

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/14/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on policy review, staff interview and observation, the facility failed to maintain a clean, comfortable and home-like environment regarding odors in the facility. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 74. Findings included: The facility's policy and procedure for Safe and Homelike Environment stated, 9.a. Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to the Housekeeping Department. On 06/29/26 at 11:30 AM upon entering the facility, the Survey Team identified a strong urine-like odor. On 06/29/26 at approximately 12:15 PM, both dining rooms had a strong urine-like odor. On 07/06/26 at 1:25 PM, a urine-like odor was identified in all three (3) hallways on the South side of the facility. Registered Nurse (RN)#23 confirmed there was a urine-like odor and reported the floors were being replaced in two (2) rooms and possibly part of the hallway flooring at the end of the middle hall on the South side of the facility due to urine-like odors. The Director of Nursing (DON) confirmed the urine-like odors on the South wing of the building, stating, Definitely here on 07/06/26 at 1:35 PM and This one, too in the front and back hallways on the South side. On 07/06/26 at 1:45 PM, the DON confirmed a urine-like odor on the North side of the facility's back hallway near the end of the hallway, close to the back door.		

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and staff interview, the facility failed to ensure complete and thorough investigations for alleged violations of resident to resident abuse and neglect were conducted. This failed practice had the potential to affect more than a limited number of residents. Resident Identifier: #29 and #84. Facility Census: 74. a) Resident #29 On 07/07/26, a Facility Reported Incident (FRI) #3017743 was reviewed. The facility did not thoroughly and completely investigate an incident of resident-to-resident abuse. Basic Information of the incident reported that a fellow resident bent and twisted Resident #29's finger at the dinner table and the residents were separated. On 05/15/26, Nurse Aide #1's statement included, While sitting at dining room table male resident grabbed resident (Resident #29) left pointer finger, twisted it and bent finger backwards. A progress note dated 05/15/26, stated, This resident was sitting in her chair in the dining room when another resident squeezed her right hand. Resident was immediately removed from the the other resident. no visible injuries noted. MD notified and said to get an x-ray if this resident has any worsening symptoms. Resident able to move hand, wrist, and all fingers without any s/s of pain or discomfort. Vitals assessment; BP-122/68, HR-71,RR-16,temp-98.3, O2-96% on room air. The allegation of abuse was verified by the facility. The five (5) Day Follow-up was reviewed, but no five-day follow-up was emailed to OHFLAC. The Administrator stated that it did not have to be reported. The State Surveyor stated the office received the Initial Investigation Report but did not receive the Five (5) Day Follow-Up. The State Surveyor reviewed that there were no witness statements nor psychosocial/emotional follow-up documentation for the victim or other residents in the dining room, if applicable. No additional investigations were listed under Steps Taken to Investigate the Allegation on the Five (5) Day Follow-up. No additional assessments were completed for the resident since the initial incident and progress report. The FRI and Five (5) Day Follow-Up were reported to the Ombudsman and Adult Protective Service, but not to the OHFLAC. On 07/07/2026 at 2:35 PM, the Administrator asked about reporting the incident and stated that she was aware of what Appendix PP stated as reportable. The State Surveyor stated that the incident should have been reported since it wasn't an accident but resident-to-resident abuse and the facility should utilize the current Appendix PP guidelines for reporting versus Reporting Requirements dated 06/2012 which the administrator had given to the State Surveyor. b) Resident #84 The facility failed to ensure an allegation of neglect was completely and thoroughly investigated following a choking episode where the resident expired in the facility. On 07/09/26, Resident #84's medical record was reviewed for a death in the facility. The resident's diet order stated, CCD diet Chopped texture, Thin Liquids consistency, double protein for weight maintenance. The following Progress Note was documented on 05/25/26: Incident Description - Nurse was notified by CNA in regards to this residents room for a possibly choking. Began to assess this resident and witnessed him sitting at a 90 degree angle, with blue lips. Nurse began the Heimlich maneuver numerous times and was unsuccessful. Other LPN began Heimlich Maneuver and was unsuccessful, RC/EMS was contacted at 1300. Oxygen applied at 2L via face mask, and suctioning performed in an attempt to clear airway, which was unsuccessful. RC/EMS arrived on scene and began assessing resident. Resident pronounced deceased by RC/EMS x2 personnel. Immediate Action Taken - Immediate intervention from floor nurses attempting Heimlich Maneuver to clear residents airway. Additional help arrived and continued to attempt to clear what was thought to be choking. Heimlich attempted and unsuccessful. Resident laid on left side and inhaled and exhaled, back thrusts, abdominal thrusts, suction all attempted without success. High flow oxygen applied with no results. Resident had agonal breaths during this time frame. RC/EMS arrived on scene and began (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessing resident. EMS stated fixed pupils and pulseless. Resident DNR. RC/EMS transferred residents body to DMC morgue for examination. Residents body will then be transferred to Tomblyn funeral Home for services. The Facility Reported Incident (FRI) was requested by the State Surveyor for the incident dated 05/25/26. The Administrator reported a FRI had not been completed. On 07/09/26 at 10:47 PM, the Administrator reported a FRI was not completed for the incident. The Administrator reported that the resident did not choke