STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215077	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Ruxton	7001 Charles Street Towson, MD 21204

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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 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, staff interview, and clinical record review it was determined that the facility staff failed to ensure a resident received showers according to personal preference. This was evident for 1 (Resident #104) out of 1 resident reviewed for preference in shower schedule.The findings include: During observation of Resident #104's wound dressing change on 2/20/26 at 2:50 PM the resident stated that he/she was supposed to get two showers twice a week in the evening but doesn't always get one. Staff #15 who was doing the dressing change offered that the resident was supposed to get showers on the 3-11 shifts. Resident said he/she wanted showers on the 7-3 shift and has told nursing staff that he/she wants showers on day shift because he/she wants the showers before wound dressings are changed not after. The resident said even if the old dressing got wet it would have to come off anyway so getting wet would not matter. The resident then stated that they did not get a shower on Tuesday, 2/17/26.This surveyor interviewed the Director of Nursing (DON) on 2/24/26 at 3:05 PM. This surveyor explained the resident's concerns and preference for shower times. The DON said she understood and would talk with the nurses on the unit to make necessary changes.A review of the facility's Documentation Survey Report on 2/24/26 revealed that the resident did not receive scheduled showers on 12/2/25, 12/5/25, 12/19/25, 12/22/25, 12/26/25, 12/30/25, 1/9/26, 1/13/26, 1/16/26, 1/20/26, 1/23/26, 1/27/26, 2/6/26, 2/13/26, 2/20/26. The resident was marked as having received a shower on 2/17/26 but the resident denied receiving one. The resident's sister was interviewed on 2/25/26 at 11:43 AM. She was asked about the resident's showers. She said that he/she has complained to the nursing staff about not getting showered and nursing staff tell him/her that he/she has to get showered at night even though he/she has told them he/she prefers to get showers during the day.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and a resident representative, it was determined that the facility failed to follow the grievance process for a resident and resident representative. This was evident for 1 (Resident #180) of 2 residents reviewed for grievances during the annual recertification and complaint survey.The findings include:A grievance is a formal or informal, written or oral complaint by a resident or resident representative regarding care, treatment, staff behavior, or quality of life. Facility staff are responsible for making prompt efforts to resolve (facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance) a grievance and to keep the resident/resident representative informed of the progress towards a resolution.On 2/24/2026 at 3:45PM, a review of Resident #180's Complaint/Grievance Forms filed by the resident representative included:1/17/2025-Failure to ensure nurses and aides have appropriate competencies: Requested water from aide working the night shift, request ignored. Pt had large amounts of antibiotics prescribed and was hot and sweaty with increased need for hydration with limited upper body mobility and range of motion in hands.2/3/2025-Failure to provide safe and appropriate pain management; pt requested to be turned and repositioned during the 3rd shift on two occasions. Ignored both occasions, slept in painful position.2/3/2025-Failure to promote and facilitate resident self determination through support of resident choice; Multiple requests made to staff and management to place resident in chair to participate in activities. 4 separate requests since 2/2/2025.2/3/2025-Failure to provide appropriate treatment and care according to orders, resident preferences and goal; Pain in both feet, infection on the right foot discovered in 2nd toe, antibiotics were prescribed but the pt still in pain with no follow up or care plan. No record of podiatry consult/appointment.2/4/2025-Failure to post nursing staff information each day; [Representative] requested staff information regarding who left the resident laying on [his/her] side throughout the night. [Representative was advised by [staff] that the information was confidential. [Representative was only able to get the information once they retrieved POA (Power of Attorney) information from the admission department.2/9/2025- Failure to provide appropriate pain management; pt informed [Physician] spasms were increasing in frequency and intensity. Requesting an immediate pain management review.2/9/2025-Failure to assist in gaining access to vision and hearing services; complaints of ear pain for the last couple of weeks (pain on right side of head). This complaint was expressed to the physician on duty. (No resolution as of 