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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, it was determined that the facility failed to ensure a proper sanitary environment in a food and equipment preparation/storage area. This was identified during multiple observations of the kitchen during the annual survey. This deficient practice has the potential to affect all residents.The findings include:Initial tour of the facility kitchen on 9/18/2025 at 8:25 AM revealed multiple areas of black substances located on the wall above the kitchen's coffee and tea maker, as well as on the ceiling panels above. The coffee and tea maker were located on a table to the left of the kitchen's ice machine. Mugs with plastic lids were observed being stored on top of the ice machine. Silverware was being stored to the left of the coffee and tea maker on the table. The coffee and tea maker were observed producing steam. Condensation was observed on the wall and ceiling above the ice machine, coffee and tea machine, and the table where silverware was being stored. This was same area where the black substance was observed by the surveyor. No ventilation system or condensate hood was observed in this area.On 9/18/2025 at 8:40 AM, an interview was conducted with the facility's kitchen manager and registered dietician (RD). Surveyor addressed concerns about black substances and condensation on the wall and ceiling around the coffee and tea maker. The kitchen manager stated they would inform maintenance.On 9/23/2025 at 10:50 AM, another tour of the kitchen was conducted. No black substance was observed around the tea and coffee maker; condensation was observed on the ceiling panels above the coffee and tea maker.On 9/24/2025 at 10:46 AM, during observation of the lunch tray service in the kitchen, steam was coming from the coffee and tea maker, and condensation was noted on the ceiling above. Mugs with lids and plates were observed being stored on top of the ice maker next to the tea and coffee maker. A dietary staff aide was observed rolling silverware on the table next to the coffee and tea maker underneath the previously noted condensation.On 9/25/2025 at 12:23 PM, a dietary aid was observed taking plates being stored on top of the ice maker, beneath condensation on the ceiling, and placing them in the facility's plate warmer for the lunch tray service. At 12:36 PM, 5 tea pitchers (4 with lids, one without) were observed being placed on the table next to the coffee and tea maker by another dietary aide, condensation was noted on the ceiling above the tea pitchers. Interview was held on 9/25/2025 at 12:55 PM where surveyor addressed concerns with the ongoing condensation caused by the coffee and tea maker in a food and kitchen equipment preparation/storage area with the RD, kitchen manager, and regional food director.On 9/24/2025 at 1:07 PM, concerns were addressed with the nursing home administrator.

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

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
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and staff interviews, it was determined that the facility failed to maintain appropriate infection control practices. This was evident during observations of the laundry area during the facility's recertification survey. The findings include:On 09/24/2025 at 7:42 AM, during a tour of the laundry room, the surveyor observed a door with signage stating, Keep Door Closed and Do Not Prop Doors Open. The door was observed propped open.On 09/24/2025 at 7:43 AM, in an interview with the Housekeeping Supervisor (Staff #15), when asked about the biohazard room, she stated that it contained biohazard waste in a red hazard bin. When asked if the door was to be left open, she stated that housekeeping staff entered the room to obtain chemicals but acknowledged that the door was not supposed to be propped open at any time. She then closed the door and confirmed that it should not have been left open.On 09/24/2025 at 7:48 AM, during a tour of the soiled laundry room, the surveyor observed the door was open. Staff #15 was observed picking up three soiled linens with her bare hands and placing them in a dirty-linen bin. When asked if she was supposed to use her hands to pick the linens, she stated that gloves were required but she had forgotten. When asked about the opened door to the soiled room, she confirmed that it was expected to always remain closed.On 09/24/2025 at 8:36 AM, in an interview with the Infection Preventionist (IP), when asked who oversaw infection control practices in the facility, she stated that she was responsible in conjunction with department heads. When the concerns regarding the propped biohazard room door, the propped soiled linen room door, and the observation of the Laundry Supervisor handling soiled linen without gloves were discussed, she acknowledged these were concerns and confirmed that the doors were required to always remain closed.On 09/24/2025 at 8:40 AM, when the surveyor discussed the concerns with the Director of Nursing (DON), she stated that staff education would be provided.

