STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215129	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Parkville	8710 Emge Road Baltimore, MD 21234

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37276 Based on medical record review and review of pertinent documents and interviews it was determined the facility staff failed to notify the resident's representative when there was a significant change in the resident's condition and a change in the resident's treatment plan. This was evident for 1 (Resident #11) of 22 residents reviewed for a complaint during the complaint survey. The findings include: On 4/10/25 at 10:19 AM a review of complaint #MD00203408 alleged that Resident #11's representative was not notified when the resident had a change in condition and was started on oxygen. The complaint alleged the resident representative found out Resident #11 was on oxygen when s/he saw the resident using oxygen during a visit on 1/29/24, and the resident's body appeared swollen and full of fluid. When Resident #11 was asked why s/he hadn't called the representative, the resident said it was because s/he was scared & exhausted from the experience. Resident #11's representative spoke with the nurse on duty, who stated s/he was new to the facility, then reviewed the resident's chart and told him/her that Resident #11 had had an x-ray, and there was excess fluid throughout his/her body. Then, on 1/30/24 at 8:30 AM, the resident representative received a call from the resident's nurse who apologized for not contacting either one of the resident's 2 representatives about Resident #11's change in condition. On 4/10/25 at 10:32 AM, a review of Resident #11's electronic medical record (EMR) was conducted and revealed Resident #11 was admitted to the facility in January 2024 following an acute hospitalization with multiple diagnosis which included stage 4 kidney disease, diabetes, hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), cellulitis (bacterial skin infection). The medical record further documented Resident #11 was transferred to the hospital in February 2024 and subsequently discharged from the facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a change in condition note, on 1/27/24 at 11:31 PM, the nurse documented that Resident #11 was short of breath (SOB) and the resident reported s/he could not breath. The nurse wrote that Resident #11 was breathing heavily, and his/her oxygen saturation (02 sat) (a measure of how much oxygen is in the blood) was 68% (normal 95% - 100%) on room air. The nurse wrote Resident #11 was given oxygen at 3 liters via nasal cannula with no improvement, that the oxygen was increased to 6 liters, and the resident was given a nebulizer (changes medication from a liquid to a mist so it can be inhaled) treatment with positive results. The nurse further documented the physician was notified on 1/27/24 at 11:43 PM, and recommended labs and a chest x-ray. In the change in condition note, the date and time of resident representative notification was documented 1/30/24 at 8:00 AM. Further review of Resident #11's medical record revealed, on 1/30/24 at 8:25 AM, in a general nurses note, the nurse documented that a clinical update was given to Resident #11's representative. No other documentation was found in the medical record to indicate that following Resident #11's change in condition on 1/27/24, the resident's representative had been informed of the significant change in Resident #11's health status or that the representative had been notified of the change in the resident's treatment plan when oxygen was implemented and an x-ray and labs were ordered. The above concerns were discussed with the Nursing Home Administrator (NHA) and Director of Nurses (DON) on 4/11/25 at approximately 1:00 PM. The NHA and DON acknowledged the concerns, and no further comments were offered at that time.

