

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2025
NAME OF PROVIDER OR SUPPLIER  Autumn Lake Healthcare at Crystal Springs		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Whitman Avenue Elkins, WV 26241	

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 record review and staff interview the facility failed to submit a five (5) day followup for a Facility Reported Incident as required. This was true for one (1) of two (2) incidents reviewed during this survey. Resident Identifier: #5 Facility Census: 76 Findings Include: a) Resident #5 On 12/29/25 at 3:03 PM record review of a Facility Reported Incident (FRI) found that the facility did not file a five-day follow-up to the investigation of this incident. On 09/18/25 at 2:30 PM the initial allegation of sexual abuse was reported to the appropriate facilities (Adult Protective Services, the Ombudsman and the Office of Inspector General). The facility investigated the allegation which was unverified. The resident was interviewed at the time of the investigation, however, she does not have capacity and reported that the incident happened months ago. There were twenty (20) additional residents (that have capacity) interviewed with no further allegations reported. The perpetrator and a co-worker were interviewed. On 12/29/25 at 3:30 PM during an interview with Resident #5, she reported to the surveyor that she did not remember anything concerning inappropriate touching. The Administrator attempted to locate the five-day follow-up report but was unable. On 12/30/25 at 10:10 AM it was confirmed with the Administrator that the facility should have filed a 5-day follow-up report to the appropriate office at which time she agreed.</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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