STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215120	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Crofton	2131 Davidsonville Road Crofton, MD 21114

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and staff interview, it was determined that the facility failed to protect a resident from abuse. This was evident for 1 (Resident #199) out of 12 residents reviewed for abuse. The findings include: On 9/24/2025 at 10:45 AM, a review of Facility Reported Incident #311885 was conducted. The incident was in regard to an allegation of Employee to Resident abuse, where Staff #35 was alleged to have shoved incorrect medications into Resident #199's mouth despite the resident refusing the medication. On 9/24/2025 at 11:29 AM, a review of the Resident #199's progress notes was conducted. In the Provider notes from 2/28/2025 at 2:42 PM, the provider stated, The patient is being evaluated for a follow-up regarding a medication administration error. It was reported that the patient inadvertently received losartan and gabapentin. On 9/24/2025 at 11:38 AM, a review of the witness statement was conducted. The witness, Staff #36, stated that they witnessed Resident #199 yelling at Staff #35, stating Im not taking this, what are you giving me. I don't take that medication. Staff #36 then witnessed Staff #35 put a spoon in Resident #199's mouth while the resident was yelling, what are you giving me, I should not have taken that. Staff #36 then asked Staff #35 what medications were given to Resident #199. Staff #35 stated that they gave the resident Gabapentin and Losartan. Staff #36 told Staff #35 that Resident #199 does not take those medications and that they made a medication error. On 9/24/2025 at 12:30 PM, a surveyor interviewed the Director of Nursing (DON) regarding a finding of substantiated abuse. The surveyor noted the finding was based on a witness's statement. The DON questioned how the incident could be considered abuse without proof of forceful medication administration. The surveyor clarified that the resident's refusal of the medication, followed by its administration, constituted abuse.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, it was determined that the facility failed to 1.) initiate treatment for a resident who reported a new clinical concern, 2.) ensure that a medication was available for a resident upon admission since the resident could not eat without the medication, 3.) follow physician orders for blood pressure (BP) measurements. This was evident for 3 resident (Resident #1, #196, and #176) out of 11 residents reviewed during the facility's recertification survey. The findings include: 1.) On 09/18/2025 at 11:54 AM, during an interview with Resident #1, the resident stated that he/she had crusts in the eyes which were also itchy, and that this concern had been reported to a nurse. On 09/22/2025 at 1:35 PM, during an interview with Licensed Practical Nurse (LPN #13), when asked if she was aware of the resident's complaint of itchy eyes with crusting, she stated that the resident had informed her on 09/18/2025 and she had told the attending physician (Staff #26). When asked about documentation, she stated she did not document the concern because the attending physician was scheduled to see the resident. When asked if she followed up, she stated she did not because the physician came in late and had said she would see the resident. LPN #13 acknowledged she should have documented the issue in the electronic health record as a reminder to other staff. On 09/22/2025 at 2:01 PM, during an interview with the attending physician (Staff #26), when asked if she was aware of the resident's complaint of crusting and itching in the eyes, she stated she was not aware. She reported that when she saw the resident on 09/18/2025, the resident had no complaints, and she did not observe redness or irritation in the eyes. She stated the only observation was that the resident appeared tired, which the nurse had reported as baseline for the resident. She added that she was planning to see the resident again on 09/22/2025. On 09/23/2025 at 8:48 AM, review of Resident #1's medical record showed a new order by Staff #26 dated 09/22/2025: “Clear Eyes Adv Dry & Itchy Relief Ophthalmic Solution 0.25% (Glycerin – Ophth Lubricant): Instill 1 drop in left eye three times a day for 7 days for dry, itchy left eye. No erythema: no drainage noted.” On 09/23/2025 at 9:02 AM, during an interview with the Unit Manager (Staff #24), when asked about the expectation when residents report a clinical concern or complaint, she stated that the nurse should address the concern by gathering information, informing the provider, and following up with the physician. On 09/23/2025 at 9:33 AM, during an interview with the Director of Nursing (DON), when asked about expectations regarding residents' clinical concerns or complaints, she stated that the nurse should assess the resident and notify the physician. When asked if documentation was required, she stated that the assessing nurse should document the concern in the electronic record. When informed about the concern regarding delay in treatment and failure to document, she agreed it was a concern and stated staff education regarding prompt attention to resident's clinical concern and documentation would be provided. 