STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215338	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Oakview	2700 Barker Street Silver Spring, MD 20910

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on record review and staff interview, it was determined the facility failed to accurately code the residents' status in the Minimum Data Set Assessment. This was evident for 4 (Resident #138, Resident #1, Resident #4 and Resident #10) out of 8 residents reviewed for Accuracy of Assessments.The findings include: Aripiprazole (often sold under the brand name Abilify) is an atypical or second-generation antipsychotic medication. It's used to treat various mental health conditions such as Bipolar. Fluoxetine hydrochloride is a widely used antidepressant medication, commonly known by its brand name Prozac. It is commonly used to treat depression. Minimum Data Set (MDS) The MDS is a federally mandated assessment tool that helps nursing home staff members gather information on each resident's strengths and needs. The information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. 1). On 7/25/2025 at 1:29 PM, a review of Resident #138's progress notes was conducted. Multiple notes on 5/11/2025 indicate that the resident discharged home Against Medical Advice (AMA). On 7/25/2025 at 1:31 PM, a review of the Resident #138's Minimum Data Set (MDS) was conducted. In the Discharge return not anticipated MDS assessment submitted on 5/19/2025, it was coded under Section A-A2105 that the discharge location of the resident was Short-Term General Hospital. On 7/28/2025 at 8:33 AM, an interview with the MDS coordinator (Staff #3) was conducted. When asked how they determined which discharge location to code the Resident in the MDS assessment, Staff #3 stated that they look at Nursing Notes, Social Services notes, and looks at the census for discharge information. This surveyor confirmed Resident #138's progress notes and MDS findings with Staff #3. Staff #3 stated that they should have coded Resident #138's discharge location as Home and not Short Term General Hospital. 2). On 7/29/2025 at 11:56 AM a review of Resident #1's medical record was conducted. The resident's active orders were Aripiprazole Oral Tablet 5mg daily for bipolar disorder and Fluoxetine hydrochloride 20 mg daily for Depression. Review of Resident #1's Medication Administration Record (MAR) revealed that the resident was currently taking medications daily indicated for bipolar disorder and Depression. Review of Resident #1's psychiatric notes dated 7/2/2025 indicated an assessment and plan to continue treatment for Bipolar as well as Depression Disorder. (continued on next page)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/2025 at 11:02 AM further review of Resident #1's MDS completed on 7/6/2025 failed to reflect an active diagnosis of Depression Disorder. On 7/30/2025 at 12:10 PM an interview with Staff #3, MDS coordinator, was conducted. She reported that she did not look at the psychiatric note dated 7/2/25 and that she missed coding Depression disorder on MDS. On 7/30/2025 at 12:35 PM the Facility Administrator and Director of Nursing (DON) were notified of the concerns. 3). A review of Resident #4's medical record on 07/29/2025 at 12:28 PM, revealed that a MDS was completed on 07/03/2025. The MDS coded that the resident, under Section N0421 (medications received), was receiving an anticoagulant in the last 7 days. On 07/29/25 at 12:33, a review of the resident's orders, at the time of the MDS review period, revealed that there was no order for anticoagulation medications. On 07/29/2025 at 12:35 PM, a review of the resident's Medication Administration Record (MAR) for June and July of 2025 revealed that the resident was not receiving anticoagulant medications. The MDS Coordinator (staff #3) was interviewed on 07/30/2025 at 11:14 AM. During the interview she stated that she would review the residents MAR and based on what she found is how she would code the MDS. On 07/30/2025 at 11:48, during a second interview, the MDS Coordinator confirmed that the MDS was coded incorrectly. After surveyor intervention, the MDS was corrected. 4). On 07/29/2025 at 11:56 AM, a review of Resident #10's medical record revealed an MDS that was completed 5/14/25. The MDS coded that the resident, under Section N0421 (medications received), was receiving an anticoagulant. On 07/29/2025 at 11:58 AM, a review of the resident's orders, at the time of the MDS review period, revealed that there was no order for anticoagulation medications. On 07/29/2025 at 12:04, a review of the resident's Medication Administration Record (MAR) for April and May of 2025 revealed that the resident was not receiving anticoagulant medications.During an interview with the MDS Coordinator (staff #3) on 07/30/2025 at 11:14 AM, she stated that she would review the residents MAR and based on what she found is how she would code the MDS. On 07/30/2025 at 11:48, during a second interview, the MDS Coordinator confirmed that the MDS was coded incorrectly. After surveyor intervention, the MDS was corrected.