to death. The Administrator reported that the airway was clear and the person was breathing and stated, He was likely having a heart attack. The Administrator reported there were nurse aides in the room. When the Administrator was asked about the nursing documentation, the Administrator stated, Absolutely not what happened, and What (Licensed Practical Nurse #28) put in the note was not accurate. The Administrator reported she was not at the facility when the incident occurred but came in when she was called and informed of the resident's death. Resident #84's death certificate was requested by the State Surveyor multiple times. On 07/14/26, the Director of Nursing (DON) reported that they did not have a death certificate. The DON stated, She (Administrator) does not have the death certificate. On 07/09/26, a folder containing witness statements was reviewed. The following witness statements were noted: On 05/25/26, Nurse Aide #3's written statement included, The Paramedic did retrieve a pretty big piece of meat which coulda had bread on it to. I didn't inspect the piece. On 05/25/26, Registered Nurse #37's written statement included, The paramedic used the laryngoscope and removed food from the airway with forceps. The resident was without respirations or pulse. On 05/25/26, Licensed Practical Nurse #24's written statement included, EMS removed object w/forceps upon arrival, object appeared to be a piece of meat that was not fully chopped. On 05/25/26, Licensed Practical Nurse #53's written statement included, When EMS arrived, a piece of meat was retrieved via forceps. On 07/14/26, the DON reported that she did not see the bolus removed but went to the kitchen afterwards. The bolus was covered with paper and she removed things to uncover the tray. The DON described the material removed from the resident's airway as having mucous on it, appearing more like bread with meat and she was able to tear the bolus apart. The DON described the material as brown, stringy and mushy and reported she felt it was bread, not fat. On 07/09/26 at 2:07 PM, the Administrator sent three (3) pictures of the resident's tray via email for the survey team to review. Photos attached. The removed bolus was identified by the Administrator on the right corner of the tray and the resident's tray card was still on the resident's lunch tray. The tray card stated, Chopped CCDDouble ProteinMonday (WV1-D2) Lunch05/25/2026HAVE A BLESSED MEMORIAL DAY!!!BBQ PORK SANDWICHESCOLE SLAWBAKED BEANSFRUIT. The photos were reviewed by the State Survey team. The pork on the resident's bun was covered by a sauce, but larger pieces of pork were judged not to be ground consistency by the team upon review. The resident had coleslaw on the tray also. The menu extension for a chopped diet level stated, Ground BBQ Pork on Bun. The menu extension for confetti coleslaw on a chopped diet recommended Chopped, Marinated Cauliflower Salad (no raw veg). The menu extension for creamy coleslaw recommended, Chopped Marinated Mixed Vegetable Salad. On 07/09/26 at 2:40 PM, the Administrator confirmed the resident should not have been served coleslaw and stated the resident was, Served what would be printed. The larger pieces of pork on the meal tray photos were reviewed with the Administrator and the survey team. The facility's guideline for Chopped consistency solids recommended, Ground texture for poultry, beef and pork. and Kitchen staff should prepare meats the same as the ground consistency unless otherwise noted on the tray ticket. The facility's policy and procedure for Aspiration Risk Precautions stated, 3. Provide the diet as ordered for solids and liquids. The facility's policy and procedure for Food: Quality and Palatability stated, 3. Food and liquids/beverages are prepared in a manner, form (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and texture that meets each resident's needs. A review of the facility's policy and procedure for Abuse, Neglect and Exploitation, stated, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or report of abuse, neglect or exploitation occur. and 6. Providing complete and thorough documentation of the investigation.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, record review, and staff interview, the facility failed to provide catheter care and services within accepted standards of practice. This deficient practice had the potential to affect one (1) of four (4) residents reviewed for the care area of urinary catheters. Resident identifier: #70. Census: 74. Findings included: a) Resident #70 The facility's policy titled Catheter Care, Urinary, with no implementation date given, stated as follows: Be sure the catheter tubing and draining bag are kept off the floor to maintain infection control. Ensure the catheter remains secure with a leg strap strapped to the resident's inner thigh to reduce friction and movement. Review of Resident #70's physician's orders showed orders relating to his suprapubic urinary catheter. An order written on 01/28/26 stated a leg strap was to be in place. On 07/09/2026 at 10:01 AM, Resident #70 was noted to be sleeping in bed. His suprapubic catheter urine collection bag was hanging off the side of his bed. His bed was in the lowest position, and the urine collection bag was resting on the floor. On 07/09/2026 at 10:44 AM, Resident #70's suprapubic catheter care was observed. The catheter care was performed by Certified Nursing Assistant (CNA) #40. When questioned about the urine collection bag being on the floor, she stated she would try to reposition the bag, so it wasn't on the floor. She stated would get a basin for the collection bag if she could not keep the bag off the floor due to the low position of the bed. It was also noted during observation of catheter care that the catheter did not have a leg strap to secure the drainage bag tubing and prevent it from being accidentally pulled. This surveyor talked to the resident about the leg strap and he said he thought he had one on. He stated he would like one to be placed. On 07/09/2026 at 10:57 AM, Licensed Practical Nurse (LPN) #93 was told Resident #70 had an order to have a catheter leg strap but didn't have one. LPN #93 stated she would place one. No further information was provided.		