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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. 31982 Based on medical record review and interview with staff it was determined that the facility failed to develop a person-centered Hospice plan of care with individualized needs and preferences. This was evident for 1 (Resident #12) of 1 residents reviewed for Hospice services during the complaint survey. The findings include: Hospice is a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease. Hospice offers physical, emotional, social, and spiritual support for patients and their families. A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Resident #12's medical record was reviewed on 4//8/25 at 1:52 PM. Resident #12 was admitted to Hospice Services on 7/11/23. A Hospice Plan of Care was developed by the facility on 7/10/23 with the focus: The resident has a terminal prognosis r/t (relate to) Resident is on [company name] Hospice services. The resident's goals were identified as: Resident #12's comfort would be maintained; and the resident's dignity and autonomy would be maintained at the highest level. The facility identified 11 interventions to assist the resident in reaching his/her goals. However, they were general interventions that did not include/reflect Resident #12's specific individual care needs or preferences. One intervention: assess the resident's coping strategies and respect his/her wishes - it did not identify what his/her coping strategies were nor his/her wishes. Another intervention stated: Consult with physician and Social Services to have Hospice care for resident in the facility. It was not resident centered. The intervention: Encourage support system of family and friends failed to identify the family and friends the resident wished to include in his/her support system. The plan did not identify Resident #12's end of life wishes, specific choices, or preferred comfort measures for staff to implement when providing end of life care. An interview was conducted on 4/9/25 at 11:12 AM with Staff #3 the Director of Social Services regarding Hospice Services and Care Plan development related to Hospice services. She confirmed that she is the facility's Hospice Liaison. The Administrator was present in the room and joined the interview. They were asked how the facility ensured that resident specific end of life wishes were identified and provided. When asked to clarify, the surveyor reviewed Resident #12's Hospice Plan of Care with them. They were made aware that the plan had not identify any resident preferences or wishes for end-of-life care needs including but not limited to end of life wishes, any specific comfort measures or if/who she would like to have at his/her bedside at end of life. They acknowledged these findings.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37276 Based on medical record review, interviews, and review of pertinent documentation, it was determined the facility failed to keep residents free from a significant medication error by failing to ensure medication was available in a timely manner for the facility to administer. This was evident for 1 (Resident #16) of 22 residents reviewed for a complaint during the complaint survey. The findings include: On 4/11/25 at 9:00 AM, a review of complaint #MD00195309 alleged Resident #16 was told that his/her medications would be at the facility when s/he arrived at the facility, however it took 2 days to get the medication and the complaint alleged that the nurse attempted to give Resident #16 another resident's insulin. Following the review of the complaint, a review of Resident #16's electronic medical record (EMR) revealed documentation that Resident #16 was admitted to the facility on [DATE], at 7:30 PM, following an acute hospitalization and discharged from the facility in the beginning of September 2023. The medical record documented Resident #16 had multiple diagnoses including type 1 diabetes. Review of Resident #16's August 2023 electronic Medication Administration Record (eMAR) revealed insulin order that had administration times signed with the code 9 (other/see nurses note). When a medication administration was coded 9, the medication order populates in an eMar medication administration note in the progress notes for the practitioner to document the reason the medication was not administered or any other pertinent information about the medication. 1) Review of Resident #16's August 2025 electronic Medication Administration Record revealed an 8/1/23 order for Basaglar (Insulin glargine) (long-acting insulin) KwikPen Subcutaneous (sq) Solution Pen-injector 100 unit/ml (milliliter) Inject 15 units subcutaneously (sq) (in fatty tissue, under the skin) at bedtime related to type 1 diabetes. On 8/2/23 at 8:00 PM, the administration time was signed off with the code 9 (other/see nurses notes). Review of Resident #16's eMar medication administration notes for when the Basaglar insulin was signed 9 revealed on 8/2/23 at 9:00 PM, the practitioner documented awaiting delivery from pharmacy, indicating the Basaglar insulin was not available in the facility for the staff to administer to the resident. 