident #14 had a witnessed fall in the bathroom while transferring from the wheelchair to the toilet with the GNA, and a new intervention, gait belt to be used with all transfers was added to the care plan, Resident #14 has had an actual fall. Continued review of the medical record revealed on 11/6/25 at 10:30 PM, in a general nurse's note, the nurse documented that when the GNA was transferring Resident #14 from the bed to the wheelchair, the resident's knees buckled, the resident went down onto the floor and sustained abrasions on each knee. The nurse documented that per the GNA, when the GNA assisted Resident #14 to transfer, the GNA did not use a gait belt resident. In an on-call practitioner note with a service date of 11/6/25 at 9:57 PM Central Time (CT), the Advanced Practice Nurse (APN) documented a telemedicine/virtual visit was conducted with Resident #14 for a fall with injury. The APN documented Resident #14 had a witnessed fall, sustained abrasions to both knees and left elbow, and treatment to the affected areas was ordered. On 11/7/25 at 12:07 AM, in a review assessment, the nurse documented Resident #14 had a fall that was witnessed by the GNA and sustained small bilateral skin tears to knees. Continued review of the medical record revealed a change in condition note with an effective date of 11/27/25 at 10:45 PM that documented Resident #14 had a witnessed fall transferring from toilet to chair and the resident was lowered to the floor by GNA. No injury. Review of a Change in Condition review 11/27/25 at 10:45 PM documented Resident #14 had a witnessed fall, with no injury. Fall Assessment documented the resident's pain was at baseline, and his/her ROM was within normal limits. The summary of the review documented that the resident had a</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>witnessed fall transferring from the toilet to the chair and was lowered to the floor by the GNA, and no injury. There was no documentation found to indicate a gait belt had been used during the resident's transfer which resulted in a fall. Further review of the 11/27/25 review and the medical record found no documentation to indicate the physician had been notified of the resident's fall or that the resident's representative had been notified of the fall. In addition, the review documented the date the resident's blood pressure, pulse and respirations was 12/11/25, indicating Resident #14 had not had vital signs obtained at the time of his/her fall. The review had an effective date of 11/27/25 at 10:45 PM, however, the date it was signed by the nurse was 12/11/25. No further documentation was found in the medical record to indicate a thorough assessment of Resident #14 at the time of his/her fall on 11/27/25. Continued review of the medical record revealed on 11/28/25 at 2:03 PM, the nurse documented the resident had a fall in the bathroom on 11/27 during transfer. On 1/23/26 at 1:14 PM, phone interview was conducted with Staff #6, Geriatric Nursing Assistant (GNA), assigned to Resident #14 on 11/6/25. Staff #6 recalled Resident #14 fell when the GNA was transferring him/her. Staff #6 stated s/he was not aware at that time that a gait belt was supposed to be used to transfer Resident #14 and stated s/he didn't think the resident had been issued a gait belt. Staff #6 stated that there is now a gait belt for the resident in his/her wheelchair, and signs on the wheelchair and door that say the resident uses a gait belt. Staff #6 stated s/he had received gait belt training at the facility, but wasn't aware s/he was supposed to use a gait belt to transfer Resident #14. On 1/23/25 at 1:33 PM, during an interview, Staff #7, RN stated s/he recalled Resident #14's having a fall in the evening of 11/6/25. Staff #7 stated the GNA came out of Resident #14's room, reported the fall, and said something about not seeing a gait belt in the room. Staff #7 indicated the resident was not receptive to talking about what happened with the fall. Staff #7 stated the resident scraped his/her knees when s/he fell, and the nurse called the on-call practitioner, and the resident's spouse. Staff #7 was not sure if a gait belt was in the resident's room at the time of the fall, and however s/he recently saw a gait belt and a sign for the resident to use a gait belt in the resident's room. On 1/23/26 at 2:48 PM, during an interview, Staff #8, Certified Occupational Therapy Assistant (COTA) stated Resident #14 was working on range of motion, function, and pain in occupational therapy, and after his/her falls, Resident #14 had right shoulder pain that was exacerbated by the falls, but had no discernable change in ROM. Staff #8 stated when Resident #14 was admitted to the facility, a gait belt was implemented for the resident