2.) The pancreas is an organ in the body that aids in digestion by secreting enzymes (protease, lipase, and amylase) to break down the foods. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ZenPep is a medication with the active ingredients of lipase, amylase, and protease to aid with digestion when a person's pancreas isn't functioning properly. The medication is prescribed for a person to take each time they eat food. On 11/14/24 a complaint was received by the State Agency (SA) stating that Resident #196 was admitted to the facility and left on 2nd day because the facility did not have his/her medication and the resident was unable to eat. A medical record review for Resident #196 on 9/24/25 at 9:56 AM revealed under the census tab that the resident was admitted [DATE] and left the next day. A review of the resident's discharge summary from the acute care hospital revealed the resident was ordered Pancrelipase 2 capsules with each meal and then there was a second order for Pancrelipase 1 capsule with snacks. According to the summary, the resident was diagnosed with type 2 diabetes. A review of the physician's orders revealed an order for Zenpep (same medication as Pancrelipase) 2 capsules with meals dated 11/12/24 and a second order for Zenpep 1 capsule as needed with snacks dated 11/12/24. The medication treatment record (MAR) revealed these medications had not been given while the resident was at the facility. There was a progress note dated 11/13/24 at 9:26 AM that noted the resident was “displeased” with his/her stay at the facility and was going home against medical advice. The resident's family member was going to pick them up at 2:00 PM. A note on 11/13/24 at 10:26 AM revealed facility staff called the family asking them to bring the medication to the resident. On 9/24/25 at 11:54 AM and interview with the Director of Nursing (DON) revealed Resident #195 arrived at the facility 11/12/24 at 8:00 PM and left the next day at 2:30 PM. She reported that the staff who review admissions would not check to see if every single medication was available at the pharmacy prior to admission. She confirmed that the resident was not able to eat the entire time s/he was at the facility because they did not have the Zenpep as ordered. She reported that the day shift nurse started was trying to get the medication at 10:30 AM which was 2 ½ hours after breakfast was served. She stated that this was a reasonable timeframe because the day shift nurse had determined it was missing that morning during the first medication pass. When family told the nurse they were coming to get the resident at 2:30 PM, no further efforts were made to get the medication for the resident. The resident was a diabetic and had not been able to eat the 19 hours s/he was at the facility. An interview with Licensed Practical Nurse (LPN) #43 on 9/24/25 at 12:56 PM revealed that the nurses received a fax from the pharmacy when a resident's medications were not available. She stated that when it was a new admission the pharmacy would fax the notice prior to delivering the resident's other medications. She reported that the fax was sent to the unit where the resident resided and all the staff have access to the fax machine. They check the fax machine periodically throughout their shift. She confirmed that they were notified by the pharmacy right away when a medication was not available. She stated this prompted the nurse to follow up with the physician or nurse practitioner. A review of Resident #196's closed medical record on 9/24/25 at 1:40 PM revealed that the pharmacy faxed a notice that Zenpep was not available and asking for a dose change on 11/12/124 at 10:07 PM. However, there was no evidence in the record that this was followed up on. Furthermore, there was a form titled, “Release of Responsibility for Discharge Against Medical Advice was signed by the resident on 11/13/24 and s/he noted at the bottom that it was not against medical advice the physician has been in since [the resident] moved in and no medication and no food. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A subsequent interview with the DON on 9/25/25 at 10:10 AM revealed she was not aware of the fax that was sent by the pharmacy the evening of the admission. She acknowledged the concerns. On 9/25/25 at 11:51 AM the concerns were reviewed with the Nursing Home Administrator. 3.) Hemodialysis is a treatment that helps remove waste products and excess fluid from the blood when the kidneys are not functioning properly. An arteriovenous (AV) fistula or AV graft is a permanent surgical connection between an artery and a vein, created in a patient's arm, to provide reliable access for hemodialysis. During an interview on 9/18/2025 at 11:57 AM with Resident #176, they stated to the surveyor that they receive hemodialysis (HD) at the facility and currently have a HD catheter in place for dialysis access on the right side of their chest. Resident #176 also stated that they had an old Arteriovenous (AV) fistula in their left arm and recently had surgery to place a new AV graft in their right arm. A sign was observed by the surveyor posted above the resident's bed that stated, “No procedures in resident left or right arm take BP on either bilateral lower extremity.” A medical record review of Resident #176 was conducted on 9/22/2025 at 9:31 AM. Record review revealed that Resident #176 had a right internal jugular (IJ) catheter that was actively being used for dialysis and had recently had an AV graft placed in their right upper extremity on 7/28/2025. Resident #176 also had two orders in their medical chart initiated on 7/30/2025: 1) No Procedures to RIGHT and LEFT arm every shift for Dialysis Access Take Blood pressure on bilateral lower extremity (BLE). 