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, facility documentation, and staff interviews, it was determined that the facility failed to maintain refrigerated food temperatures at a safe level. This was found to be evident for the 3rd floor nourishment room refrigerator during the annual survey.The findings include:PHF (Potentially Hazardous Food) and TCS (Time/Temperature Control for Safety) foods are foods that require specific time and temperature controls to limit the growth of harmful microorganisms. According to the Food and Drug Administration recommendations and regulations, TCS/PHF foods must be stored at 41 F or below.The 3rd floor nourishment room refrigerator was observed by the survey team on 7/24/2025 at 10:24 AM. A sign located on the outside of the refrigerator stated the refrigerator is reserved for resident's only. It was observed by the surveyor that the thermostat inside the refrigerator read 52 F. Review of the temperature logbook located on top of the refrigerator showed signed documentation from staff that the refrigerator temperature was 38 F on 7/24/2025.The 3rd floor nourishment room refrigerator was observed on 7/25/2025 at 11:48 AM by the survey team and the thermostat inside the refrigerator read a temperature of 50 F. The logbook was reviewed and showed the documented temperature by staff was 38 F on that day. An additional observation on 7/28/2025 at 12:50 PM by the survey team revealed the thermostat inside the refrigerator read 54 F but the logbook kept by the facility had a documented temperature of 38 F.Geriatric Nursing Assistant (GNA) #11 was interviewed on 7/28/2025 at 1:09 PM and asked to show where food brought from outside the facility is stored for residents on the 3rd floor. GNA #11 showed the surveyor the 3rd floor nourishment room refrigerator and stated that outside food is dated and labeled and placed inside the refrigerator for residents. At 1:12 PM, the 3rd floor unit manager registered nurse (RN) #12 was asked to show where resident food brought from outside the facility is stored. RN #12 showed the surveyor the same refrigerator as GNA #11. RN #12 was asked if the thermostat inside the refrigerator is used for documenting temperatures and they answered yes. Surveyor addressed concerns to RN #12 about the actual reading temperature of the thermostat and what was being documented in the temperature logbook. RN #12 stated they were not aware of temperature discrepancies and stated that night shift nurse is responsible for documenting the daily temperature of the refrigerator. They also stated they would inform maintenance and educate staff.The surveyor addressed concerns about the refrigerator temperature with the Director of Nursing (DON) on 7/28/2025 at 1:46 PM. They stated the would talk with the 3rd floor unit manager and make maintenance aware.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on resident interview, facility documentation review, and staff interviews, it was determined that the facility failed to ensure that a resident's requested shower preference was honored. That was found to be evident in 1 (Resident #11) of 3 residents reviewed for choices during the annual survey. The findings Include: On 7/24/2025 at 10:30 AM, Resident #11 was interviewed by the survey team. When questioned by the surveyor if they had received a shower this week, Resident #11 shook their head no. When the resident was asked if they would like to receive showers, the resident nodded their head and said yes. On 7/28/2025 at 10:30 AM, Resident #11's medical record was reviewed by the surveyor. The resident had an order for bi-weekly showers during day shift on Mondays and Thursdays. Review of the documentation survey report for May 2025, June 2025, and July 2025 showed the resident was documented as having bed baths on scheduled shower days. Further review of Resident #11's records revealed no documentation of their refusal to shower. On 7/28/2025 at 12:54 PM, Resident #11 was asked by surveyor if they received their scheduled shower for the day and they stated no. When asked if they received a bed bath for the day, the resident replied yes. The resident stated to the surveyor that they would like a shower. On 7/28/2025 at 12:58 PM, Licensed Practical Nurse (LPN) #13 was interviewed by the survey team, in attendance was the Assistant Director of Nursing (ADON) and the 3rd floor unit manager registered nurse (RN) #12. When asked why Resident #11 received a bed bath on a scheduled shower day, LPN #12 stated the resident wants to get into their power chair quickly in the morning and prefers bed baths. Surveyor addressed to staff the lack of documentation showing bed baths as the resident's preference and Resident #11's desire to receive their shower on schedule shower days. The ADON stated they would go talk with the resident. On 7/28/2025 at 2:11 PM, the surveyor's concern with Resident #11 not receiving showers on their scheduled days was addressed with the Director of Nursing (DON). The DON stated she will educate staff about honoring Resident #11's preferences.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review, resident interviews, and staff interviews, it was determined the facility failed to record and make prompt efforts to resolve grievances. 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, it was determined that the facility failed to prevent a resident with cognitive impairment from leaving the facility unsupervised. This was evident for 1 (#143) of 3 residents reviewed for elopement.The findings include:On 7/28/25 at 9:49 AM a review of the facility's policy titled, Elopement, Risk Prevention and Management of Missing Residents, implemented 1/15/20 revealed that staff were to conduct an elopement assessment upon admission, readmission, quarterly, and upon significant change. If a resident was deemed a low risk (0-8 points) for elopement there was no intervention implemented. If they are deemed to be at risk (9-10 points) the IDT was to review the assessment and determine the care plan interventions and if they were a high-risk (11 or more points) staff were to implement a wander