STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215266	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Lake Healthcare at Glen Burnie	7355 Furnace Branch Road East Glen Burnie, MD 21060

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of Facility Reported Incident (FRI) investigative file and interviews, it was determined that the facility failed to report a misappropriation of resident property to the Office of Health Care Quality (OHCQ) within the required 24 hours after the allegation was made. This was found to be evident for 1 FRI (#3004409) out 7 FRIs reviewed during the annual recertification survey.The findings include:On 5/4/2026 at 9:47AM, during an interview with Resident #158's resident representative (RP), the Surveyor was informed that the resident's rings were stolen by a facility staff member. The RP stated that he/she called the police and informed the Nursing Home Administrator (NHA #1), who is currently investigating the allegation.On 5/6/2026 at 12:00PM, a review of Resident #158's FRI #3004409 revealed that the night supervisor was made aware of the allegation on 4/26/2026 at about 8:00AM and the NHA #1 was made aware of the allegation on 4/26/2026 at about 9:00AM. Further review revealed that the facility submitted the initial report to OHCQ on 4/28/2026 at 9:48AM.On 5/8/2026 at 12:00PM, during an interview with the NHA #1, the Surveyor expressed the concern of failure to timely report Resident #158's and RP's allegation of misappropriation of resident property to OHCQ within 24 hours.

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 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 written notification of transfer and bed hold policy. This was evident in 2 (#6, #19) of 3 resident records reviewed for discharge processes. The findings include: 1. On 5/11/26 at 6:37 AM, Resident #6's medical record was reviewed. The record review revealed that according to Resident #6's AUTM Change in Condition/Concurrent Review 2.0 – V 13 form, dated 1/21/26, Resident #6 was hospitalized for complaints of chest pain on 1/21/26. It is also documented that Resident #6's responsible party was onsite at the facility and aware of the resident being transferred to the hospital. On 5/11/26 at 6:59 AM, Resident #6's medical record was reviewed. The record review revealed that the facility listed Resident #6's name on the bed hold policy for when Resident #6 was being transferred to the hospital on 1/21/26; however, the facility did not have Resident #6's responsible party sign the bed hold policy, although Resident #6's responsible party was onsite at the facility during the time Resident #6 was transferred to the hospital on 1/21/26. On 5/11/26 at 10:03 AM, the surveyor interviewed the Nursing Home Administrator (NHA #1). During the interview, the NHA #1 mentioned that although Resident #6's responsibility party was present at the facility during the time Resident #6 was transferred to the hospital on 1/21/26, the facility did not have Resident #6's responsibility party sign the bed hold policy. 2. On 5/4/2026 at 8:48AM, a review of Resident #19's electronic medical record revealed that the resident was transferred to the hospital on [DATE] and 1/17/2026. There was no documentation indicating that the resident representative received written notification of these transfers or the bed hold policy upon transfer to the hospital. On 5/7/2026 at 9:54AM, the Nursing Home Administrator (NHA #1) was asked to provide the Surveyor with Resident #19's written reason for transfer/discharge notification and bed hold documentation that was sent to the resident representative for the transfer on 12/13/2025 and 1/17/2026. On 5/8/2026 at 3:00PM, a review of the documentation provided by the NHA #1 failed to reveal that the required written notifications were sent to Resident #19's resident representative for hospitalizations on 12/13/2025 and 1/17/2026. During an interview with the NHA #1 on 5/11/2026 at 8:00AM, the Surveyors findings were confirmed. The NHA acknowledged that facility was not providing written notification of transfers to the hospital and the facility's bed hold policy to the resident representatives. The NHA stated that the business office will now be responsible for sending these notifications via certified mail or the representative's preferred written method.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on review of complaint #s 2723504 and 2788226, resident records, and staff interviews, it was determined that the facility failed to adhere to professional standards of practice when administering medications to residents. This was found to be evident for 1 (Resident #6) out of 1 resident reviewed for medications during the annual recertification survey.The findings include:On 5/5/26 at 2:07 PM, the surveyor reviewed complaint #s 2723504 and 2788226. Complaint #s 2723504 and 2788226 indicated that Resident #6's medication was not administered timely.On 5/7/26 at 2:36 PM, the surveyor reviewed Resident #6's medical records. Resident #6's Medication Admin Audit Report indicated that Resident #6 received the following medications late on 1/28/26:-Miconazole Nitrate External Cream 2 % (Miconazole Nitrate [Topical]) for rash, was scheduled for 3:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Icosapent Ethyl Oral Capsule 1 GM (Icosapent Ethyl) for hyperlipidemia, was scheduled for 5:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Methenamine Hippurate Oral Tablet 1 GM (Methenamine Hippurate) for recurrent UTI, was scheduled for 5:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl) for BPH, was scheduled for 5:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Gabapentin Capsule 300 MG for nerve pain, was scheduled for 8:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Memantine HCl Oral Tablet 10 MG (Memantine HCl) for dementia, was scheduled for 8:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26; Xarelto Oral Tablet 20 MG (Rivaroxaban) for A-fib, was scheduled for 9:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Melatonin Oral Tablet 3 MG (Melatonin) for sleep, was scheduled for 9:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26; Mirtazapine Oral Tablet 15 MG (Mirtazapine) for depression, was scheduled for 9:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Lactulose Solution 10 GM/15ML for bowel regimen, was scheduled for 9:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26; Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride) for Alzheimer's, was scheduled for 9:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.