STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215258	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Spa Creek	35 Milkshake Lane Annapolis, MD 21403

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews and record reviews it was determined that the facility failed to ensure staff provided services that met professional standards of practice. This was found to be evident for 5 (Resident #55, #131, #81, #142, and #96) out of 5 Residents reviewed for Services Meet Professional Standards of Practice during the recertification survey.The findings include: 1) During a medication administration observation conducted on 07/31/25 at 7:31 AM, this Surveyor observed License Practice Nurse (LPN) #4 administer Resident #55’s morning medications. The following medications were administered: Amlodipine 10 mg (milligram)1 tab (tablet) Aspirin 81 mg 1 tab, Escitalopram Oxala 5 mg 1 tab, Losartan Potassium 100 mg 1 tab, Metoprolol 25 mg 1 tab, and Vitamin D 25 mcg (microgram) 1000 iu (international unit). During a review of Resident #55’s Medication Administration Record (MAR) conducted on 07/31/25 at 7:41AM, it was discovered that LPN #4 documented that she administered Bio freeze topical to the right foot. However, during the medication administration observation this Surveyor did not observe the LPN administer that medication. 2) During a medication administration observation conducted on 07/31/25 at 7:48 AM, this Surveyor observed LPN #4 administer Resident #131’s morning medications. The following medications were administered: Multivitamin Centrum Sil 300 -600 mcg 1 tab, Levothyroxine 125 mcg 1 tab before meal, Gabapentin 300 mg 1-tab, Ferrous Sulfate 325 mg elemental 65 mg 1 tab, Pantoprazole 40 mg 1 tab, 30 cc (cubic centimeter) Lactulose and 1 Lidocaine patch 4%. During the application of the Lidocaine 4% patch, Resident #131 advised LPN #4 that the night shift had placed a Lidocaine patch on his/her lower right back. The LPN removed the Lidocaine patch dated 07/31/25 11p-7a and placed her Lidocaine 4% patch on the Resident. During an interview following the medication administration observation, this Surveyor discussed the concern that the Lidocaine patch would now be applied to Resident #131 for an extended period time. When asked what the facility’s expectation was when there was a discrepancy in a medication administration, the LPN #4 replied that she had to follow the MAR. During a review of Resident #55’s MAR conducted on 07/31/25 at 8:07 AM, it was discovered that LPN #4 signed off on an order for Bio Freeze apply to right foot that she administered the medication. However, this Surveyor did not observe the LPN administer that medication. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident #131’s MAR conducted on 07/31/25 at 8:09 AM, it was discovered that LPN #4 signed off that that she administered 1 tab of Entecavir oral. However, during the medication administration observation this Surveyor did not observe the LPN administer that medication. A review of the Lidocaine patch order showed there were two active orders for the Lidocaine patch: Lidocaine External Patch 4% apply to lower right Back topically in the morning for pain remove at PM (after midday) and remove per schedule – Apply 0800 Remove 1959 Order Date - 12/13/24; and Lidoderm External Patch 5% (Lidocaine) apply to lower back topically in the morning for back pain leave on 12 hours only Order date- 07/29/25 Apply 0600. During an interview conducted on 07/31/25 at 8:13 AM, LPN #4 acknowledged that she had not applied Resident #55’s Bio Freeze to the right foot. The LPN further stated that she spoke with her unit manager and had Resident #131’s Lidocaine orders clarified. After clarifying the orders, the order for Lidoderm (Lidocaine) 5% was discontinued. The LPN stated that she believed that she administered the Resident #131’s 1 tab of Entecavir oral medication. However, the LPN admitted that prior to administering the medications this Surveyor and the LPN reviewed each medication that was to be administered and Entecavir was not included in the medications reviewed. 3) During Resident #81’s medication administration observation conducted on 07/31/25 at 8:18 AM, LPN #11 administered the following medications: Aspirin 81 mg 1 tab, Amlodipine 10 mg 1 tab, Carvedilol 3. 125mg 1 tab, Escitalopram Oxalate 10 mg 1 tab, Hydralizam HCL 25 mg 1 tab, and Multivitamin. During a review of Resident #81’s MAR it was discovered that LPN #11 signed off that she administered 1 tab of Brillanta Oral tab 90 mg. However, this Surveyor did not observe this medication administered. 