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	07/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on administrative and medical record review, observations and interviews with facility staff and family it was determined that the facility failed to prevent a cognitively impaired resident who is at risk for wandering from exiting the facility unsupervised. This was evident for 1 (Resident #1) of 4 residents reviewed during the facility's complaint survey. This failure resulted in an Immediate Jeopardy for Resident #1. The facility implemented effective and thorough corrective measures following this incident. The facility's plan and action were verified during this survey; therefore, this deficiency will be cited as past noncompliance. The date of correction was 6/27/25. The findings include: Medical record review on 6/30/25 at 10:00AM revealed that Resident #1's diagnoses included but were not limited to Alzheimer's Disease (a progressive brain disorder that slowly destroys memory and thinking skills). The resident has a Brief Interview of Mental Status (BIMS) score of 3/15 indicating severe cognitive impairment. Review of a recent wander risk assessment completed on 4/18/25 indicated the resident was at risk for wandering and the resident had a care plan to address wandering behaviors to include a wander guard placement. The facility provided a copy of a timeline of events for Resident # 1 and their investigation to the survey team on 6/30/25 at 10:20 AM and the following information was reviewed: On 6/22/25 at 2:00PM Resident #1 was last seen by 7-3 Charge Nurse (CN) #7. A statement provided by the CN #7 indicated that she returned from lunch and assisted Geriatric Nurse Assistant (GNA) #5 with a resident. Afterwards she walked down the hallway and saw Resident #1 lying on the bed in their room. Review of a statement provided by GNA #4, she indicated on 6/22/25 she arrived at work at approximately 3:05 PM and heard an alarm sound. She described it as a soft beep, like a patient call light and it did not sound urgent. She noticed the evening nurse, Staff # 6 performing rounds. The nurse asked where Resident # 1 was and GNA #4 replied she did not know as she was in the process of making rounds. GNA #4 asked the nurse where the noise was coming from and both the GNA and nurse proceeded to the exit door and noticed it was slightly open. The nurse opened the adjacent door (a door leading outside the building) and discovered that it was unlocked. The alarm continued to sound as they both entered back through the door. They began asking staff if they knew the whereabouts of Resident # 1, and the resident location was unknown. They continued to search for the resident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a statement provided by the weekend RN Supervisor (RNS) #8, she stated that on 6/22/25 at approximately 3:40PM she was informed by the 3-11PM Licensed Practical Nurse (LPN), #6, that Resident # 1 was missing. The RNS (#8) activated the code purple for missing residents. A facility wide search was conducted to include the exterior and surrounding neighborhood. Further review of the investigation and timeline revealed the Director of Nursing and Administrator were notified on 6/22/25 at 4:33PM, and a voice mail message was left with the resident family at 4:36 PM. At 4:40 PM local law enforcement arrived at the facility to conduct a search. All available department managers were notified to report to the facility to assist with canvassing the facility and neighborhood. At 5:42 PM the NHA was able to reach the resident's family to inform them of the situation. At 7:30PM the staff continued searching after clearance from local law enforcement. An interview was conducted with the NHA on 6/30/25 at 10:10AM and he stated that he was notified that Resident #1 had eloped on 6/22/25 at approximately 4:30PM. He stated that he immediately came to the building and notified the resident's family. He further stated that the police came to the facility and stopped the facility staff from any further search due to this interfering with the police dog scent. The NHA went on to say that the next day, 6/23/25 at approximately 7:45 AM, a staff member was driving by and saw the resident in a wooded area near the facility. He stated that the resident had never eloped prior to this incident. Emergency Medical Services (EMT) was called, and the resident was brought back to the facility and assessed by EMS on-site. The resident did not have any injuries, however, was taken to the hospital for further evaluation. The NHA stated that the resident had a Urinary Tract Infection (UTI) and was able to leave the facility by way of the exit door located on the first floor due to a very low alarm sounding which was barely heard from the nursing station. He went on to say that the facility provided education to staff and has put stop exit alarms in the building that alarms loudly. An interview was conducted with the resident family on 7/1/25 at 9:30AM and they stated that they were notified as soon as the facility was aware of the resident leaving the building. They stated they had come to the facility and the police had a K-nine unit on the grounds. S/he stated that the search continued to approximately 9:00PM and then another person from their department was brought in with a drone that uses thermal imaging. The family said the police department provided an update at approximately 11:30-12:00AM when s/he contacted them, that they would continue to monitor but did not locate the resident. S/he stated that the facility informed him/her the next morning that the resident was located at the end of the property. They stated that Resident #1 was not injured but taken to the hospital for further evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 7/1/25 at 10:41 AM with the evening nurse, LPN #6 and he stated the following: He worked on 6/22/25 and arrived on duty a few minutes after 3:00PM. He was walking down the hall doing rounds and GNA #4 came to him and reported that an alarm was sounding. He stated that when he and the GNA went to the area where the sound was coming from, the door was open. They went outside and looked around the grounds and did not see anyone. They came back into the building and began a head count of all residents and noted that the resident was missing. The nurse stated that the supervisor was notified, Administrator and 911 were called. The nurse stated that when the police arrived, the staff were made to stay inside. During observation rounds during the complaint survey on 6/30/25 and 7/1/25 accompanied by the NHA and the Director of Maintenance (DOM), the following observations were made: There are 2 exit doors located on the first floor on the Chapel Way Unit and 1 exit door on the Garden View Unit. On the second floor there were 2 Exit doors at the Nightingale Unit and 2 Exit doors at the Forest View Unit. Each of the exit doors has an egress (allows 15 seconds to alarm before it locks) once the door is pushed and then the alarm sounds. Beyond the exit door on Chapel Way and Garden View on the unit, there is another exit door that allows exit to the ground. All the exit doors have a red box stop exit alarm that sounds loud to alert the staff. Both alarms sounded and staff responded. The stop exit alarms were put into place after the resident eloped as part of an intervention. Further observations were made of the exit doors that have a wander guard system in place as follows: The Dining Room located on Chapel Way leads to a fenced courtyard with a functioning system. The wander guard located at both exit doors on the Memorial Garden Unit located across from the Laundry Room has a functioning system. The exit door that leads to the courtyard located in the dining room of the Garden View Unit has a functioning system. In addition, there are functioning wander guards located in the entrance to the kitchen/employee area and the exit door where the trash and dumpster area are located. The front entrance lobby area and the entrance door have a wander guard. All observed areas had a functioning wander guard system. During a consequential meeting with the NHA, he provided documentation on elopement prevention done by maintenance, inspection of the exit doors and door alarm response in service training for all staff prior to installation of the red stop box alarms. During another interview with the NHA on 7/1/24 at 1:30 PM he provided documentation of the elopement prevention plan that the facility put into place following the elopement. Upon review it revealed the following: On 6/23/25 education was started and provided to all facility staff. Nurses were provided education on testing wander guard bracelets for placement and function. All staff were educated on responding to door alarms immediately and notifying the supervisor. Further education on elopement prevention was provided, to all staff on emergency doors, frequent rounds and the red stop box alarms placed at exit doors. The box alarm is a loud alarm that sounds when someone is exiting the door. The alarms were installed on 6/27/25. All education was provided by the ADN, DON and Director of Maintenance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All concerns were discussed at the exit conference on 7/1/25 at 3:30PM. Based on the above actions taken by the facility and verified by the surveyor on-site, it was determined that the facility had corrected the deficient practice by 6/27/2025, prior to the start of the survey.