STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215090	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Loch Raven	8720 Emge Road Baltimore, MD 21234

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, it was determined that facility staff failed to follow a physician's order. This was evident for 1 (#111) of 2 residents reviewed for pain management.The findings include:A medical record review for Resident #111 on 9/9/25 at 9:43 AM revealed a medication administration record (MAR) for May of 2025, which noted the resident was ordered an opioid 10 mg as needed every 4 hours for a pain level of 7-10. However, on the following dates and times facility staff failed to follow the physicians orders and gave the medications for a pain level less than 7; 5/7 at 9:00 PM for pain level of 6, 5/9 at 1:22 PM for a pain level of 0, 5/13 at 12:09 AM for a pain level of 0, 5/14 at 6:30 PM for a pain level of 6, 5/17 at 1:18 PM for a pain level of 0, 5/27 at 9:44 PM for a pain level of 6, 5/28 at 6:00 PM for a pain level of 0, 5/28 at 11:59 PM of a pain level of 6, 5/29 at 2:15 PM for a pain level of 0, 5/30 at 8:41 PM for a pain level of 6, and 5/31 at 10:10 AM for a pain level of 4. The following dates were for June 2025; 6/2 at 2:17 PM for a pain level of 0 and 6/5 at 5:08 PM for a pain level of 0. An interview with Licensed Practical Nurse (LPN) #34 on 9/10/25 12:21 PM revealed that she was aware that the medication was to be given based on the physician's parameters of a pain level of a 7-10. She reported Resident #111 was demanding when s/he requested their pain medication and would not give a pain score at times. Reviewed the MAR with LPN #34 when she documented a pain score of 0 on 6/5/25 and administered the pain medication. She reported she could not recall if the resident did not give a pain score or if it was a typographical error. When asked if she had documented a pain assessment in the progress notes she reported she had not. During an interview with the Director of Nursing (DON) on 9/10/25 at 1:49 PM she reported staff were expected to provide and level of pain for the resident and then give the medication according to the parameters. The DON acknowledge the concern.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 surveyor observation, review of the medical records, and interview with facility staff, it was determined the facility failed to provide quality care to residents by 1) not following physician orders for oxygen therapy and 2) not reporting a change in condition. This was found to be evident for 2 residents (Residents #45 and #47) out of 4 residents observed on oxygen therapy and 1 resident (Resident #115) of 2 residents reviewed for pressure ulcer complaints during the facility's recertification survey.The findings include:1) Oxygen (O2) therapy is a treatment that provides you with extra oxygen to breathe in. It is also called supplemental oxygen. It is only available through a prescription from the health care provider. Oxygen saturation or SpO2, is a medical measurement that indicates the percentage of oxygen-carrying hemoglobin in the blood compared to the total amount of hemoglobin. It is a key indicator of how well oxygen is being distributed from the lungs to the rest of the body. An oxygen flow rate is the volume of oxygen delivered to a patient per minute, usually measured in liters per minute (LPM). On 09/04/2025 at 8:08 AM, during the initial tour of the facility, Resident #45 was observed in bed with a nasal cannula in place and oxygen flowing at 3.5 liters per minute (LPM). On 09/04/2025 at 8:21 AM, in an interview with Registered Nurse (RN#3), when asked how many liters of oxygen was prescribed for Resident #45, she stated it was 3 LPM. When called to verify the oxygen flow rate, she confirmed it was set to 3.5 LPM and stated she would readjust it since the surveyor had noticed the discrepancy. When asked how often oxygen flow rate was checked, she stated that it was checked every other day and that it was also checked during the tubing changes. When asked when it was last checked, she stated that she did not know. On 09/04/2025 8:23 AM, Registered Nurse (RN#3) informed the surveyor that after checking the physician's order for Resident #45, he/she was to receive oxygen at 2 LPM. She immediately adjusted the flow meter to 2 LPM. On 09/04/2025 at 8:43 AM, during the continued tour of the facility, Resident #47 was observed in bed with oxygen running at 2.5 LPM via a nasal cannula. On 09/04/2025 at 8:45 AM, in an interview with Licensed Practical Nurse (LPN#4) when asked how many liters of oxygen was prescribed for Resident #47, she stated that he/she was prescribed 2 liters of oxygen and when asked for dual observation of the oxygen flow rate, she confirmed it was set to 2.5 LPM and readjusted it to 2 LPM. On 09/04/2025 at 12:02 PM, review of Resident #45's order on 09/05/2024 showed “Oxygen Inhalation (via nasal cannula at 2 LPM) to keep oxygen saturation greater than 90% related to Chronic Obstructive Pulmonary Disease (COPD) every shift for shortness of breath”. On 09/04/2025 at 12:13 PM, reviewed of Resident #47's order on 10/06/2024 showed “oxygen at 2L/min via nasal cannula continuously every shift”. