

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/05/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Lake Healthcare at Oakview		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Barker Street Silver Spring, MD 20910	

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 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on record review, resident interview, and staff interview, it was determined that the facility failed to maintain proper bookkeeping techniques as evidenced by not giving the resident or retaining a copy of a receipt of a transaction. This was evident for 1 (Resident #44) out of 1 resident reviewed for personal funds. The findings include: On 8/1/2025 at 8:32 AM, a review of Complaint #335655 was conducted. The complainant, Resident #44, questioned a deduction of \$1000 from his funds on 9/22/2022. On 8/1/2025 at 12:44 PM, an interview was conducted with Resident #44 in regards to Complaint #335655. Resident #44 reiterated wants to know what a \$1000 dollar charge was for on 9/22/2022. They stated that they have talked to the Business office and the corporate financial group about the \$1000 dollar charge. The resident provided the survey team with a copy of his quarterly statement with the questioned \$1000 deduction from his account labeled Personal Needs Items. The resident stated when he requested a copy of the receipt for the transaction, the facility was unable to provide it. On 8/1/2025 at 2:24 PM, an Interview was conducted with the Business Office Manager (Staff #19). When asking the Staff #19 if and when they became aware of Resident #44's concern, they stated a complaint was received by the social services department in the form of a grievance from Resident #44 on 3/28/2025. They stated that the grievance was investigated to see if a receipt and record of the \$1000 transaction labeled Personal Needs Items was in the business office records, but it was not found. The Business office manager stated that on 4/4/2025, they reported this to the Nursing Home Administrator (NHA). A copy of the email notification made to the NHA and the original grievance from Resident #44 was provided to the survey team. The grievance form was dated 3/28/2025. The email was dated on 4/4/2025. When asked if they have provided Resident #44 with a response to his concern in writing, Staff #19 stated No.</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
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<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 review of facility investigations, resident medical records, and interviews with facility staff, it was determined that the facility failed to ensure that residents remained free of abuse. This was true for 3 (Resident #104, Resident #21 and Resident #146) of 11 residents reviewed for abuse during the survey. The Findings include: 1) The facility's investigation related to facility reported incident 335653 was reviewed by the survey team on 8/4/2025 at 8:04 AM. Per medical record review and review of the facility investigation, on 3/18/2025 at 12 PM, Licensed Practical Nurse (LPN) #1 witnessed Resident #104 walk out of their room and walk next to Resident #33, who was sitting in a chair outside of their room. LPN #1 then witnessed Resident #33 hit Resident #104 in the abdomen which caused them to fall and sustain a hematoma to their head and be sent to the emergency room for evaluation.</p> <p>LPN #1 was interviewed by the survey team on 8/4/2025 at 2:28 PM. LPN #1 confirmed she witnessed Resident #33 push Resident #104 unprovoked, who then fell to the floor and sustained an injury.</p> <p>2) The facility's investigation related to facility reported incident 335654 was reviewed by the survey team on 8/4/2025 at 9:53 AM. In the investigation, the facility substantiated through witnesses (LPN #20, Geriatric Nursing Assistant (GNA) #21, GNA #22) that Resident #33 pushed Resident #21 which resulted in Resident #21 falling to the floor and being sent to the emergency room due to pain.</p> <p>On 8/4/2025 at 3:27 PM, GNA #21 was interviewed by the survey team about the incident. GNA #21 stated that Resident #21 was seating in a chair and got up when Resident #33 sat down in the chair. Resident #21 then walked back to the seat when Resident #33 stood up and pushed Resident #21 who fell to the ground.</p> <p>On 8/4/2025 at 3:40 PM, the Nursing Home Administrator (NHA) was interviewed by the survey team. The NHA verbally stated that both incidents of alleged resident to resident abuse were substantiated through their respective investigations.</p> <p>3) A medical record review for Resident #146 on 7/29/25 at 7:54 PM revealed the resident had a diagnosis of dementia and resided on the locked unit.</p> <p>On 7/29/25 at 8:14 PM a review of the facility's investigation file revealed the initial report form that read the facility received an allegation of abuse involving Resident #146 on 12/6/24 at 7:55 PM. According to the final report form, a family member of a resident who resided on the locked unit, was trying to find the charge nurse to let them out of the locked unit and observed the nurse slapping the Resident #146. The family member reported what they saw to facility staff. The nurse was asked to leave the facility immediately and was terminated when the abuse was substantiated. The resident no longer resided in the facility.</p> <p>An attempt was made on 8/5/25 at 10:22 AM to call the family member who had witnessed and reported the incident, but it was unsuccessful.</p> <p>During an interview with the Director of Nursing (DON) on 8/5/25 at 10:25 AM, she confirmed the findings. She stated that the family member, who had been coming to the facility for a long time, was visibly upset by the incident and believable.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>Based on record review, resident interviews, and staff interviews, it was determined the facility failed to protect the resident from misappropriation of property. This was evident for 1 out of 1 resident reviewed for personal funds. The findings include: On 8/1/2025 at 8:32 AM, a review of Complaint #335655 was conducted. The complainant, Resident #44, questioned a deduction of \$1000 from their funds on 9/22/2022. On 8/1/2025 at 12:44 PM, an interview was conducted with Resident #44 in regards to Complaint #335655. Resident #44 reiterated wants to know what a \$1000 dollar charge was for on 9/22/2022. They stated that they have talked to the Business office and the corporate financial group about the \$1000 dollar charge. The resident provided the survey team with a copy of their quarterly statement with the questioned \$1000 deduction from their account labeled Personal Needs Items. The resident stated when they requested a copy of the receipt for the transaction, the facility was unable to provide it. On 8/1/2025 at 2:24 PM, an Interview was conducted with the Business Office Manager (Staff #19). When asking the Staff #19 how they became aware of this incident, they stated a complaint was received by the social services department in the form of a grievance from Resident #44 on 3/28/2025. They stated that the grievance was investigated to see if a receipt and record of this transaction was in the business office records, but it was not found. The Business office manager stated that on 4/4/2025, they reported this to the Nursing Home Administrator (NHA). A copy of the email notification made to the NHA and the original grievance from Resident #44 was provided to the survey team. The grievance form was dated 3/28/2025. The email was dated on 4/4/2025. When asked if they have provided Resident #44 with a response or resolution to their concern, Staff #19 stated No. On 8/1/2025 at 2:48 PM, during an interview with the NHA, when asked if they were aware of Resident #44's concern regarding \$1000 missing finances from their account in September of 2022. The NHA stated they were aware and have been trying to get the issue resolved with their corporate finance group. When asked if they reported the alleged incident of misappropriation of Resident #44's funds to the proper authorities on April 4th, 2025; the NHA stated that they did not. On 8/04/2025 at 9:10 AM, an interview was conducted with the NHA. When asked to provide an update on Resident #44's concern, the NHA stated that on 8/1/2025 they requested their finance group to process the return of funds if they are unable to provide the facility with records of the receipt of the 1000 dollar Personal Needs Items transaction.</p>		