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	215120	A. Building B. Wing	09/25/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews, it was determined that the facility 1.) failed to ensure that resident rights are maintained by knocking prior to entering a resident's room and 2.) failed to protect the resident's dignity by not ensuring urine bags were covered. This was evident for 1 (Resident #69 and Resident #102) out of 4 resident's reviewed during the annual survey . The findings include: 1.) On 09/18/2025 at 1:25 PM, during an interview with Resident #69, Geriatric Nursing Assistant (Staff #10) walked into Resident #69's room, but failed to knock on the door prior to entering the room. On 09/18/2025 at 1:49 PM, an interview with Staff #10 revealed that the expectation was to knock and wait for the resident's response. On 09/19/2025 at 8:42 AM, the surveyor reviewed the concern with the Director of Nursing. She indicated that the expectation was that staff should knock on every resident's door prior to entering and at a level that the resident would be able to hear. 2.) A urine bag, or urinary drainage bag, is a medical device that collects urine from the body via a urinary catheter or stoma, serving as a temporary or long-term collection system when a person cannot urinate normally or for post-surgical reasons. On 09/18/2025 at 8:47 AM, Resident #102 was observed in bed with a Foley catheter and urine bag visible. On 09/18/2025 at 9:39 AM, Licensed Practical Nurse (LPN #12) was called for a dual observation and confirmed that no dignity bag was in place. When asked about staff expectations regarding privacy of urine bags, LPN #12 stated that all residents with Foley catheters and urine bags were to have two dignity bags each: one for use while in bed and one for use while in a chair or out of bed. She added that urine bags should not be visible. LPN #12 stated she would look for a dignity bag to cover the urine bag. On 09/23/2025 at 12:21 PM, during an interview with Geriatric Nurse Assistant (GNA #27), when asked about expectations for privacy of urine bags, she stated that urine bags were to be covered with a dignity bag always, whether residents were in bed or in chairs, to ensure dignity and prevent visibility. On 09/23/2025 at 12:27 PM, during an interview with the Director of Nursing (DON), when asked about expectations for urine bag privacy, she stated that all residents with urine bags should have dignity covers regardless of whether they were in bed or in chairs. When the concern was discussed with her, she stated the Unit Manager had informed her about it, that residents with urine bags were audited, and that dignity bags were provided. She added that in-service education for nursing staff on dignity bag use had been initiated and was ongoing.

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	215120	A. Building B. Wing	09/25/2025

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure a copy of 1.) a resident's medical power of attorney (POA) and 2.) a copy of a resident's advance directive was in the resident's medical records. This deficient practice was evident for 2 (Resident #25 and Resident #40) out of 3 residents reviewed for advanced directives during the annual survey.Advance Directive (AD) is a written instruction, such as a living will or durable power of attorney (POA) for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.The findings include: 1.) On 09/18/2025 at 11:52 AM, a review of Resident #25's medical record revealed the resident was admitted to the facility on [DATE]. Further review showed that on 07/13/23 Social Worker (SW) #6 completed an initial assessment noting that the resident had an AD and would ask their family to provide their healthcare POA information for the resident's medical records. A review of the residents' electronic medical records and paper charts failed to show evidence of a healthcare POA. On 09/19/2025 at 11:19 AM, during an interview with SW #6, SW #7, and SW #8, they explained the facility's AD process. They stated that during the admission screening, AD are discussed with the resident and/or the resident's representative. If a resident does not have an AD, the social workers assist the resident or representative with obtaining one. For residents who have an AD or POA prior to admission, the social worker documents a note in the resident medical record indicating that the resident or family will provide a copy. When asked about the follow up process for existing AD or POA, the SW #6 explained that the follow up is conducted during care plan meetings. The surveyor informed the social workers of the initial assessment for Resident #25 and requested the healthcare POA documents. The SW #6 stated that the facility did not have healthcare POA documents for Resident #25. On 09/25/2025 at 10:35AM, the surveyor informed the Administrator of the missing healthcare POA documents for Resident # 25. 2.) On 09/18/2025 at 12:08 PM, during a review of Resident #40's paper chart, the surveyor observed there was no advance directive in the chart. On 09/18/2025 at 1:26 PM, during a review of Resident #40's electronic health record, the surveyor observed there was no advance directive in the electronic record. On 09/19/2025 at 1:29 PM, during an interview with Licensed Social Service staff (Staff #7), when asked how advance directives were obtained from residents, she stated that advance directives were discussed at the time of admission with the resident or family. She explained that residents or family members were asked to provide a copy if they had one, or an advance directive was offered if they did not have one. She further stated that advance directives would be placed in the chart and uploaded into the electronic record. On 09/19/2025 at 1: 33 PM, when asked specifically about Resident #40's advance directive, Staff #7 reviewed the electronic record and stated that the resident did not have one. The surveyor informed her that her social assessment note dated 07/21/2025 indicated: Patient expressed agreement with current orders. Patient stated she has an advance directive at home with her will. This writer will (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow up with family to attempt to obtain a copy for the chart. Staff #7 stated that she had followed up with Resident #40's son regarding the advance directive but failed to obtain it or document the follow-up in the record. She added that she would ask Resident #40 for the advance directive again, and that she would ensure that Resident #40's advance directive was placed in his/her chart and in the electronic record. On 09/19/2025 at 2:03 PM, these concerns were discussed with the Director of Nursing (DON), who acknowledged the findings.