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/04/2025 at 1:48 PM, in an interview with the Director of Nursing (DON) while the Nursing Home Administrator (NHA) was present, when she was asked how often the oxygen flow meters were checked, she stated that the nurses checked it weekly when changing the tubing. When she was asked how the nurses would know the amount of oxygen the residents were getting every shift, if it was checked weekly, she stated “There was no how the nurses would have known.” When she was informed about the concerns with oxygen flow rate for the residents and staff not following the order for the amount of oxygen level every shift, She acknowledged the error and stated that she would provide in-service education on following physician's order and to ensure flow meters were checked every shift going forward so as to prevent future occurrences of increased or decreased oxygen rate. 2) On 9/4/25 at 10:53 AM a review of a complaint received regarding Resident #115 revealed that the resident was sent to the hospital from the facility 4 days after admission in 2023. The complainant reported that the resident had low blood sugar and was septic from his/her wounds. The complainant reported that when the facility nurse called to report the resident was being sent to the hospital but was unable to provide any details as to what was going on with the resident. A medical record review for Resident #115 on 9/8/25 at 5:03 PM revealed a discharge summary from the acute care hospital dated 6/8/23. It was documented that the resident came to the hospital due to low blood pressure and anemia. The summary read that the resident had an extended stay in the hospital between April and May of 2023 and was bedbound at home which caused a sacral pressure ulcer. A review of the history and physical conducted by the attending physician on 6/9/23, revealed the resident was being treated for the following conditions; end stage renal disease and required peritoneal dialysis, type 2 diabetes, hypothyroidism, gastrointestinal bleeding, leukocytosis, sacral ulcer, and delirium related to high doses of steroid treatment during hospitalization. Review of the admission minimum data set (MDS) with the assessment reference date of 6/12/23 revealed that the resident had no cognitive impairment. Review of the progress notes revealed that on 6/12/23 at 9:59 AM it was noted the resident was refusing to eat breakfast. Then at 1:34 PM Registered Nurse (RN) #23 wrote that the resident reported s/he had vomited 4 times in the morning but there was no evidence of emesis and no staff reported vomiting so the nurse will continue to monitor. There was no change in condition found or a progress note documenting that the nurse conducted an assessment of the resident for this change in condition or notification to a practitioner. Further review of the progress notes revealed at 4:44 PM the same nurse wrote the resident was found to be lethargic and she obtained an order to send the resident to the hospital. RN #23 started a change in condition evaluation and upon review of the document it was revealed the nurse failed to obtain vital signs at the time of the change, she failed to obtain a blood sugar level, and failed to complete a thorough assessment of the resident prior to sending them to the hospital. On 9/9/25 at 9:45 AM a review of the emergency department (ED) report dated 6/12/23 for Resident #115 revealed that EMS (emergency medical system) reported that the resident's blood sugar was 37 (normal blood sugar levels are between 70 – 110) and they administered a glucose (sugar) past and IV (intravenous) fluids prior to arrival to the ED. The ED physician documented that the resident was able to report that s/he was feeling ok but was having pain in the sacrum. On 9/9/25 at 8:56 AM and 9:39 AM contact information for RN #23 was requested, but facility staff failed to provide the information. Therefore, the nurse was unavailable for an interview. