STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215315	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Oak Manor	3415 Greencastle Road Burtonsville, MD 20866

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on facility documentation, medical record review and interviews, it was determined the facility staff failed to treat a resident with dignity and respect. This was evident for 1 (Resident #6) of 6 residents reviewed during a compliant survey. The findings include:Review of Facility Reported Incident 3023073 was conducted on 5/27/26 regarding Physical Therapist (PT) #5 walking in on Resident #6 unclothed on 5/22/26.Review of Resident #6's medical record revealed the Resident was admitted to the facility for rehabilitation following a hospitalization in April 2026.Further review of Resident #6's medical record revealed the Resident was assessed on 4/21/26 by the facility staff to have a BIMS (Brief Interview for Mental Status) of 15 out of 15, indicating the Resident is cognitively intact.During interview with Resident #6 on 5/27/26 at 11:30 AM, Resident #6 stated last Friday (5/22/26) he/she was in the bathroom with the door closed and unclothed from the waist up. The Resident stated a man from physical therapy (PT #5) knocked on his/her door. Resident #6 stated he/she said someone is in here but the man opened the door anyway. The Resident stated PT #5 stated: I don't care I am from physical therapy, and I need to see (another resident's name which the Resident couldn't remember). The Resident stated he/she told PT #5 You don't need to be in here and turned from him to cover myself'. The Resident stated PT #5 had the door wide open and stood there for what seemed like 2-3 minutes. The Resident stated I reported it to the staff and they had me write up a grievance.During interview with PT #5 via the phone on 5/27/26 at 12:16 PM, PT #5 stated he/she got his list of residents to see and mistakenly went to the wrong floor. PT #5 stated he knocked on the door of Resident #6 twice, but no one answered so he entered the room and was expecting to see the Resident in bed. PT #5 stated he then proceeded to look around the room and didn't see the Resident. PT #5 stated as he was leaving the room he noticed the bathroom door was closed. PT #5 stated he knocked on the door and heard someone say I am in the bathroom. PT #5 stated he should have asked the Resident if they were okay but instead cracked the door open because he stated he was worried about the Resident's safety. PT #5 stated the Resident then said to him, You shouldn't have done that. PT #5 stated he/she believed the Resident was covered but could not recall what the Resident was wearing. PT #5 stated he only opened the door a few inches. PT #5 stated the Resident was seated in a wheelchair turned sideways. PT #5 stated he then closed the door and apologized to the Resident through the closed door.Interview with the Administrator on 5/27/26 at 12:56 PM confirmed PT #5 failed to treat Resident #6 with respect and dignity by opening the bathroom door without the Resident's consent.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on review of complaint 2997160, medical record review, and interview, it was determined that the facility staff failed to notify the resident's physician/nurse practitioner when the resident had a change in vital signs that had the potential for physician intervention. This was evident for 1 (Resident #2) of 7 residents reviewed during a complaint survey.The findings include:On 5/28/26 at 7:47 AM a review of complaint 2997160 alleged communication concerns.Review of Resident #2's medical record revealed the resident was admitted to the facility in January 2026 with diagnoses including cerebral infarction, hypertension, atherosclerotic heart disease, and inappropriate sinus tachycardia (a heart rhythm condition where the heart beats too fast for no apparent reason, exceeding 100 beats per minute (bpm) at rest). A normal resting heart rate is 60 to 100 bpm.Review of Resident #2's heart rates from January 2026 to 3/4/26 ranged from 57 beats per minute to 89 beats per minute.Review of Resident #2's March 2026 Medication Administration Record (MAR) revealed the resident's heart rate was documented as elevated to 122 beats per minute on 3/5/26 at 9:00 AM.Continued review of Resident #2's medical record failed to produce documentation that the physician or nurse practitioner (NP) were notified of the increase in heart rate since that was the first time that the heart rate was documented over 100 bpm since the resident's admission in January 2026.On 5/28/26 an interview was conducted with Licensed Practical Nurse (LPN) #11, who was also the unit manager. LPN #11 was asked what she would expect the nurse to do if a resident's heart rate was 122 and the resident's normal range averaged in the 70s to 80s. LPN #11 stated she would expect the physician to be notified because, looking at the range of heart rates, the resident's rate was way off. LPN #11 stated, I would notify the doctor to let him know what the