2) No vascular access (blood work) or blood pressure should be permitted on the Right and Left arm every shift. Further medical record review of Resident #176's vital signs showed that since 7/30/2025, facility staff had documented a total of 27 BP measurements in either Resident #176's left or right arm. Resident #176 was interviewed by surveyor on 9/23/2025 at 1:50 PM. When asked if facility staff performed BP measurements in their arms, Resident #176 stated that they make sure it is never their right arm, but facility staff use their legs and sometimes their left arm for BP measurements. On 9/24/2025 at 9:10 AM, Resident #176's record review revealed that Licensed Practical Nurse (LPN) #21 documented Resident #176's BP had been taken on their right arm that day at 8:35 AM. Resident #176 was interviewed on 9/25/2025 at 9:30 AM and stated to the surveyor that the facility staff had placed the BP cuff that morning on their left arm. On 9/24/2025 at 10:50 AM, LPN #21 was interviewed by surveyor and stated that she had used Resident #176's left arm for BP measurement. LPN #21 was informed by surveyor that she had documented in the resident's chart that she used Resident 176's right arm. LPN #21 stated that it was a mistake and would change the documentation to the left arm. Surveyor also asked LPN #21 if she was aware that Resident #176 had orders in their chart not to use either arm for BP measurements, and that there was a sign posted above Resident #176's bed informing staff not to use either of Resident #176's arm for BP measurements. LPN #21 stated to surveyor that she did not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/2025 at 11:00 AM, Registered Nurse (RN) #20, the Unit Manager was interviewed and informed about the surveyor findings. RN #20 stated they were not aware BP measurements were being done on Resident #176's left arm and stated that her expectation is that staff follows orders. On 9/25/2025 at 8:53 AM, the Director of Nursing (DON) was made aware of surveyor concerns.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and staff interviews, it was determined that the facility failed to prevent a significant medication error. This was evidenced in 1 (Resident #199) out of 6 residents reviewed for medications. The findings include: On 9/24/2025 at 10:45 AM, a review of Facility Reported Incident #311885 was conducted. The incident was in regard to an allegation of Employee to Resident abuse, where Staff #35 was alleged to have shoved incorrect medications into Resident #199's mouth despite the resident refusing the medication. 9/24/2025 at 11:20 AM, an interview with the Director of Nursing (DON) was conducted. When asked about the facility's outcome of incident #311885, the DON stated that the facility determined the medication error to be substantiated and the alleged abuse to be inconclusive. On 9/24/2025 at 11:29 AM, a review of Resident 199's progress notes was conducted. In the Provider notes from 2/28/2025 at 2:42 PM, the provider stated, The patient is being evaluated for a follow-up regarding a medication administration error. It was reported that the patient inadvertently received losartan [100 mg] and gabapentin [100 mg]. A comprehensive investigation has been initiated to examine the circumstances surrounding this medication administration error. Educational sessions have been conducted with both nursing staff and medical aides to ensure they recognize the potential side effects associated with the inadvertently administered medications. Primary symptoms to monitor related to losartan include hypotension and renal failure. In relation to gabapentin, the key signs to observe include the presence of hallucinations, excessive somnolence, altered mental status, excessive lethargy or fatigue, malaise, and generalized muscle weakness. The Director of Nursing has been apprised of the findings. A thorough investigation is currently underway to assess the systems involved. Losartan is a medication used to lower blood pressure. Gabapentin is an anticonvulsant medication used to treat seizures and nerve pain. On 9/24/2025 at 11:38 AM, a review of the witness statement was conducted. The witness, Staff #36, stated that they witnessed Resident #199 yelling at Staff #35, stating Im not taking this, what are you giving me. I don't take that medication. Staff #36 then witnessed Staff #35 put a spoon in Resident #199's mouth while the resident was yelling, what are you giving me, I should not have taken that. Staff #36 then asked Staff #35 what medications were given to Resident #199. Staff #35 stated that they gave the resident Gabapentin and Losartan. Staff #36 told Staff #35 that Resident #199 does not take those medications and that they made a medication error.