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<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 record review and staff interviews, it was determined that the facility failed to: 1) report an injury of unknown origin to the state agency in a timely manner, and 2) ensure that incidents of alleged abuse were reported to the state agency in a timely manner. This was found to be evident in 3 (Incident 335642, Incident 335653 and Complaint 335655) of 29 intakes investigated during the survey. The findings include:</p> <p>1) On 8/1/2025 at 12:26 PM, documentation provided by facility regarding Incident 335642 was reviewed by the survey team involving Resident #121. Per record review, Resident #121 was noted to have discoloration around their left eye during AM care on 7/20/2024 by staff. Resident #121 has a diagnosis of dementia and could not provide information on injury at the time it was noticed. Further record review revealed that the Director of Nursing (DON) and Nursing Home Administrator (NHA) were notified of the injury of unknown origin on 7/22/2024. Email documentation showed that the initial report of the injury of unknown origin was sent to the state survey agency on 7/22/2024 at 4:44 PM.</p> <p>The NHA was interviewed on 8/1/2025 at 2:30 PM. They stated that it's the facility's expectation that staff inform the DON and NHA of alleged abuse or injuries of unknown origin immediately so the appropriate state agencies can be notified, and the facility can begin their investigation. The NHA stated the notification of these incidents has been an on-going problem and they have had multiple in-services with staff on this issue. Surveyor addressed concern with the NHA that facility did not report the injury of unknown origin in the appropriate timeframe. 2a.) On 8/4/2025 at 8:04 AM, documentation provided by the facility regarding Incident 335653 was reviewed by the survey team involving Resident #104. Per record review, on 3/18/2025 at 12 PM, Resident #104 was witnessed by Licensed Practical Nurse (LPN) #1 walking next to another resident that was sitting in a chair outside of their room. The resident in the chair then hit Resident #104 in the abdomen resulting in them falling and sustaining a hematoma to their head. Further record review showed the NHA was made aware of the incident on 3/19/2025 at 10:00 AM. Per email confirmation, the incident was reported to the state survey agency on 3/19/2025 at 1:20 PM. On 8/4/2025 at 3:40 PM, the surveyor addressed concerns about the alleged resident-to-resident abuse not being reported in the 2-hour time frame to the state survey agency to the NHA. The NHA verbally substantiated the resident-to-resident abuse and stated that the facility's expectation is to report the alleged abuse within the 2-hour timeframe. 2b.) On 8/1/2025 at 8:32 AM, a review of Complaint #335655 was conducted. The complainant, Resident #44, questioned a deduction of \$1000 from their funds on 9/22/2022. On 8/1/2025 at 2:24 PM, an interview with the Business office manager (Staff #19) was conducted. When asked about when they became aware of the resident's concern, Staff #19 stated that a grievance came from the social services department, and it was investigated to see if a receipt or record of this transaction was in their records. It was not found, so on 4/4/2025 I reported this to Nursing Home Administrator (NHA). A copy of email notification made to NHA dated 4/4/2025 and a copy of the grievance from Resident #44 dated 3/28/2025 was provided to the survey team. On 8/1/2025 at 2:48 PM, during an interview with the NHA, when asked if they were aware of Resident #44's concern regarding \$1000 missing finances from their account in September of 2022. The NHA stated they were aware and have been trying to get the issue resolved with their corporate finance group. When asked if they reported the alleged incident of misappropriation of Resident #44's funds to the proper authorities on April 4th, 2025; the NHA stated that they did not.</p>		