4) A PEG tube, or Percutaneous Endoscopic Gastrostomy tube, is a feeding tube inserted through the abdominal wall into the stomach, providing direct access for nutrition, hydration, and medication. It's used when a person can't safely swallow or eat enough to meet their nutritional needs. During Resident #142’s medication administration observation conducted on 07/31/25 at 8:32 AM. This Surveyor observed LPN #11 crush each of the following medications individually and place each medication in a separate medication cup in preparation to administer them in the Resident’s PEG tube. The following medications were crushed: Clopidogrel 75 mg 1 tab, Metformin HCL 100 mg 1-tab, Ferrous Sulfate 325 mg 1 tab, Lisinopril 2.5 mg 1 tab, Aspirin 81 mg 1 tab, and Senna enteric coated 5 mg. The bottle of Senna reads enteric coated do not crush. This Surveyor observed LPN #11 fill each medication cup with 30 ml (millimeters) of warm water and then flushed the Peg tube with 30 ml of water. The LPN began to administer each medication separately. The LPN flushed the PEG tube after each medication alternating the amount of water between 10 ml, 20 ml, and 30 ml. Once the medications were administered this Surveyor observed undissolved medication in each medication cup. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LPN #11 following the medication administration, this Surveyor expressed concern that Resident #142 had not received the full dosage of each medication. The LPN agreed and stated that “it’s impossible to dissolve the medications.” During a review of Resident’s #142’s MAR, it was discovered that LPN #11 signed off on an order for Omeprazole Oral Tablet Release 20 mg Order Date- 07/25/25 at 2139. However, this Surveyor did not observe LPN #11 administer that medication. A continued review of the MAR showed an order that stated: “Enteral Feed: Flush tube with 15 ml of water before each medication pass every shift Order Date – 07/25/25 at 2040.” Another order stated: “Flush tube with at least 15 ml of water after final medication every shift Order date- 07/25/25 at 2040.” During a follow up interview conducted on 07/31/25 at 12:09 PM, LPN #11 reviewed Resident 81’s MAR and confirmed that she had not administered Brillanta 90 mg. During a review of Resident #142’s MAR, LPN #11 confirmed that she had not administered Omeprazole Oral Table 20 mg. She also reviewed the order for flushing before each medication administration and acknowledged that she did not follow the order to flush with 15 ml of water before each medication. An interview was conducted on 07/31/25 at 1:07 PM with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). During the interview the DON stated he would notify the physician of the missed medications and incomplete dosages of medications administered. He further stated that he would provide an in-service on the education of proper medication administration and following physician orders. 5) During an interview conducted on 08/04/25 at 2:14 PM, Resident #96 reported that on the evening of 08/01/25 he/she felt anxious. The Resident explained that his/her anxiety had been previously treated with 1 mg of Lorazepam. The Resident stated that he/she advised License Practice Nurse (LPN) #12 of his/her anxiety and requested Lorazepam. The Resident further stated that LPN #12 returned and advised that the Lorazepam order had been discontinued and she would need to contact the physician. The LPN returned and informed the Resident that the Physician ordered 0.5 mg (milligram) of Lorazepam. The Resident reported that he/she told the LPN that the dose was incorrect and that his/her anxiety had been previously treated effectively with 1 mg of Lorazepam. According to the Resident the LPN did not administer the medication nor communicate that she would contact the Physician. The Resident advised as a result his/her anxiety was not treated. On 08/04/2025 at approximately 3:00 PM, this surveyor conducted a record review of Resident #96’s Medication Administration Record (MAR) for July and August 2025. The July 2025 MAR showed that Resident #96 had an order for Lorazepam Oral Tablet 0.5 MG with instructions to “Give 0.5 tablet by mouth every 12 hours as needed for anxiety for 14 days. May give two ½ tabs of (0.5 mg) to equal 1 mg dosing until med supply complete, then can switch to full tab of 1 mg.” This order was placed on 07/17/2025 at 12:22 PM. The MAR indicated that Resident #96 had received this medication and that it had been effective on July 19th, 20th, 25th, 27th, and 28th. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/04/2025 at approximately 3:10 PM, this surveyor conducted a continued review of Resident #96’s Medication Administration Record (MAR) for August 2025. The MAR showed that Lorazepam Oral Tablet 0.5 mg was ordered on 07/31/2025 at 11:45 PM to “Give 2 tablets by mouth every 12 hours as needed for anxiety for 1 day,” which was discontinued on 08/01/2025 at 4:34 PM. A subsequent order for Lorazepam 0.5 mg was started on 08/01/2025 at 4:32 PM to “Give 0.5 tablet by mouth every 12 hours as needed for anxiety for 14 days.” According to the MAR, there was no documentation showing that this medication was administered to Resident #96 on 08/01/2025. This order was discontinued on 08/04/2025 at 11:47 AM, and a new order was initiated at that time to “Give 2 tablets by mouth every 12 hours as needed for anxiety for 14 days.” On 08/04/2025 at approximately 3:30 PM, this surveyor conducted a record review of #96’s progress notes. A note documented by the Advanced Practice Nurse (APN) on 08/01/2025 at 12:46 AM stated, “Communication from patient received via nurse requesting a medication. Counseled that bridge supply will be ordered until evaluated by the primary team. Patient was prescribed 0.5 mg Lorazepam tablet, take 2 tablets by mouth twice daily for anxiety. This fell off the MAR this evening. Patient requesting a dose. No previous side effects reported.” At this time, there were no progress notes found that discussed Resident #96 requesting the lorazepam dose be changed to 1 mg instead of 0.5 mg. On 08/05/2025 at 9:00 AM, this surveyor attempted to contact LPN #12, who cared for Resident #96 on 08/01/2025, for an interview. There was no answer, and a voicemail was left. On 08/05/2025 at 10:00 AM, this surveyor conducted an interview with the Director of Nursing (DON) to discuss his expectations when a resident refuses medication. The DON stated that if a resident refuses any medication, the nurse is expected to notify the physician by calling the on-call doctor and documenting the notification in a progress note. When asked about the procedure if the medication offered is not the correct dose or if the resident requests a different dose, the DON responded that the nurse should notify the physician, who will then decide how to proceed. During the interview, the surveyor informed the DON of concerns that Resident #96 did not receive the lorazepam needed for anxiety. Specifically, Resident #96 had requested a 1 mg dose instead of 0.5 mg, and there was no documentation indicating that LPN #12 had contacted the physician to report the resident’s refusal or to request a medication change. The DON stated he would need to speak with the nurse to clarify what had occurred. On 08/05/2025 at 12:00 PM, this surveyor conducted record review of the narcotic book, which showed an order for Lorazepam 0.5 mg under Resident #96’s name. For the date 08/01/2025, the entry stated “Wasted 1 tablet,” signed with a signature bearing the same first initial and full last name as LPN #12. A photograph of this page in the narcotic book was taken at that time.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations and interviews it was determined that the facility failed to ensure equipment was operational. This was found to be evident for 1 out of 1 observation for the door alarm operating system during the recertification survey.The findings include: During a facility tour conducted on 08/01/25 at 6:30 AM, this Surveyor and the Maintenance Director (MD) opened an exit door located in the first-floor stairwell due to a concern of a recent elopement. The MD explained that only authorized personnel are allowed to use the stairwell door. If an authorized personnel inputs the code into the pin pad then an audible alarm will not sound at the first-floor nursing station. He further stated if no code is entered on the pin pad then an audible alarm will sound at the first-floor nursing station. Both this Surveyor and MD went to the first-floor nursing station to observe the audible alarm however the alarm had not sounded. The MD explained that we would not have heard the audible alarm because he had inputted the code on the pin pad located next to the first-floor stairwell exit door. The MD then attempted to open the wall panel however this Surveyor advised the MD to not change anything but to return to the stairwell door and open it without inputting the code on the pin pad to allow the audible alarm to sound. This Surveyor remained at the first-floor nursing station while the MD returned to the first-floor stairwell to open the exit door that leads outside of the facility. The MD returned to the stairwell and opened the first-floor stairwell exit door; this Surveyor observed the number 36 illuminated on the panel, however no audible alarm sounded. There were 4 staff members at the first-floor nursing station: Unit Secretary #14, LPN #15, LPN #16, and LPN Supervisor #1 all unaware that the number 36 light had illuminated to alert the staff that the stairwell door that leads directly outside of the facility had been opened. The MD returned and stated that there should have been an audible alarm. He then opened the wall panel of the door alarm system and connected two wires which then resulted in an audible alarm sounding.