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	215120	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interviews, it was determined that the facility failed to ensure resident medical records were maintained secure and confidential. This was evident during 1 of several observations of the 400 hallway during the annual survey.The findings include:On 09/18/2025 at 2:01 PM, an observation on the 400 hallway (where residents, staff, and visitors walk through) revealed an unattended medication cart with a laptop on top of it. The laptop screen was on, open, and slightly pointed downward (facing the public hallway), but failed to reveal that the computer was locked or turned off, to maintain security and confidentiality of the residents medical records. On 09/18/2025 at 2:06 PM, the unattended medication cart with the laptop on top of it was still in the same spot with the screen on, open, and slightly pointed downward. On 09/18/2025 at 2:07 PM, an interview with Geriatric Nursing Assistant (Staff #10) who at the time became present during the observation, revealed that the expectation of staff was to lock the computer screen every time they walk away from the laptop, to maintain security and confidentiality of resident medical records. She further indicated it was Certified Medication Aide (Staff #9) who was logged in on the computer, and proceeded to go and find the staff.On 09/18/2025 at 2:07 PM, Staff #9 approached the surveyor, who was at the same spot by the computer on top of the medication cart. At the same time, an interview with Staff #9 revealed that the expectation of staff was to lock the laptop screens when they walk away from the computer, and that he must've gotten pulled away from the computer and forgot to lock the screen.On 09/19/2025 at 8:42 AM, the surveyor reviewed the concern with the Director of Nursing and she understood it was a concern.

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	215120	A. Building B. Wing	09/25/2025

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Autumn Lake Healthcare at Crofton	2131 Davidsonville Road Crofton, MD 21114

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and interview, it was determined that facility staff failed to ensure that the residents were free of misappropriation of property. This was evident for 1 (#195) of 1 resident reviewed for misappropriation of property. The findings include:On 9/23/25 at 11:32 AM a record review for Resident #195 revealed under the census tab that the resident had been in the facility for less than 2 weeks. A review of the minimum data set (MDS) with an assessment reference date of 3/13/25 revealed the resident did not have any cognitive impairment. According to Nurse Practitioner (NP) #34's visit note for 3/10/25, the resident was admitted for mobility and activity of daily living (ADL: bathing, dressing, eating, personal hygiene, etc.) dysfunction. A review of the facility's investigation file for the self-reported incident #310886 on 9/22/25 at 11:47 AM revealed an initial report form that noted Resident #195 reported to facility staff that his/her credit card was missing on 3/19/25 at 12:20 PM and she had last seen the card on 3/14/25. According to the report, the resident called the credit card company and determined there were fraudulent charges on the credit card. A list of charges starting on 3/15/25 and ending on 3/18/25 was included in the file with names of the businesses and their addresses included. According to the final report form, one employee reported last seeing the resident with the credit card on 3/14/25 but had not seen it since. The Nursing Home Administrator (NHA) noted on the final form that they were unable to determine who stole the credit card. However, further review of the investigation file revealed they reported Geriatric Nursing Assistant (GNA) #37 (agency GNA) to the state licensing board for misappropriation of resident property on 4/15/25. It was noted in the file that facility staff attempted to call the GNA and were unable to reach her or leave a message because her mailbox was full. An interview with the Nursing Home Administrator (NHA) on 9/22/25 at 1:07 PM revealed she called the credit card company with Resident #195, so she could document the fraudulent charges and the locations. She stated that they interviewed staff and was checked to see if any of them lived near the area the charges were made. They were unable to figure out who stole the credit card by the time they submitted the 5-day report to the State Agency (SA). However, she reported that it was later when she became aware GNA #37 had a different address than the one listed in her paperwork from the agency. The new address was across the street from one location where the card was used and within a mile of the other locations. She reported that once they found this, they reported the GNA to the state licensing board. Cross Reference: F607