2/12/2025)2/10/2025-Failure to reasonably accommodate the needs and preferences of the patient; Pt was advised the [NAME] chair was not available to get [him/her] out of bed. When [representative] visited on 2/8 and 2/10 the chair was right outside the door in the hall.2/12/2025-Failure to ensure there is a pest program; complaints of rodents in patient room; Initially discussed last week.2/12/2025- Failure to provide and implement infection prevention and control program; within one month patient has acquired bedsores, UTI, foot infection (right foot), and possible finger infection on left hand, along with what appears to be an infection of both ears.2/12/2025-Failure to develop and implement a complete care plan that meets all the resident's needs with timetables and measurable action. [Representative] requesting a meeting with the complete care team responsible for [resident] care.Further review of all the Complaint/Grievance Forms completed and submitted by the resident representative revealed that once forms have been submitted, a facility representative will review and contact the complainant regarding their statement within 72 hours. The bottom portion of the form was labeled Facility Representative to complete the following. The facility staff completed the Findings and the How was this issue (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolved section and the forms were all signed by the Grievance Officer (signature unknown by facility staff) and NHA (Nursing Home Administrator) #1 on 2/6/2025. The facility staff failed to document the Referred to, Date Form Received, and the Date shared with the person filing the complaint/grievance portion of the form.On 2/25/2026 at 10:13AM, during an interview with the Resident #180's resident representative, the Surveyor was informed that they filed grievances in January and February 2025 via the Complaint/Grievance Form provided by the facility. The facility failed to acknowledge receipt of the complaint/grievance and the resident representative was not made aware of the progress of the facility's investigation or informed of the findings or resolutions to the complaint /grievance they submitted to the facility.On 2/25/2026 at 11:46AM, during an interview conducted with the Director of Nursing (DON), the Surveyor was informed that if the resident or resident representative has a complaint/grievance, any staff member can receive the grievance and record specific information on the grievance form, they can assist the complainant to complete the form, or the complainant can fill the form out themselves. The grievance form would then be sent to the Grievance Officer and distributed to the specific department manager to follow up with the complaint. Once the department completes its investigation or determines a resolution, the form should be returned to NHA #1. NHA #1 is the Grievance Officer and oversees the grievance process. The Surveyor requested NHA #1's date of hire.On 2/25/2026 at 2:27PM, an interview with Unit Manager #29 revealed that Resident #180's resident representative and UM #29 had numerous conversations regarding the care provided for the resident. UM #29 stated that any concerns the resident representative brought to their attention, were addressed with the resident representative as soon as possible. UM #29 does not recall receiving any complaint/grievance forms with concerns regarding Resident #180.On 2/25/2026 at 3:00PM, during an interview with the DON, the Surveyor confirmed that NHA #1 was hired on 2/24/2025. The Surveyor expressed the concern that Resident #180's resident representative submitted Complaint/Grievance Forms on 1/17/2025, 2/3/2025, 2/4/2025, 2/9/2025, 2/10/2025, and 2/12/2025 and all forms were signed as completed by a Grievance Officer (unknown signature) and NHA #1 on 2/6/2025. 2/6/2025 was prior to NHA #1's hire and after grievances filed on 1/17/2025, 2/3/2025, and 2/4/2025.Further review of the Complaint/Grievance form, in the section, Facility Representative to complete the following, the facility failed to document who the concern was referred to, the date the form was received, and the date shared with the person filing the complaint/grievance.The Surveyor questioned the DON about the documentation on the Complaint/Grievance Forms and was unable to give an explanation. The Surveyor also expressed the concerns that the facility failed to acknowledge receipt of the Complaint/Grievance Forms and inform Resident #180's resident representative of the findings and any resolutions to their concerns outlined on the forms. A review of the Resident and Family Grievances policy revealed that the Grievance Officer will issue a written decision on the grievance to the resident or resident representative and that documentation was not provided to the resident representative.