STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215189	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Calvert Manor	1881 Telegraph Road Rising Sun, MD 21911

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility staff failed to notify a Resident's responsible party for a change in condition (Resident #3). This was evident for 1 of 10 residents reviewed during a complaint survey. The findings include:Review of Resident #3's medical record on 12/9/25 revealed the Resident was admitted to the facility on [DATE] at 11:55 AM with a diagnosis to include Alzheimer's disease. Alzheimer's disease is a type of dementia that affects memory, thinking and behavior.The facility staff assessed the Resident on 9/11/25 at 1:19 PM to be a high risk for wandering/elopement.Further review of the Resident's medical record revealed a nurse's note on 9/11/25 at 6:07 PM that states several attempts to leave unit. Wander Guard placed on right ankle.Review of Resident #3's medical record revealed no notification to Resident #3's responsible party of placement of a Wander GuardDuring interview with Resident #3's responsible party (RP) on 12/10/25 at 11:06 AM, the RP stated no one called him/her on 9/11/25 to advise him/her the Resident was wandering, attempting to leave the unit and the facility staff placed a Wander Guard on the Resident.Interview with the Director of Nursing on 12/10/25 at 11:25 AM confirmed there is no documentation in Resident #3's medical record of notification to the RP of placement of the Wander Guard on 9/11/25.

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
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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 - 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 medical record review and interview, it was determined that the facility staff failed to administer medications, treatments and supplements as ordered in a timely manner (Resident #3 and #6). This was evident for 2 of 10 residents reviewed during a complaint survey.The findings include:1. The facility staff failed to administer medication as ordered for Resident #3.Review of Resident #3's medical record on 12/9/25 revealed the Resident was admitted to the facility on [DATE] at 11:55 AM with a diagnosis to include dementia. Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.Further review of Resident #3's medical record revealed on 9/11/25 the Resident was ordered Donepezil 5 mg at bedtime for dementia.Review of Resident #3's Medication Administration Record revealed on 9/11/25 at 8:00 PM the Donepezil 5 mg was not administered with a code of 9 (Other/see nurses note).Review of Resident #3's nursing notes revealed Donepezil 5 mg on order from pharmacy.Review of Omnicell Inventory listed provided by the Director of Nursing (DON) on 12/9/25 revealed the Omnicell contains Donepezil 5 mg.Interview with the Director of Nursing on 12/10/25 at 9:40 AM confirmed Resident #3 was not administered Donepezil 5 mg on 9/11/25 as ordered by the physician.2.The facility staff failed to order and administer supplements timely for Resident #6.Review of Resident #6's medical record on 12/9/25 revealed the Resident was admitted to the facility in September 2025 with diagnosis to include malnutrition.Further review of Resident #6's medical record revealed the Resident was assessed by the Registered Dietitian (RD) on 9/26/25 who documented Resident appears very thin and his/her overall intakes slowly improving. Will recommend add 8 oz house supplement shake every day. Review of Resident's Patient Orders revealed the RD communicated to the Nurse Practitioner (NP) on 9/26/25 at 12:51 PM: new admission with varied intakes, 116 pounds = well below ideal body weight = agreed to supplement = malnourished recommend add 8 oz house supplement every day On 9/26/25 at 12:56 PM the NP (Staff #9) documented Ok. Review of the Resident's physician orders revealed the house supplement shake was not ordered until 9/29/25. Review of the Resident's September 2025 Medication Administration Record revealed the Resident was not administered the supplement shake until 9/30/25, 4 days after it was ordered.Interview with the Director of Nursing on 12/10/25 at 9:21 AM confirmed the facility staff fail to order and administer supplement shakes for Resident #6 timely.3.The facility staff failed to administer wound treatments as ordered for Resident #6.Review of Resident #6's medical record on 12/9/25 revealed the Resident was admitted to the facility in September 2025 with a diagnosis to include diabetes and peripheral neuropathy.Further review of Resident #6's medical record revealed the Resident was assessed by the Wound Nurse Practitioner on 10/14/25 for a left foot wound and treatment ordered.Review of the physician orders revealed on 10/15/25 the left foot wound orders were changed to Apply Calcium Alginate between the toes and cover the top and bottom of left foot every shift.Review of Resident October 2025 Treatment Administration Record revealed there is no documentation of the administration of left foot wound treatments on 10/18/25 3-11 PM, 10/19/25 3-11 PM, 10/24/25 11 PM - 7 AM and 10/26/25 3-11 PM. Interview with the Director of Nursing on 12/10/25 at 9:25 AM confirmed there is no documentation the facility staff administered left foot wound treatments for Resident #6 on 10/18/25 3-11 PM, 10/19/25 3-11 PM, 10/24/25 11 PM - 7 AM and 10/26/25 3-11 PM.