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record review and interview, it was determined that the facility failed to develop and implement abuse prevention policies and procedures. This was evident for 1 of 1 abuse policy reviewed.The findings include: On 9/23/25 at 1:47 PM a review of the policy titled, Abuse, Neglect, and Exploitation revealed that it was dated 11/13/23 as the date reviewed, however there was no date of implementation. Under policy section it read, It is the policy of this facility to provide protection, welfare, and rights of each resident by developing and implementing written polices and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. However, the policy failed to address how the facility would prevent abuse by agency staff and ensure they reported allegations of abuse and injuries of unknown source. 1. During a review of the facility's investigation file for the self-reported incident #310886 on 9/22/25 at 11:47 AM it was revealed that an agency Geriatric Nursing Assistant (GNA) #37 had worked in the facility one shift on 3/14/25. She was assigned to Resident #195 who reported his/her credit card missing on 3/19/25 and thought s/he had not seen it since 3/14/25. When the resident notified the credit card company it was determined that there were fraudulent charges on the card starting on 3/15/25. The Nursing Home Administrator (NHA) was interviewed on 9/22/25 at 1:07 PM to determine why GNA #37 had been reported to the state licensing board. She reported that Resident #195 called the credit card while she was present so she could write down the information about the fraudulent charges. She stated that they checked to see if any of the staff working that day lived near the area where the charges were made. She reported that she became aware GNA #37 had a different address than the one in her paperwork from the agency. The new address was across the street from one location where the card was used and within a mile of the other locations. She reported that once they found this, they reported the GNA to the state licensing board. However, they failed to prevent the abuse and therefore, failed to implement their abuse prevention policy. 2. A review of the facility's investigation file for self-reported incident #311888 on 9/24/25 at 7:01 PM revealed GNA #40 reported that Resident #201 had a large bruise on his/her leg of an unknown source to agency Licensed Practical Nurse (LPN) #42. However, the nurse failed to report it to a supervisor and/or Administration. On 9/25/25 at 11:39 AM the Director of Nursing (DON) was interviewed and was asked what the facility did to correct the issue. She stated that it was an agency nurse, so they called the agency and asked them not to send her back. However, they failed to find out the reason she had not reported the injury of unknown origin. Furthermore, the abuse prevention policy had not addressed how the facility ensure that agency staff were educated on abuse and their abuse policies and procedures. Cross Reference: F602 and F609