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to Ensure a resident had their wound dressing changed according to physician's order for 1 (#104) of 1 resident wound dressing observation, and to ensure medications were administered as ordered by the physician for 1 (#140) of 1 resident reviewed for medication administration. The findings were evident during the facility's annual Medicare/Medicaid survey.The findings include: 1.) This surveyor observed Resident #104's wound dressing on the resident's left leg on 2/18/26 at 2:20 PM. The dressing was dated 2/17/26 which told the observer that was when the dressing was put on the resident's leg. This surveyor observed on 2/20/26 at 2:50 PM the wound dressing being changed. The nurse (Staff #15) doing the wound dressing change showed this surveyor the dressing prior to removing the dressing and treating the leg. The old dressing that was being removed had a date of 2/17/26 on it. Staff #15 confirmed the date and that she was the one who put the dressing on the resident's leg on 2/17/26. The date indicated that the dressing had not been changed for six shifts over a two-day period. A review of Resident #104's clinical record revealed that the resident's primary physician wrote an order of the wound dressing to be changed every day during the day shift. It also revealed that there was an order for diabetic foot care checks. The nursing staff were ordered to check the feet and ankles of the resident. Staff signed off that they checked the feet and ankles. Any staff checking the foot and ankle would have seen the date on the dressing. The Director of Nursing (DON) was interviewed on 2/24/26 at 3:05 PM. The observation was explained to her. She said she understood that the dressing should have been changed according to the physician's order. She said she would investigate the observations. 2.) Review of the medical record on 2/20/26 for investigation of complaint #2641772, which alleged Resident #140 did not receive medications as ordered by the physician, revealed the following: On 2/20/26 at 11:00 a.m., review of the medical record revealed: Medications scheduled for 10/10/25: Oxybutynin Chloride Oral Tablet 5 mg by mouth for overactive bladder, scheduled for 8:00 a.m. Midodrine HCl Oral Tablet 5 mg by mouth for low blood pressure (Do not give after evening meal or within 4 hours of bedtime. Hold if systolic blood pressure greater than 130), scheduled for 8:00 a.m. Review of the Medication Administration Record (MAR) audit revealed both medications were not signed off as administered until 12:22 p.m., approximately four hours after the scheduled administration time. Tizanidine HCl Oral Tablet 4 mg, give 4 mg by mouth one time a day for muscle spasms, scheduled for 9:00 a.m. Review of the MAR audit revealed this medication was not signed off as administered until 12:20 p.m., approximately three hours after the scheduled administration time. Medications scheduled for 10/14/25: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Eliquis (Apixaban) Oral Tablet 2.5 mg, give one tablet by mouth at 5:00 p.m. for atrial fibrillation. Review of the MAR audit revealed the medication was not signed off as administered until 8:22 p.m., more than three hours after the scheduled time. Oxybutynin Chloride Oral Tablet 5 mg and Midodrine HCl Oral Tablet 5 mg, scheduled for administration at 4:00 p.m. Review of the MAR audit revealed both medications were not signed off as administered until 8:21 p.m., more than four hours after the scheduled time. There was no documentation in the medical record to indicate the medications were held per physician order, refused by the resident, or delayed for a clinical reason. There was no documentation of physician notification regarding the delayed administration. During an interview with Staff #30 on 2/20/26 at 1:00 p.m., and during an interview with the Director of Nursing on 2/20/26 at 1:30 p.m., neither individual was able to provide a reason or documentation explaining why the medications were signed off as being administered late.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident interview, staff interview, observation, and clinical record review it was determined that the facility failed to ensure a resident's pain management was adequately addressed. This was evident for 1 (#104) out of 1 resident being reviewed for wound care.The findings include:This surveyor observed Resident #104 having a wound dressing changed on 2/20/26 at 2:50 PM by a nurse (Staff #15). While the nurse was changing the resident's dressing, Resident #104 stated that he/she asked for some pain medication at 2:30 PM but did not get any before wound care started. Staff #15 interjected and said she was doing another resident's dressing change so she could not give him/her any pain medication before she started. She asked the resident if they were in pain and the resident replied that they are in pain all of the time. She said she would give him/her pain medication as soon as she finished. The resident said that was acceptable.A review of Resident #104's clinical record on 2/24/26 revealed that the primary physician ordered on 2/4/26 Oxycodone 15 mg by mouth every 4 hours as needed for pain 5-10 on a 1-10 scale. This surveyor interviewed the Director of Nursing (DON) on 2/24/26 at 3:05 PM. The findings were explained to the DON. She confirmed that the pain medication should have been administered prior to the would care. She said she would get back to the survey team with any needed follow up.