STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215141	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Patuxent River	14200 Laurel Park Drive Laurel, MD 20707

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on medical record review, observation and interview it was determined that the facility failed to complete accurate assessments of a resident related to the functional use of extremities on the quarterly and annual minimum data set (MDS). This was determined during the review of an injury of unknown origin for 1 of 3 residents (Resident #1)The findings included: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. The medical record of Resident #1 was reviewed on 4/10/26 at 7:48 AM related to a report of injury of unknown origin. This review identified a healed treated wound on the inside of a bed bound residents' leg, with interventions put in place. The facility MDS coordinator was interviewed on 4/10/26 at 10:10 AM. She was asked specifically about Resident #1's assessment and stated that ?if I am able to move it, its coded no impairment though its passive, the resident can't follow directions to move on their own.' It was reviewed at this time that on the 2/26/25, 5/30/25 and 8/28/25 MDS assessments, all were coded as Resident #1 had bilateral impairments to the lower extremities.On the 11/24/25 and 3/4/26 MDS assessments the bilateral lower extremities were coded as no impairment. Staff # 3 was asked what the change was, or why she coded differently. She stated that she just codes what is presented at the time. Surveyor observed the healed area on Resident #1's leg with the assigned nurse LPN #11 on 4/10/26 at 11:55 AM. LPN #11 attempted to reposition the residents' legs and they were difficult to move. At this time this surveyor requested the MDS nurse to come to the resident's room. At 12:00 PM she arrived at the resident room with the facility DON. She was asked to show how she performed her assessments to properly code the resident's status on the MDS.MDS staff #3 then proceeded to flex Resident #1's left ankle back and forth. This surveyor asked if staff #3 thought that that was full flexion, and she stated that ?it's moving.' This surveyor looked at the DON and stated that this would be reviewed with the office MDS coordinator. These concerns were reviewed again during exit on 4/13/26 with the facility Administrator and DON.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on medical record review and staff interview it was determined that the facility staff failed to administer medications according to the physician orders. This was evident for 2 out 3 Resident (#16 and #7) reviewed during the complaint survey regarding medication administration.The findings include:Documentation is an integral part of medication administration. Documentation communicates the timing, dosing, and effect of any medications received by a patient. In the setting of skilled nursing care, residents are often prescribed multiple medications for significant medical conditions. They are also often more vulnerable to medication errors and more prone to changes in conditions that require review and adjustment of their medication regimen. Inaccurate medication documentation has the potential to place residents at significant risk of medication error, provide incomplete or inaccurate information for providers and care givers to evaluate, and represents a failure of basic medication administration principles.Late documentation is a form of inaccurate documentation and is worsened if the documentation does not document when medications were actually given. 'Late administration' is defined as giving medication greater than 1 hour after a medication is due. 'Late documentation' is defined as not documenting immediately after administration. 1. Secondary to a complaint, the medical record for Resident #16 was reviewed. The complaint alleged that insulin was administered late or after meals. The family was further concerned, as the resident was admitted with a wound and they reported the surgeon was adamant about glucose control.Review of the medical record for Resident #16 on 4/7/26 at 8:50 AM revealed admission to the facility for strict diabetic monitoring secondary to wound healing.On admission, according to the hospital discharge instructions, Resident #16, was to be administered Novolog flex pen 7 units prior to meals, ordered at 630, 1130, 1630 and 2000, additionally, on 3/27/26 Resident #16 was placed on a sliding scale schedule before meals and at bedtime, 630, 1130, 1630 and 2000 to coincide with the Novolog flex pen 7 units.A closer review of the administration times of the medication on 4/8/26 at 7:35 AM revealed:Novolog Flex pen for 3/20/26 4:30 PM signed off at 7:23 PM,Novolog signed flex pen and sliding scale signed off on 3/30/26 for 11:30 AM at 1:02 PM,4/1/26 for 11:30 AM flex pen signed off at 1:12 PM and sliding scale signed off at 2:40 PM, 8:00 PM signed off at 9:31 PM,4/2/26 for 11:30 AM both flex pen and sliding scale signed off at 1:00 PM,4/3/26 8:00 PM sliding scale signed off at 10:00 PM,4/4/26 6:30 AM both flex pen and sliding scale signed off at 8:17 AM, 11:30 AM both signed off at 2:45 PM, 4:30 PM AND 8:00 PM sliding scale signed off at 10:03 PM,4/5/26 11:30 AM both flex pen and sliding scale signed off at 1:32 PM.A review of Resident #16's documented blood glucose from 3/15-4/9/26 ranged from 70 mg/dl to 349mg/dl. The identified concerns were reviewed with the DON starting on 4/7/26 and throughout the survey. 