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 provide a notice of transfer/discharge to a resident and/or the resident's responsible party (RP). This was evident for 1 resident (Resident #71) out of 2 residents reviewed for discharge process during the facility's recertification survey.The findings include:On 09/18/2025 at 1:17 PM, during an interview with Resident #71, the resident stated that he/she had fallen twice and was sent to the hospital.On 09/22/2025 at 8:23 AM, review of Resident #71's electronic health record showed that he/she was transferred to the hospital on [DATE] for shoulder swelling and shaking, and again on 08/30/2025 due to bleeding on the left brow and a skin tear after a fall.On 09/22/2025 at 10:20 AM, review of the hospital transfer notifications in the electronic record showed a notice of transfer/discharge for the 08/27/2025 hospitalization but there was no hospital transfer notification for the 08/30/2025 hospitalization in the electronic record.On 09/22/2025 at 10:25 AM, review of the resident's paper chart showed a notice of transfer form dated 08/30/2025 without the name of the responsible party, discharge location, resident's and or responsible party's (RP) acknowledgement signature and date.On 09/22/2025 at 10:34 AM, during an interview with the Unit Manager (Staff #24), when asked about the process for notifying the resident and responsible party (RP) of a hospital transfer, she stated that the notice of transfer/discharge form was duly completed and sent with the resident to the hospital, while a copy was provided to the RP if present, or mailed to the RP if they were not in the facility at the time of transfer. When asked if Resident #71 received a notice of transfer to the hospital, she stated she was not sure he received it. When asked if the RP had received a notice of transfer to the hospital, she stated that she did not know.On 09/22/2025 at 10:45 AM, during an interview with the DON, when asked about the facility's process for notices of transfer, she stated that a notice of transfer and bed-hold policy were completed and sent with the resident to the hospital. A copy was also provided to the RP if present, or mailed to them if not. When asked who was responsible for mailing the notice, she stated it was the Nursing Home Administrator (NHA).On 09/22/2025 at 10:50 AM, during an interview with the Nursing Home Administrator (NHA), when asked about the process for notices of transfer/discharge, she stated that the notice was sent on the next business day regardless of whether the RP was present. She added that she ensured another copy was mailed in case the one provided at the facility was misplaced. When asked who was responsible for completing the notice of transfer/discharge forms, she stated that the nurses were responsible for completing them and that copies were uploaded into the electronic health record once the hard copy had been mailed to the RP.On 09/22/2025 10:54 AM, when asked specifically if Resident #71's RP received a notice of transfer, the NHA stated she did not send one because the resident returned the same day. When asked if the notice should have been provided to both the resident and the RP, she stated that both should have received it. She also acknowledged that the form was not duly completed, and the RP did not receive one. When informed this was a concern, she verbalized understanding and stated that the form should have been completed and sent/mailed to the RP.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review and staff interview it was determined that the facility staff failed to code a resident's status accurately on the Minimum Data Set (MDS) assessment. This was evidentfor 1 (Resident #122) out of 2 residents reviewed for accidents during the annual survey. The findings include:The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure that each Resident receives the care they need.On 09/18/2025 at 9:07 AM, an interview with Resident #122 revealed they had a fall recently.On 09/19/2025 at 10:23 AM, review of Resident #122's medical record revealed that the resident had a fall on 07/18/2025 and 08/20/2025. On 09/22/2025 at 9:32 AM, review of Resident #122 medical records revealed an MDS dated [DATE] which failed to reveal the falls on 7/18/25 and 8/20/25 were coded. On 09/23/2025 at 8:40 AM, an interview with MDS coordinator #17 revealed that if a resident were to fall after the last resident assessment (MDS), that it would be coded on the following assessment. On 09/23/2025 at 8:49 AM, during an interview with MDS coordinator #11, the surveyor reviewed the concern and he acknowledged that he failed to code the resident's two falls on the MDS dated [DATE]On 09/23/2025 at 1:37 PM, the surveyor reviewed the concern with the Director of Nursing and she understood the concern.