guard bracelet per standing order. A closed medical record review for Resident #143 on 7/25/25 1:55 PM revealed a transfer report from the acute care hospital the documented the resident had been at another facility owned by the same corporate company and was admitted for hypoglycemia (low sugar levels in the blood). Review of the document revealed the resident had a diagnosis of dementia The H&P from Suburban Hospital DOS 1/30/24 revealed a diagnosis of dementia and the plan for treatment was Paxil (antidepressant) and tramadol (pain medication). A History and Physical assessment from the hospital was included and read that the resident had the diagnosis of dementia and the treatment plan noted the resident was on Paxil and Tramadol to treat the dementia. A review of the electronic medical record on 7/25/25 at 2:05 PM revealed an admit/readmit screener dated 2/5/24 that read the resident had a diagnosis of dementia, the resident was able to walk in their room, in the hallways on and off the unit with limited assistance, and no wheelchair was marked. Review of a wandering/elopement assessment that was completed on 2/5/24 by License Practical Nurse (LPN) Staff #24. She failed to note that the resident had a diagnosis of dementia which was 5 points versus 0 and she failed to mark that the resident was ambulatory which was another 3 points versus 1 point. These inaccurate responses gave the resident a score of 2 points making the resident a low risk, however it should have been 9 points making the resident at risk for elopement and according to the policy the IDT would have reviewed the resident and determined the appropriate intervention to ensure the resident's safety. The baseline care plan that was completed on 4/6/24 by Unit Manager (UM) Staff #12 noted the resident did not have a wheelchair, the cognitive status was blank, and the resident was marked as not an elopement risk. On 2/6/24 the attending physician deemed the resident not to have capacity to make decisions. On 2/7/24 a second physician confirmed this finding. There were no additional wandering/elopement assessments completed until 4/5/24. The facility's investigation file for self-reported incident #MD00335640 was reviewed on 7/25/25 at 10:15 AM. The initial report read that Resident #143 was found outside in the parking lot on 4/5/24 at 4:05 PM attached to the report was a Resident sign in and out log for 4/5/24, that showed the resident had signed at 4:03 PM. A handwritten interview with Receptionist Staff #25 revealed the resident wanted to go outside and because the resident wasn't on the elopement risk list, she allowed the resident to sign out. Staff #25 reported the resident was going up the hill and was about 100 ft from the property line when an employee drove up behind the resident. She reported the resident was brought back inside by the UM Staff #12. On the same handwritten note it read the resident was reassessed and determined to be an elopement risk and a wander guard bracelet (causes alarm to sound if the resident is too close to the front doors) was put on the resident. LPN #24 was interviewed on 7/31/25 at 2:47 PM regarding the wandering/elopement risk assessment she completed on 2/5/24 for Resident #143. She referred to the transfer report in the medical record as the report she used to complete the wander elopement assessment. She reported that she missed the diagnosis of dementia on the elopement sheet. When asked about the resident's mobility, she stated she marked it wrong on the elopement assessment because she remembers the resident was up and walking on the day of admission. While reviewing the wandering/elopement risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment she was asked if she thought the resident was an elopement risk. She stated she did not think s/he was because the resident was not exit seeking on admission. Reviewed the inaccurate answers and the score should have been a 9 deeming the resident at risk for elopement, she was asked what she would have done differently? She stated she would have called the front desk immediately to make them aware, notified her supervisor, and monitored the resident more closely. The concerns were reviewed with the Director of Nursing (DON) on 7/31/25 at 3:21 PM. The DON stated that the ambulatory status of the resident may be difficult to determine. However, when shown the facility admission screening documentation and LPN #24's report that the resident had been walking around the day of admission, she would have expected the resident to be marked ambulatory. In addition, she confirmed the diagnosis of dementia should have been marked appropriately making the resident at risk for elopement.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observations, record review, and interviews, it was determined that the facility staff failed to properly assess and monitor a resident's wander guard. This was evident for 1 (Resident #39) of 2 residents reviewed for elopement during the recertification survey.The findings include:On 7/24/2025 at 3:33 PM While conducting second floor unit observations, Resident #39 approached the surveyor and said that they would like to go home. The resident stated, this place feels like a prison. The surveyor then redirected the resident to the second-floor nurses' station. On 7/24/2025 at 3:43 PM A review of Resident #39's medical record was conducted. The review indicated that the resident scored as high risk for elopement on 6/17/25 with a note that stated the resident had multiple attempts to elope. On 7/17/25, there was an order entry to check wander guard placement