2. A review of Resident #7's medical record was completed on 4/10/26 at 12:15 PM secondary to a facility reported incident. The family had concerns with the care provided on 1/11/26.A review of the available documentation of nursing notes, vital signs, and ordered medication revealed multiple inconsistencies. According to the residents vital signs column in the electronic medical record, at 10:38 AM his/her blood pressure was 90/60 mm/Hg, the next recorded was at 2:06 PM was 122/71 mm/Hg.Review of the medication administration record (MAR) revealed that the order was for the blood pressure to be checked at 8AM-12PM-4PM-8PM. It is checked with the concurrent administration of Midodrine (treats low blood pressure).Further review of the administration of the Midodrine and blood pressure checks since admission noted for the ordered 1/8/26 8:00 AM was signed off at 10:07 AM, 1/9/26 8:00 AM was signed off at 12:03 PM which was 4 hours after the scheduled dose. Resident #7 was sent to the emergency room on 1/11/26 secondary to hypotension.The identified concerns were reviewed with the DON on 4/13/26 and the facility Administrator during exit on 4/13/26.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on record review and interview it was determined that facility staff failed to ensure that physician visits notes were available in the medical record for each resident. This was evident for 1 (#15) of 8 residents reviewed for complaints. The findings include:A medical record review for Resident #15 on 4/9/26 at 11:45 AM revealed the last attending physician note found was dated 11/30/25. The last physician visit note was requested on 4/10/26 at 1:00 PM.A review of the documentation provided by the Director of Nursing (DON) on 4/10/26 at 8:30 AM revealed they had not included the last physician provider note. The DON was made aware on 4/10/26 at 8:38 AM. She confirmed that the last attending physician note on the medical record was dated 11/30/25. She stated that she was going to investigate what happened because the new attending physician #16 started on 3/23/26 and she thought the resident was seen. On 4/10/26 at 11:37 AM the DON brought evidence that Resident #15 had been seen by attending physician #16 on 3/26/26 but the note was not available in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on random observations, interviews and medical record review, it was determined that the facility failed to ensure infection control orders were followed and consistent throughout the facility. This was evident for 1 (Resident #12) of 20 residents reviewed during the complaint survey.The findings include:1) On 4/13/26 at 12:07 PM during an observation of Resident #12, Geriatric Nursing Assistant (GNA) #14 was observed in the resident's room without a gown on. He was carrying a basin of water to the bathroom. There was a sign on the door that indicated the resident was on enhanced barrier precautions (EBP) and the resident's name tag was highlighted orange. There was a linen cart sitting in the doorway of the resident's room with the blue cover pulled up and the linen was exposed. Inside the room there were linens lying directly on the floor and a plastic bag with linen lying next to them. An interview with GNA #14 on 4/13/26 at 12:12 PM revealed he was in the room providing incontinent care. He reported he was wearing a gown but took it off, before he finished providing care, because it was in his way. When asked about the EBP he reported he was to wear a gown and gloves during care, but he was not sure which resident the sign was for. When asked about the linens on the floor and the linen cart outside the doorway and open, he agreed that he should not have done that due to contamination. On 4/13/26 at 12:19 PM Licensed Practical Nursing (LPN) #15 was interviewed. He looked up Resident #12's physician's orders and stated the resident was on EBP. He went with the surveyor and observed the laundry cart sitting outside the room door and agreed that it should have been covered. Reviewed the observation and concerns and he acknowledged the concerns. On 4/13/26 at 12:35 PM the concerns were reviewed with the Director of Nursing (DON) and Nursing Home Administrator (NHA) and they reported that the orange highlighted name tag did mean that it was that resident who was on EBP. However, they did not think Resident #12 was on EBP. However, they agreed that if a staff member saw the signage and the orange highlighted tag, they should have followed the signage. Acknowledged the other concerns.