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
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews and staff interviews, it was determined that the facility failed to develop comprehensive care plan for residents This was evident for 1 resident (Resident #1) out of 2 residents reviewed for care plan during the facility's recertification survey.The findings include: Anemia is a medical condition characterized by a low red blood cell count or hemoglobin levels. Hemoglobin is an iron-rich protein in red blood cells that carries oxygen throughout the body.A care plan is an outline of nursing care showing all the residents' needs and the ways of meeting the needs. Care plans provide direction for individualized care of the resident. A care plan flows from each resident's unique list of diagnoses and should be organized by the individual's specific needs. It is a dynamic document initiated at admission and subject to continuous reassessment and change by the nursing staff caring for the resident. The care plan typically includes nursing and medical diagnoses, nursing interventions, and outcomes to ensure consistency of care.On 09/23/2025 at 8:23 AM, review Resident #1's medical record showed that the resident had diagnosis of anemia and was transferred to the hospital for low hemoglobin and hematocrit (They are common blood tests used to assess the body's ability to carry oxygen).On 09/23/2025 at 8:28 AM, review of Resident #1's care plan showed there was no care plan in place that addressed the anemia diagnosis.On 09/23/2025 at 9:14 AM, during an interview with the Unit Manager (Staff #24), when asked who was responsible for care plans, she stated that nurses were responsible for initiating care plans and that she updated them. She further stated that all nurses, including herself, completed baseline care plans. When asked if she was aware that Resident #1 had a diagnosis of anemia, she stated she would check the electronic health record to confirm.On 09/23/2025 at 9:19 AM, while the surveyor was present, the Unit Manager (Staff #24) confirmed the resident had a diagnosis of anemia and acknowledged there was no initial care plan for Resident #1 that addressed anemia diagnosis. When asked for her expectations regarding care plans, she stated all residents should have a care plan initiated at admission which would addressed their current diagnoses and would be updated as appropriate. On 09/23/2025 at 9:38 AM, during an interview with the Director of Nursing (DON), when she was asked who was responsible for initiating care plans, she stated that nurses and unit managers were responsible. When asked about the expectations for care plans, she stated that residents should have care plans addressing all diagnoses. When informed of the concern regarding Resident #1's care plan regarding his/her anemia diagnosis, she stated she would review the resident's care plan and provide the surveyor with her findings.On 09/23/2025 at 10:06 AM, the DON confirmed that Resident #1 had a diagnosis of anemia and that there was no care plan that addressed the condition in the resident's electronic health record. She further stated that a care plan was initiated after she discovered the omission.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Number of residents sampled: Number of residents cited: Based on interviews and medical record reviews, it was determined that the facility staff failed to ensure the resident's primary health care representative was invited to care plan meetings. This deficient practice was evident for one (#13) resident reviewed for care plan timing and revision during the annual survey.The findings include:On 09/19/2025 at 9:12 AM, during a phone interview Resident #13's healthcare representative #1, they stated that the last care plan meeting they attended was in the previous year. On 09/19/2025 at 11:43 AM, a review of Resident #13 medical records revealed a social service progress note indicating that quarterly care plan invitations had been electronically sent to healthcare representative #2 on 01/08/25, 04/04/25, and 07/02/25.Further review of the medical records revealed that quarterly care plan meetings were conducted on 11/12/24, 02/11/25, 05/13/25, and 08/12/25. For each care plan meeting progress note, the Social Worker (SW #6) documented that healthcare representative #2 declined to attend. On 09/19/25 at 11:51 AM, during an interviews with SW #6 and SW #7, both explained the facility's process for conducting resident care plan meetings, which includes the frequency of meeting, required attendees, and the rights of residents and their representatives. The surveyor informed SW #6 of the care plan invitations that had been sent to Healthcare Representative #2, along with Representative #2's continued decline of attendance. The surveyor then asked why invitations were only sent to Healthcare Representative #2 and not to Healthcare Representative #1. SW #6 stated that she used the email address listed in the resident's chart to send the quarterly care plan meeting invitations. When asked why Healthcare Representative #1 was not contacted after Representative #2 repeatedly declined, SW #6 was unable to provide an answer. The surveyor then requested to review the resident's advance directive (AD). On 09/19/25 at 12:17 PM, a review of Resident #13's AD revealed that Healthcare Representatives #1 was designated as the resident's primary healthcare agent, with a telephone number listed for contact. Further review of the document indicated that if primary healthcare agent cannot be reached, Healthcare Representatives #2 was designated as the backup agent, with a telephone number also provided. The advance directive was signed by Resident #13, SW #6 and SW #8 on 09/18/24. On 09/25/2025 at 10:35AM, the surveyor informed the Administrator that care plan meeting invitations had been sent to Healthcare Representative #2 instead of Healthcare Representative #1.

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	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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interviews and record reviews, it was determined that the facility failed to provide and document activities in accordance with resident preferences. This was evident for 1 resident (Resident #102) out of 2 residents reviewed for activities during the facility's recertification survey. The findings include:On 09/23/2025 at 1:04 PM, during an interview with Resident #102 regarding his/her activities in the facility, the resident stated he/she did not participate in any activity. When asked about the type of activity he/she liked, Resident #102 stated that he/ she liked reading. When he/she was asked if the books were provided by the activity staff members, he/she stated his/her daughter brought them. At the time of the interview and observation, no books were present at the resident's bedside.On 09/23/2025 at 1:30 PM, review of Resident #102's care plan goal initiated on 06/27/2025 showed: Resident will choose a leisure pastime within my comfortable abilities through a combination of self-directed activities and scheduled group programs within 90 days.Interventions included: My favorite hobbies include, but are not limited to, reading magazines (especially First); listening to jazz music during relaxation; interest in pet therapy or animal visits; watching TV game shows, comedies, Westerns, and news (especially late morning and evening); and completing word searches and crossword puzzles independently during downtime.On 09/23/2025 at 1:37 PM, during an interview with the Activity Director (Staff #25), who had been in the position since June 2025 (previously an aide), she stated she was absent in July and returned in August. When asked about activities offered to Resident #102, she stated the resident was short term and had not attended any group activities. She explained that group activities were offered, and residents were encouraged to participate, but if they declined, they were offered independent materials such as magazines. When asked about the type of activity that had been offered to Resident #102, she stated that the resident was given magazines. When asked for the resident's activity log, she acknowledged that documentation had not been completed and that although the resident had activity preferences, they were not documented.On 09/23/2025 at 1:49 PM, the surveyor requested three months of activity logs from Staff #25.On 09/23/2025 at 1:52 PM, staff #25 presented three months of activity logs. Review showed only one documented activity (salon services on 07/18/2025); the remainder of the records were blank. When asked about the lack of documentation, Staff #25 acknowledged that the logs had not been completed and confirmed that although Resident #102 had activity preferences, they were not documented.On 09/23/2025 at 1:59 PM, during an interview with the Nursing Home Administrator (NHA), when asked about activity staff expectations for residents' activities and documentation, she stated each resident should have a participation record that reflected their activities of interest, including a coding system for activity programs and interventions. She added that documentation should reflect attendance or refusal of activities. When informed of the concern, the NHA stated that Staff #25 should have ensured that Resident #102's activity preferences were observed and documented in his/her logbook appropriately.