every shift daily. On 7/30/2025 at 7:11 AM Surveyor observed Resident #39 walking around the first floor. When surveyor asked Resident #39 if they needed assistance, the resident replied that they were desperate to leave the facility. The resident had no wander guard on the right ankle. On 7/30/2025 at 7:25 AM A brief review of the resident's record revealed that facility staff had checked placement of the wander guard on 7/29/25, morning, afternoon and nightshift. On 7/30/2025 at 7:38 AM The surveyor redirected Resident #39 to the second floor. Staff #23, the night shift supervisor, confirmed that the resident did not have a wander guard on. When asked where the wander guard was, Resident #39 replied that they threw the wander guard in the toilet 4 days ago because they felt like they were being tracked. On 7/30/2025 at 7:49 AM An interview with the Staff #7 was conducted. She acknowledged that she documented that the wander guard was on the Resident #39's right ankle without checking for the wander guard placement. On 7/30/2025 at 8:12 AM An interview with the Facility Administrator was conducted. He stated that Resident #39 was at a very high risk for elopement, and that he was aware of the resident's request to leave the facility. The surveyor then briefed the administrator of the wander guard concerns identified.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interviews and record review, it was determined that the facility failed to accommodate resident's food preferences and intolerances. This was evident for 1 (Resident #133) of 3 residents reviewed for food choices during the recertification survey. The findings include:On 8/01/2025 at 10:00 AM During the resident council meeting, a facility task that was completed during the survey, Resident #133 reported that the facility kept serving them Lactaid milk and oatmeal even though they have communicated their dislikes and preferences to Staff #5, dietary manager, several times. Furthermore, Resident #133 stated that for breakfast on 8/01/25 they received oatmeal and Lactaid milk, 2 items that they dislike because they cause diarrhea episodes. The resident reported that they do not eat the oatmeal provided by the facility because it was cooked with milk, and that they have requested cream of wheat instead.On 8/01/2025 at 11:00 AM A review of Resident #133's medical record was conducted. The review revealed that the resident had lactose intolerance. On 8/01/2025 at 1:00 PM An Interview with staff #16 was conducted. They confirmed that Resident #133 had Lactaid milk and oatmeal on their breakfast tray this morning. On 8/01/2025 at 1:24 PM An Interview with the dietary manager was conducted. He confirmed that he had a discussion with Resident #133 regarding their dislike of oatmeal and Lactaid milk last week, and that he was not sure why the resident was still served the disliked items. On 8/01/2025 at 2:04 PM Administrator and Director of Nursing (DON) were notified of these concerns.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and interviews, it was determined that the facility failed to maintain a safe and sanitary environment for a resident. This was evident for 1 (Resident #126) of 8 residents reviewed for safe, sanitary and functional environment during the recertification survey.The findings include:On 7/24/2025 at 1:15 PM An observation of Resident #126's room was conducted. The surveyor noted a strong musty smell and observed black substance underneath the resident's bathroom sink. On 8/01/2025 at 10:30 AM Another room observation was conducted with 2 surveyors. Upon opening the door, both surveyors noted a strong moldy smell coming from Resident #126's room. The second-floor Unit manager, Staff #4, was asked to enter the room with the surveyors. She also acknowledged the strong moldy odor coming from the resident's room. The bathroom floor was noted to have black substances. On 8/01/2025 at 10:30 AM An interview with Staff #4 was conducted. Staff #4 reported that she became aware of the mold problem in the resident's bathroom last week. She added that at times Resident #126 does not allow staff to enter or stay in their room for too long. When asked if the Director of Nursing (DON) was aware of the mold concern, Staff #4 stated that the DON was not aware, but she would notify her of the concern immediately. On 8/04/2025 at 9:20 AM The Facility Administrator was made aware of the safe environment concerns.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observation and interview, it was determined that the facility failed to have a process in place to ensure that handrails were securely attached to the wall. This was evident for 1 of 1 unit observed.The findings include:An observation of the 2nd floor nursing unit on 7/24/25 at 8:15 AM revealed a loose handrail that was directly across the hallway from the elevator doors. The metal bracket that secured the handrail to the wall was pulled away with the drywall attached. The handrail to the right, when stepping out of the elevator, was loose. The metal bracket that secured the handrail to the wall was pulled away with drywall attached.During an observation of the loose handrails on the 2nd floor nursing unit on 8/5/25 at 12:34 PM with the Maintenance Director and the Nursing Home Administrator (NHA), they acknowledged the concerns. The maintenance director reported that he had instructed his maintenance workers to check the handrails periodically, however there was no documentation of this task. He stated that he was going to create something to have them sign off that they were checking the handrails in the future.