normal heart rate has been and if he wanted to do anything or just watch it. I would also recheck the heart rate after the medication was given to see if there was any improvement.On 5/28/26 at 12:45 PM an interview was conducted with Nurse Practitioner (NP) #13. NP #13 was asked if he would expect to be notified about a heart rate of 122 and he said, yes, I would expect to be notified because a lot of things are going through my mind right now. Is the patient symptomatic, is the respiratory rate up, is he/she septic. I always try to tell the nurse when you get an abnormal rate, is the patient stable, recheck it, maybe they have pain or are positioned incorrectly. Let us know what is going on.On 5/28/26 at 2:10 PM the Director of Nursing (DON) and the Corporate Nurse were informed of the findings. They both agreed with the findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of complaint 2997160, medical record review, and interview, it was determined that the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 1 (Resident #2) of 7 residents reviewed during a complaint survey.The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate.On [DATE] at 7:47 AM a review of complaint 2997160 alleged concerns related to medications being delayed or missed.Review of Resident #2's medical record revealed the resident was admitted to the facility in [DATE] with diagnoses including cerebral infarction, hypertension, atherosclerotic heart disease, and inappropriate sinus tachycardia (a heart rhythm condition where the heart beats too fast for no apparent reason, exceeding 100 beats per minute (bpm) at rest). A normal resting heart rate is 60 to 100 bpm.Review of Resident #2's heart rates from [DATE] to [DATE] ranged from 57 to 89 beats per minute.Review of Resident #2's [DATE] Medication Administration Record (MAR) revealed the resident's heart rate was documented as elevated to 122 beats per minute on [DATE] at 9:00 AM.Review of nursing progress notes, evaluations, and the vital sign section of the electronic medical record failed to produce documentation that the resident's heart rate was assessed between 9:00 AM and 8:00 PM on [DATE]. There was no documentation regarding whether the heart rate decreased or if Resident #2 had any symptoms related to the increased heart rate.Continued review of Resident #2's [DATE] MAR documented that on [DATE] at 8:00 PM the medications Atorvastatin, Famotidine, Metoprolol, and Acetaminophen were signed off as not given because Resident #2 had passed away suddenly.Review of a [DATE] at 22:36 (10:36 PM) change in condition note documented Resident #2 was assessed with no pulse, no BP, and no respiration at 10:00 PM. A code blue was called and 911 was called. The paramedics entered the resident's room at 10:07 PM as CPR was in progress. Paramedics took over CPR until 10:36 PM when the resident was pronounced as deceased .On [DATE] an interview was conducted with Licensed Practical Nurse (LPN) #11, who was also the unit manager. LPN #11 was asked what she would expect the nurse to do if a resident's heart rate was 122 and the resident's normal range averaged in the 70s to 80s. LPN #11 stated, I would notify the doctor to let him know what the normal heart rate has been and if he wanted to do anything or just watch it. I would also recheck the heart rate after the medication was given to see if there was any improvement. LPN #11 confirmed there was no documentation in the medical record that the resident's heart rate was reassessed after the morning medication was given.On [DATE] at 10:13 PM Registered Nurse (RN) #12 was interviewed and asked why Resident #2's 8:00 PM medications were not signed off at 8:00 PM on [DATE] but were signed off as not given due to the resident passing away at 10:36 PM on [DATE]. RN #12 stated that she gave Resident #2 the medications at 9:00 PM. RN #12 stated, I was supposed to sign the MAR afterwards, but I had to wait for [him/her] for about 15-20 minutes to swallow the medications and then I went to the next patient, so I didn't sign it off until later. RN #12 stated, the office asked me to write a statement about the medication, but before I signed the medication off the code happened, but [he/she] did take the medication. On [DATE] at 10:40 AM the Director of Nursing (DON) gave the surveyor an employee statement for the incident on [DATE] at 10:00 PM. The nurse (RN #12) documented in the statement that the evening medications were given at 9 PM. However, discussed with the DON that the medical record did not reflect that the medications were given.Further review of RN #12's written statement revealed that Resident #2 was assessed after RN #12 came on duty after 3:00 PM on [DATE]. The statement documented that vital signs were normal during her shift and that Resident #2 had no complaints or adverse effects from the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elevated heart rate in the morning, however the medical record did not reflect Resident #2's health status as there was no documentation. The DON confirmed the surveyor's findings.