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) #6 on 9/9/25 at 8:56 AM revealed that as the Unit Manager she remembered Resident #115 as a pleasant person who was cognitively intact. She would have expected the nurse to complete a change in condition (an assessment form) for a resident who was complaining of vomiting and to notify the practitioner. She stated that when the nurse found the resident lethargic, she would have expected her to obtain a set of vital signs and check the resident's blood sugar since she was diabetic and reported vomiting earlier in the day. Furthermore, she stated that the change in condition form should have been fully completed prompting the nurse to do a thorough assessment. She stated that the nurse was an agency nurse and was not currently working at the facility. Requested the last known contact for the nurse. On 9/9/25 at 9:39 AM the concerns were reviewed with the Director of Nursing (DON) and she acknowledged the concerns.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and staff interviews, it was determined that the facility 1) failed to provide services for pressure ulcer for a new admission and 2) to document and provide ordered treatment to promote healing of pressure injuries. This was found to be evident for 2 (Resident #115 and Resident #113) of 4 residents reviewed for pressure injuries during the survey. The findings include:1) On 9/4/25 at 10:53 AM a review of a complaint received regarding Resident #115 revealed that the resident was sent to the hospital from the facility 4 days after admission in 2023. The complainant reported that the resident's wounds had worsened, and s/he was diagnosed with sepsis because the wounds were infected. A medical record review for Resident #115 on 9/8/25 at 5:03 PM revealed a discharge summary from the acute care hospital dated 6/8/23. It was documented that the resident came to the hospital after being bedbound at home with a sacral pressure ulcer. The wound care was ordered as follows; clean daily with normal saline, pat dry, and apply medihoney (a wound treatment ointment or gel) and cover with bordered foam. A review of the Admit/Readmit Screener completed on 6/8/23 for Resident #115 revealed the nurse documented that the resident had a sacral wound. A review of the physician orders revealed an order dated 6/8/23, read “clean with normal saline, pat dry apply Midihoney [medihoney] on the sacral wound and cover with bordered foam. One time a day for wound care”. However, review of the treatment administration record (TAR) revealed staff failed to provide treatment to the wound until 6/10/23, 2 days after the resident was admitted . Further review revealed the resident was seen by the wound specialist on 6/12/23, and it was recommended that the resident had blood drawn and an x-ray of the sacral region to rule out an infection, however, this was not done because the resident was sent to the hospital that day for lethargy. An interview with the Director of Nursing (DON) on 9/9/25 at 9:39 AM revealed her expectation was that staff would remove the sacral wound dressing while conducting the admission assessment (admit/readmit screener) and then provide the wound treatment as ordered by the physician. She stated that it was unacceptable to wait 2 days after the admission to provide wound treatment for the resident. 2) On 9/11/25 at 10:53 AM, Complaint #344422 was reviewed. The complaint alleged Resident #113 was not receiving proper care and treatment to prevent pressure wounds. On 9/11/25 at 11:15 AM, a review of Resident #113's records was conducted. The resident has an order for wound care to be completed daily and as needed and an order for the resident to be turned and repositioned. In the Treatment administration record, the facility did not document wound care on 6/10/24 and 6/17/24. In the task documentation survey report, the facility did not document Resident #113 being turned and repositioned for 6/4/24 Night, 6/8/24 Day and Night, 6/10/24 Night, 6/12/24 Night, 6/13/24 Evening and Night, 6/14/24 Day, 6/15/24 Night, 6/16/24 Night, 6/17/24 Day and Evening. The facility documented the resident was not being turned and repositioned on 6/5/24 and 6/15/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/25 at 11:45 AM, an interview was conducted with the Director of Nursing (DON). When asked what is expected from nurses when documenting wound care, The DON stated that the nurses completing the wound care are expected to document the treatment and description of the wound. When asked who is responsible for documenting the wound care is expected to document the treatment in the TAR, the Person completing wound care for resident should be documenting the wound care completed in the TAR. This surveyor told the DON of missing documentation for wound care and turning and repositioning for Resident #113. The DON was made aware of concerns with documentation and resident not being turned as evidenced by task documentation.