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

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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. ZenPep is a medication with the active ingredients of lipase, amylase, and protease to aid with (continued on next page)

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	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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. A subsequent interview with the DON on 9/25/25 at 10:10 AM revealed she was not aware of the fax (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. On 9/24/2025 at 11:00 AM, Registered Nurse (RN) #20, the Unit Manager was interviewed and (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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	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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, medical record review, and interview, it was determined the facility staff failed to ensure that residents received respiratory care consistent with professional standards of practice. This was evident for 2 resident (Resident #107 and Resident #9) out of 4 residents reviewed for respiratory therapy 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 tubing is a medical-grade hose that connects an oxygen source (like a concentrator or tank) to an oxygen delivery device, such as a nasal cannula or mask. It is designed to be lightweight, flexible, and kink-resistant to ensure a steady and uninterrupted flow of oxygen for therapy. On 09/18/2025 at 8:50 AM, during the initial tour of the facility, Resident #102 was observed seated in a chair with oxygen administered via nasal cannula connected to oxygen tubing. The surveyor observed that the oxygen tubing was not dated. On 09/18/2025 at 8:58 AM, during an interview with Licensed Practical Nurse (LPN #12), when asked when the oxygen tubing had last been changed, she checked the tubing and stated she did not know when it was changed. She added that it was the night shift's duty to change it weekly. LPN #12 stated she would have known when the tubing was last changed if it had been dated. When asked about the expectation regarding dating the oxygen tubing, she stated that they must be dated after each change. On 09/23/2025 at 11:55 AM, during an interview with LPN #28, when asked for the expectation regarding oxygen tubing, she stated it should be changed weekly, and the humidifier should be changed when it is less than one-quarter full. She also stated the tubing should be dated immediately after changing. On 09/23/2025 at 12:03 PM, during an interview with LPN #12, when asked how she would know if an oxygen machine was not working properly, she stated that air would not be felt and the mercury indicator would drop to the bottom, showing it was not functioning. She stated maintenance staff would be notified immediately if the machine was found to be defective. On 09/23/2025 at 12:33 PM, during an interview with the Director of Nursing (DON), when asked about the expectation for oxygen tubing, she stated that it should be changed weekly and as needed. When asked how it was documented, she stated that the nurse signed it off. When asked if tubing should be dated after being changed, she stated, Yes, absolutely. The DON added that when she was made aware of the undated oxygen tubing, all residents on oxygen were audited, and staff were in-serviced on oxygen tubing turnover and dating requirements. She also added that the in-service was on-going. 2. On 09/18/2025 at 9:16 AM, during the initial tour of the facility, the surveyor observed Resident #9 in bed receiving oxygen therapy. Upon further observation, it was discovered that the resident's oxygen tubing was dated 9/9/25. On 09/19/2025 at 12:54 PM, a review of Resident #9's orders revealed an order that read, Maintain O2 equipment/ Change per protocol if used: Wkly/MONDAY 11-7. every night shift for label new tubing with date per protocol. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/19/2025 at 1:15 PM, a review of facility oxygen administration policy revealed, under Policy Explanation and Compliance Guidelines, #5b stated Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. On 09/19/2025 at 1:19 PM, another observation of Resident #9 revealed that the oxygen tubing was still labeled and dated 9/9/25. On 09/19/2025 at 1:21 PM, during the observation, the Administrator was shown the oxygen tubing that was still labeled 9/9/25. The Administrator confirmed the findings and was made aware of the concern at this time. On 09/19/2025 at 1:25 PM, in an Interview with the Director of Nursing (DON), she stated that the expectation is that oxygen tubing should be changed weekly or as needed. She stated that the nursing staff should be following the orders and the policy for oxygen tubing changes. At this time the DON was made aware of the concerns.