2) An order for Sliding Scale insulin means the person's blood sugar is checked prior to administration of the insulin and the amount of insulin to be administered changes or slides up or down based on the person's blood sugar. Normal fasting blood sugar levels are generally considered to be between 70 and 100 mg/dL (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a) Review Resident #16's of the MAR revealed an 8/1/23 order for Novolog (fast-acting insulin) FlexPen subcutaneous (sq) solution, administer per sliding scale sq before meals and at bedtime related to type 1 diabetes revealed on 8/3/23, 2 (6:00 AM, 4:00 PM) administration times were signed off with the code 9: - on 8/3/23 at 0600 AM, the resident's blood sugar result was documented as 343 and the administration time was signed off with the code 9. - on 8/3/23 at 4:00 PM, blood sugar result was documented as NA (nor applicable), indicating the resident's blood sugar was not checked, and the order was coded 9 Review of Resident #16's eMar medication administration notes for when the order for Novolog sliding scale insulin administration time was signed off with the code 9 revealed the Novolog insulin was not available in the facility for the staff to administer to the resident and documented the following: - on 8/3/23 at 7:28 AM, Notified on call [Staff #6, Nurse Practitioner], no coverage for Aspart (Novolog insulin) due to not being available at facility. Per on call NP, continue monitoring and assess for s/s of stress. - on 8/3/23 at 7:34 AM, Not available on call NP made aware - on 8/3/23 at 4:26 PM, Resident insulin in transit from the pharmacy. MD aware 2b) Further review of Resident #16's order for Novolog FlexPen sq solution to be administered per sliding scale in the August 2023 MAR revealed on 8/3/23 at 11:00 AM, Resident #16's blood sugar was documented as 275, and documented that 6 units of insulin were given. This was in contravention to documentation indicating Novolog insulin for Resident #16 was not in the facility to give to the resident. Review of Resident #16's eMar medication administration notes for Novolog insulin per sliding scale revealed documentation indicating the Novolog insulin was not available for the staff to administer, and documented the following: - on 8/3/23 at 11:52 AM insulin still on order, NP aware. Pt. monitored for s/s of hyperglycemia high blood sugar) (none noted) - on 8/3/23 at 2:47 PM, meds still on order, pharmacy called in for stat delivery . NP aware 3) Continued review of Resident #16's August 2023 MAR revealed an 8/1/23 order for NovoLog (fast-acting insulin) FlexPen Subcutaneous (sq) Solution Pen-injector 100 unit/ml, Inject 4 units sq with meals related to type 1 diabetes, indicating the Novolog insulin should be administered routinely at 6:00 AM, 11:00 AM, and 4:00 PM. The MAR documented on 8/3/24 the Novolog order was signed off with the code 9 on 3 (6:00 AM, 11:00 AM, and 4:00 PM) administration times. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's eMar medication administration notes for when the order for Novolog insulin, 4 units, administer routinely with meals was signed off with the code 9 revealed the Novolog insulin was not available in the facility for the staff to administer to the resident and documented the following: - on 8/3/23 at 7:33 AM, Not available. - on 8/3/23 at 11:56 AM , insulin on order , pharmacy called in for stat delivery, NP aware - on 8/3/23 at 4:25 PM, Resident insulin in transit from the pharmacy, Md (medical doctor) aware On 4/14/25 at approximately 11:30 AM, the Nursing Home Administrator and the Director of Nurses were made aware of the above concern that prescribed medication was not available in the facility in a timely manner resulting in missed administrations, and made aware of the concern that, in the MAR, the order for Novolog per sliding scale was documented as given on 8/3/23 at 11:00 AM with no evidence the Novolog insulin prescribed for Resident #16 had been available to give. The NHA and DON acknowledged the concerns, with no further comments offered at that time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31982 Based on medical record review and interview with staff it was determined facility staff failed to maintain complete and accurately documented medical records. This was evident for 1 (Resident #12) of 1 residents reviewed for Hospice services during the complaint survey. The findings include: Resident #12's medical record and facility's Hospice contract were reviewed on 4//,d+[DATE] at 1:52 PM. The record revealed that Resident #12 was admitted to Hospice services on [DATE]. The facility's contract with Resident #12's Hospice provider included: 2.Responsibilities of Facility (d) coordination of care, (iv) Notification of Change in Condition. Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient. It included but was not limited to the death of a Hospice Patient. A Nursing Progress Note dated [DATE] at 20:04 [8:04 PM] indicated Low blood pressure. Action: Monitoring resident blood pressure, Response: Resident is hospice and declining. There was no documentation indicating the resident's representative or Hospice provider were made aware of these findings. Another progress note dated [DATE] at 11:47 AM indicated: Patient expired this morning at 9:30 am, family came to be with the patient at bed side. Patient body was release to Maryland Cremation services at 11:00am. The note was not clear if the resident's family was with him/her when he/she expired or arrived afterward. There was no documentation of an assessment of the resident with the findings that led the nurse to conclude that the resident had expired. The documentation did not indicate when, if or how the contracted Hospice provider was notified that Resident #12 had expired. The Administrator and Director of Nursing were made aware of these concerns and confirmed the above findings on [DATE] at 1:20 PM.