STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215097	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Catonsville	16 Fusting Avenue Catonsville, MD 21228

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 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 interviews it was determined that the facility staff failed to complete a thorough investigation of an allegation of misappropriation of property. This deficient practice was evidenced in 1 (#1) of 1 investigation reviewed during the complaint survey.The findings include:On 06/16/26 at 2:57 pm while reviewing the facility's investigation related to an allegation of misappropriation of property concerning Resident #1, the surveyor noticed the staffing sheet for the unit where the alleged incident occurred was not included with the investigation.On 06/16/26 at 3:49 pm during an interview with Administrator#1 the surveyor asked how the facility staff determines who should be interviewed during an investigation. Administrator #1 verbalized they mostly conducted the investigation and they interviewed anybody that was around. Resident #1 reported GNA #6 took the money right in their presence. Also, they ask around to see if someone witnessed anything.On 06/16/26 at 3:56 pm the surveyor received a copy of the staffing sheet for Unit D dated 05/16/26. A review of the staffing sheet and statements revealed there was not a statement from GNA #4 and Registered Nurse (RN) Supervisor #5. GNA #4 worked on Unit D and RN Supervisor #5 was the supervisor on duty.On 06/17/26 at 12:55 pm during an interview with Administrator #1, the surveyor asked why a statement from GNA #4, and RN Supervisor #5 was not included in the investigation. Administrator #1 verbalized they remember having a conversation with RN Supervisor #5 although a statement was not in the file. When Resident #1 specifically said GNA #6 took their money, they went to interview GNA #6 and cut straight to the chase.

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews it was determined that the facility staff failed to dispose of refuse properly. This deficient practice was discovered during the complaint survey.The findings include:On 06/16/26 at 10:49 am the surveyor observed two large blue colored dumpsters in the back of the parking lot. The dumpster on the left had a yellow and white label on the front. The top of the dumpster was half open. The dumpster on the right had a white sticker on the front. The top of the dumpster was half open and the side door was opened. The surveyor observed a large white cart with a turquoise cover, a damaged box of grey tile, cabinets, and a black metal bed frame on the ground next to the dumpster on the left.On 06/16/26 at 6:11 pm the surveyor observed a white bag of rubbish was on top of the dumpster on the right. The side door of the dumpster remained open. The top of the dumpster on the left remained open. The items the surveyor observed during the morning was still in the ground next to the dumpster on the left.On 06/17/26 at 10:45 am during an interview with Maintenance Director #8 the surveyor reported their observations of the dumpsters and asked who is responsible for ensuring the area was kept clear & clean. Maintenance Director #8 verbalized the maintenance department, environmental services, and the kitchen staff used the dumpsters, but EVS & the kitchen staff used the dumpster often. Recently they replaced some of the wardrobes; the ones outside needed to go to the dump. Someone was coming to dispose of all the items. At 10:54 am during an interview with EVS Director #9 they verbalized the staff take the trash out and if the doors are open the staff were instructed to close the doors. If anything was on the ground near the dumpster they were instructed to pick it up. They EVS staff typically use the dumpsters twice a day.At 11:10 am during an interview with Food Service Manager #10 they verbalized the kitchen staff are supposed to dispose of the waste three times a day. They are aware the doors and the top of the dumpsters are supposed to be closed. They know to close the doors after using the dumpsters.At 3:02 pm the surveyor counted 13 dressers on the ground beside the left dumpster. There was a black chair with gold trim and a tire behind the dumpster on the left. The dumpster on the right was missing half of the lid which prevented the top of the dumpster from being closed fully.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews it was determined that the facility staff failed to document contact with family members regarding care concerns. This deficient practice was evidenced in 1 (#2) of 2 resident records reviewed for ADL care. Additionally the facility failed to accurately document all items in a crash cart on 1 of 4 units. The findings include:1. On 06/17/26 at 11:07 am the surveyor received a copy of a Grievance Form dated 05/11/26 related to Resident #2. The resident's family member contacted the facility to inform staff the resident called them to report they needed incontinence care. The form indicated the family member's concern were addressed. There was no documentation to verify the facility staff contacted the resident's family member after their concerns were addressed. On 06/17/26 at 1:22 pm during an interview with Director of Nursing #2 they verbalized they conclude the grievance by telling the person who submitted the grievance what their findings were after their concern was investigated. There should have been documentation to verify the person who filed the grievance was notified.2. On 06/17/26 at 12:06 pm the surveyor spoke with Resident #2's family member. The family member reported Admissions Director #11 provided them with paper & pen in their office to write their concerns so they could be addressed. The surveyor spoke with Admissions Director #11 about the family members' note, and they had no recollection of the note written by Resident #2's family member.On 06/17/26 at 2:25 pm the surveyor went to follow up with admission Director #11 concerning Resident #2's family member written note with their concerns. Admissions Director #11 verbalized they would have written the concerns on a form and provided the form to the Administrator. The surveyor asked for a copy of the form. admission Director #11 verbalized they don't have the emails because they were received over 90 days ago. Admissions Director #11 initially reported they wrote the concerns down, then they reported the concerns were received via email. There was no documentation to verify the family members' concerns reported to Admissions Director #11 were addressed. Administrator #1 and Director of Nursing #2 were made aware. Top of Form3. On 6/16/26 at 8:00 am, the surveyor reviewed an anonymous complaint (3028181) received by OHCQ on 5/27/26 which alleged the facility failed to stock intravenous (IV) tubing in their crash (emergency) carts. On 6/17/26 at 9:00am, the surveyor visited Unit D and observed the crash cart was locked; the surveyor was unable to verify if Unit D stocked IV tubing in the crash cart. The surveyor observed the crash cart had a logbook which contained a monthly inventory of all items in the crash cart. The surveyor reviewed June 2026's inventory sheet and there was no entry for IV tubing on the inventory sheet. During an interview with LPN# 7 on 06/18/26 at 9:15am revealed Unit D didn't have any residents that required IV tubing for their medical care. LPN #7 also stated they never had to use IV tubing for emergency services and they were unsure if the crash cart had IV tubing available for emergency uses. The surveyor asked LPN #7 who was responsible for ensuring the crash cart contents were accurately documented. LPN #7 stated the unit managers were responsible for that task; the unit manager was not available for an interview. LPN #7 then stated that residents with a need for IV medication are on Unit A- the skilled unit. Any IV medications and equipment needed to dispense the medications were in the medication storage for Unit A. Interview with the DON on 6/18/26 at 11:10am revealed IV tubing should be in the crash cart and the crash cart inventory form should have IV tubing as an inventory item. The surveyor showed the crash cart form from Unit D and the DON confirmed IV tubing was not on the form. Interview with the DON on 6/18/26 at 1:18pm re-confirmed the crash cart inventory form was incorrect on unit D. The DON stated that due to surveyor intervention, the facility audited all of the crash cart inventory forms and updated the inventory forms to truly reflect the contents of the crash cart. The DON then provided the surveyor with a copy of the updated crash cart inventory form. The surveyor reviewed the updated crash cart inventory form and confirmed IV tubing was on the form. The DON and the surveyor then viewed the contents of the crash cart on Unit D and confirmed that IV tubing was in the crash cart. Bottom of Form