who already had a gait belt that was provided by the family. Staff #8 stated that a resident who requires 1 person contact guard, minimal, moderate, or maximum assistance with transfers should use a gait belt. On 1/23/26 at 2:02 PM, during an interview, Staff #9, Physical Therapist (PT), stated s/he was Resident #14's primary PT and had done the resident's PT evaluation and treatment. Staff #9 stated Resident #14 has had a problem with his/her right arm and pain in the arm prior to coming to the facility. Staff #9 stated that Resident #14 had his/her own gait belt since coming from the hospital, and after the resident's first fall, therapy put a sign to use a gait belt on the resident's wheelchair, overbed tray and on the door. Staff #9 stated that after a resident is evaluated, a communication form with the resident's functional status is filled out and put in the resident's paper chart. Staff #9 stated that a gait belt should be used for residents who require 1- or 2-person assistance for transfer and that all the GNA's should know they need to use a gait belt for these residents. On 1/23/25 at 3:30 PM, during an interview, Resident #14 stated that s/he's had a gait belt since being admitted to the facility, that the staff know they're supposed to use the gait belt to transfer him/her, but sometimes they don't, and s/he still needs to tell them to use it to transfer him/her. Resident #14 stated s/he has had 3 falls during</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215313	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glade Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 56 West Frederick Street Walkersville, MD 21793	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a transfer, and is terrified of falling again. Resident #14 indicated that before s/he fell, s/he had right shoulder pain, and indicated his/her pain was worse after the falls and during therapy. On 1/23/26 at 4:01 PM, during an interview, the Director of Nurses (DON), was asked how staff would know they were to use a gait belt with a resident, and the DON responded that it would be in the resident's documentation and indicated staff would know which residents need to use the gait belt for transfers based on the training they received. The DON stated that the training began on 10/15/25, that gait belts were purchased around that time, that now, in every room there is a gait belt for each resident and prior to the training, gait belts were not available in the facility. During an interview on 1/23/26 AT 5:00 PM, Staff #8, COTA, stated the expectation is for a gait belt to be used on all residents assessed as needing minimal, moderate, maximum and contact guard assistance with transfers. Staff #8 stated that a resident's ability to transfer is assessed by PT on admission, documented in an initial PT evaluation, and a notice is put in the resident's paper chart. Staff #8 stated the PT assessment does not directly state the need for a gait belt; however, all staff were trained to know when a gait belt should be used. Staff #8 stated that a facility wide policy was implemented for gait belts to be used on all residents assessed as needing minimum, moderate, maximum and contact guard assistance with transfers, and there is a gait belt for each resident bed hanging on a hook in all resident rooms. Staff #8 stated that upon admission to the facility, a resident's ability to transfer is assessed by the physical therapist (PT) and documented in an initial PT evaluation, and a notice is put in the resident's paper chart. Staff #8 stated a facility wide policy for gait belts to be used on all residents assessed as needing minimum, moderate, maximum and contact guard assistance with transfers and there is a gait belt for each resident bed hanging on a hook in all the resident rooms. Staff #8 stated the PT evaluation does not state the need for a gait belt; however, all staff were trained to know when a gait belt should be used. On 1/23/26 at 6:33 PM, the DON was made aware of the above concerns with the facility staff transferring Resident #14 without the use of a gait belt, which resulted in 3 avoidable falls, including one fall with injury (11/6/25). The DON acknowledged the concerns and indicated one of the falls was related to the wheelchair moving back and the resident was given an antilock wheelchair. The DON was made aware that the intervention for an antilock wheelchair was initiated on 11/28/25, after his/her fall on 11/27/25, and no documentation about the wheelchair moving was found in the medical record to indicate it was a factor in the fall. The concerns with incomplete assessment documentation following the resident falls was discussed with the DON, and the DON acknowledged the concerns at that time.</p>		