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	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

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and staff interviews, it was determined that the facility failed to ensure residents were educated on the benefits and risks of pneumococcal vaccine following a refusal. This was evident for 1 resident (Resident #40) out of 5 residents reviewed for immunizations.The findings include:A BIMS score is derived from the Brief Interview for Mental Status, a brief screening tool for assessing cognitive function in long-term care settings. A score between 0 and 15, where higher scores indicate better cognitive ability, helps facilities track cognitive changes. Scores are categorized: 0-7 is severe impairment, 8-12 is moderate impairment, and 13-15 is cognitively intact. The assessment evaluates temporal orientation and short-term recallOn 09/24/2025 at 10:01 AM, review of Resident #40's immunization record showed no documentation that education regarding the risks and benefits of the pneumococcal vaccine was provided following the resident's refusal.On 09/24/2025 at 10:12 AM, during an interview with the Infection Preventionist (IP), when asked about the facility's expectation regarding vaccination education to residents, she stated the facility's expectation was that education regarding risks and benefits of vaccines is to be provided whether a resident consents or declines, and that such education must be documented. When asked if Resident #40, who had a BIMS score of 15, was educated after refusing the pneumococcal vaccine, she stated that she would check the resident's electronic health record and paper chat for confirmation.On 09/24/2025 at 10:19 AM, the IP returned and confirmed that review of Resident #40's record showed no documentation of education regarding the risks and benefits of the pneumococcal vaccine following the resident's refusal. The IP stated Resident #40 should have received education and further stated she would begin auditing all vaccine refusals to ensure education was provided and documented.On 09/24/2025 at 11:08 AM, during an interview with the Director of Nursing (DON), when asked about the facility's expectation regarding resident education after vaccine refusal, she stated residents are expected to be educated on the risks and benefits of vaccines following refusal. After being informed of the concern, the DON acknowledged the issue and stated staff would receive in-service education.

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

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on record reviews and interviews, it was determined that the facility failed to ensure all direct care staff received effective communication training. This was evident for 1 (Staff #38) out of 5 staff reviewed for staff training. The findings include: On 09/23/2025 at 1:20 PM, review of Geriatric Nursing Assistant's (Staff #38) training failed to reveal that they completed effective communication training. On 09/23/2025 at 1:27 PM, the surveyor reviewed the concern with the Director of Nursing (DON) and she indicated that the expectation was that the agency provided training for agency staff. She further indicated she had no further training to provide for Staff #38. During the same interview, the DON indicated there was not a process in place to ensure that all required training was completed by agency staff, including effective communication training that was not on the list of educational trainings completed for Staff #38.

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

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on record reviews and interviews, it was determined that the facility failed to ensure all staff received mandatory Quality Assurance and Performance Improvement (QAPI) training. This was evident for 1 (Staff #38) out of 5 staff reviewed for staff training. The findings include: Quality Assurance and Performance Improvement training informs staff of the elements and goals of the facility's QAPI program. On 09/23/2025 at 1:20 PM, review of Geriatric Nursing Assistant's (Staff #38) training failed to reveal that they completed QAPI training. On 09/23/2025 at 1:27 PM, the surveyor reviewed the concern with the Director of Nursing (DON) and she indicated that the expectation was that the agency provided training for agency staff. She further indicated she had no further training to provide for Staff #38. During the same interview, the DON indicated there was not a process in place to ensure that all required training was completed by agency staff, including the training that was not provided by the agency (including QAPI training).

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

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. Based on record reviews and interviews, it was determined that the facility failed to ensure staff received the required compliance and ethics training. This was evident for 1 (Staff #38) out of 5 staff reviewed for staff training. The findings include: On 09/23/2025 at 1:20 PM, review of Geriatric Nursing Assistant's (Staff #38) training failed to reveal that they completed compliance and ethics training. On 09/23/2025 at 1:27 PM, the surveyor reviewed the concern with the Director of Nursing (DON) and she indicated that the expectation was that the agency provided training for agency staff. She further indicated she had no further training to provide for Staff #38. During the same interview, The DON indicated there was not a process in place to ensure that all required training was completed by agency staff, including the training that was not provided by the agency (compliance and ethics training).