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on clinical record review and staff interview, it was determined that the facility staff failed to ensure a pain medication was administered according to the physician's order. This was evident for 1 (#104) out 1 resident reviewed for pain medication.The findings are:A review of Resident #104's clinical record on 2/24/26 revealed that the primary physician ordered on 2/4/26 Oxycodone 15 mg by mouth every 4 hours as needed for pain 5-10 on a 1-10 scale. A review of the Medication Administration Record revealed that: on 2/6/26 at 8:25 PM the resident's pain level was 4 but medication was administered, on 2/10/26 at 10:37 AM and 5:55 PM the resident's pain level was 4 but medication was administered, on 2/11/26 at 1:50 AM the resident's pain level was 4 but medication was administered, on 2/13/26 at 9:17 PM the resident's pain level was 4 but medication was administered, on 2/14/26 at 1:30 AM and 6:05 AM the resident's pain level was 4 but medication was administered, and on 2/15/26 at 4:33 PM and 8:55 PM the resident's pain level was 4 but medication was administered.Pain medication was administered when the pain level was 4, outside the parameters of the physicians order. The Director of Nursing (DON) was interviewed on 2/24/26 at 3:05 PM. She was informed of the findings and she agreed that the medication should not have been administered. She said she would talk to the nurses involved.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on clinical record review, observation, and staff interview, it was determined that the facility staff failed to ensure a resident received routine and follow-up dental care. This was evident for 2 residents (#9 and # 180) out of 2 residents reviewed for dental care during the facility's annual Medicare/Medicaid survey.The findings include:1.During the initial tour of the facility on 2/18/26 at 8:31 AM Resident #9 was observed to have few if any teeth. A review of the clinical record on 2/20/26 revealed that the resident has not had a dental consult in over a year. The resident was required to receive, but not limited to, an annual inspection of the mouth and jaw for signs of disease as well as a diagnosis of any dental disease. The Director of Nursing (DON) was interviewed on the morning of 2/24/26. This surveyor informed her of the finding and asked if she could provide evidence that the resident has either gone to the dentist or has had a dentist assess the resident at the facility. The DON was interviewed on 2/24/26 at 12:00 PM. She confirmed that she could not find a dental consult or examination in the clinical record. This surveyor asked when the last dental consult was. She replied that the resident has not been seen by a dentist and/or dental company since 2023. 2.On 2/24/2024 at 8:00AM, during a review of a complaint received concerning Resident #180, it was reported that the resident is missing teeth and cavities, and the facility was unable to provide information regarding when the resident received routine dental services since their admission in May 2024. During a review of Resident #180's electronic medical record on 2/24/2026 at 8:15AM, the Surveyor discovered that [Dental Company] attempted to see the resident on 8/20/2024; however, the resident was not in the room or hallways; a dental exam was completed on 9/17/2024, with notation of (Nv prophy-next visit prophylaxis or routine cleaning); a dental hygiene encounter was attempted on 10/17/2024; however, the resident could not be seen due to isolation, and a dental exam was completed on 10/31/2025, with notation of (Nv prophy-next visit prophylaxis or routine cleaning). Additional review failed to reveal documentation of a rescheduled dental hygiene encounter after the resident was unable to be seen on 10/17/2024's dental hygiene visit. Further review of Resident #180's electronic medical record revealed a change in condition nursing note dated 10/25/2025 which stated tooth came out, left upper molar, the resident spit the tooth out while talking. No bleeding or pain noted. The resident was ordered to be seen by dental services. On 2/25/2026 at 11:30AM, an interview with the Director of Nursing (DON) revealed the facility does provide dental services to residents. The DON stated that the [Dental Company] comes in monthly to see active residents. The facility can refer residents for dental services as needed. The Surveyor expressed the concern that Resident #180 was unable to be seen for a recommended dental hygiene appointment on 10/17/2024 and it was never rescheduled. The last dental visit was documented, 10/31/2025, after the left upper molar tooth fell out on 10/25/2025 and the resident was ordered to be seen by dental services.