-Ropinirole HCl Oral Tablet 2 MG (Ropinirole Hydrochloride) for restless leg syndrome, was scheduled for 9:00 PM on 1/28/26, administered at 12:47 AM on 1/29/26, and documented at 12:47 AM on 1/29/26.On 5/7/26 at 3:03 PM, the surveyor interviewed the Nursing Home Administrator (NHA #1). During the interviewer, the surveyor mentioned to NHA #1 that according to Resident #6's Medication Admin Audit Report, resident #6 received mediation late on 1/28/26. NHA #1 indicated that medication should be administered one hour before or one hour after the mediation is due.On 5/8/26 at 6:55 AM, the surveyor interviewed Licensed Practical Nurse (LPN #11). During the interview, the surveyor mentioned to LPN #11 that according resident #6's Medication Admin Audit Report, resident #6 received mediation late on 1/28/26. LPN #11 reviewed Resident #6's Medication Admin Audit Report, and she indicated that on 1/28/26 she administered Resident #6's medication on time; however, she documented the medication administration late because it can get busy on the unit. The surveyor asked LPN #11 what the expectation is when documenting a medication administration. LPN #11 indicated that the expectation is to document a medication administration immediately after administering the medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, staff interviews, and record review, it was determined that the facility failed to:1.Maintain medical records in accordance with accepted professional standards and practices. This was evident for 1 (#186) of 9 residents reviewed for baseline care plans during this annual survey.2(a-c).Accurately document the baseline care plan. This was found to be evident for 8 (#193, #192, #44, #55, #78, #96, #118, #181) of 19 residents reviewed for smoking ,and 1 (#10) of 2 residents' Kardex reviewed.The findings include: 1. A tracheostomy is a hole that surgeons create in the front of the neck, into the windpipe (trachea). Surgeons place a tracheostomy tube into the hole to keep it open for breathing. The term for the surgical procedure to create this opening is tracheotomy. On 5/7/26 at 3:35 PM, the GNA (GNA #22) that had provided care to Resident #186 on the day in question was interviewed by the surveyor about what had happened. GNA 22 stated that she and the nurse had just provided tracheostomy and suction care to the resident approximately 20-30 minutes before the daughter's arrival, and the resident was not lying flat but was positioned 30-60 degrees elevated in the bed. The GNA also stated that she believes that the daughter had laid the bed flat. On 5/8/26 at 9:30 AM, the record review revealed that the nurse had documented the interaction with the daughter and the resident in the progress notes. The progress note stated in summary that the daughter came into the resident's room and immediately requested that the resident go out to the hospital due to the amount of secretions that the resident was producing, despite the resident's response of being fine. The facility complied quickly with the daughter's request to send the resident to the hospital. The facility filed a Complaint Report on 10/30/25, stating that the daughter walked into the resident's room and saw the resident lying flat, with secretions coming from the trachea. The daughter was adamant that Resident #186 needed to be sent out to the hospital. So the facility sent the resident out to the hospital. Review of the orders for Resident #186 showed that the resident was ordered for Oxygen at 5L per min via Trach continuously every shift, Suction tracheostomy tube as needed to clear the airway, Tracheostomy Care every shift and PRN, and Tracheostomy site dressing change every shift and PRN if soiled. Review of the baseline care plan revealed that under the section 3A - Health Conditions, it was documented that the resident was not on 1a. Oxygen therapy, but under 1aa. Type and L/per minute, it was documented Trach at discharge is #7 Portex cuff, less 21%. Section 1b was selected for suctioning care while a resident. Section 1c was not selected for Tracheostomy care. The facility failed to accurately document in the baseline care plan that the resident should have tracheostomy care and oxygen care. On 5/8/26 at 10 AM, the surveyor interviewed the DON about what happened with Resident #186. The DON stated that Resident #186 was only here for 2 days, and that the daughter came to the facility with a rolling cart prepared to remove Resident #186 from the facility. The DON continued to explain (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident #186 was allegedly lying flat when the daughter came for a visit, with a large amount of secretions. The daughter had already called 911 and was requesting that Resident #186 go to the hospital. Resident #186 repeatedly stated that they were fine and did not need to go to the hospital. But the daughter was insisting that the resident be transferred out to the hospital. The facility complied, and Resident #186 was sent to the hospital. The surveyor then asked the DON to take a look at the baseline care plan for Resident #186. The surveyor asked the DON why it was not documented that Resident #186 needed tracheostomy care and oxygen care, but it was documented under oxygen, the size of the trach (#7 Portex cuff), and why it was selected for suctioning only. The DON reviewed the baseline care plan and then stated that it was a mistake. She was uncertain why the nurse had documented the baseline care plan the way she had, especially since the information was provided for trach care. 2a. On 5/5/2026 at 11:06AM, during a review of Resident #193's electronic medical record, the Surveyor discovered that the resident was admitted to the facility on [DATE]. Further review failed to reveal a Smoking Safety Screen assessment completed on admission. On 5/5/2026 at 2:10PM, during an interview with Resident #192, the Surveyor was informed that the resident likes to smoke at least one cigarette a day. A review of Resident #192's electronic medical record revealed that the resident was admitted to the facility on [DATE]. Further review failed to reveal a Smoking Safety Screen assessment completed on admission. On 5/6/2026 at 10:20AM, a review of the facility's updated Smoker's List identified Resident #192 and Resident #193 as current smokers. A review of Resident #193's electronic medical record revealed a Smoking Safety Screen assessment completed on 5/6/2026. During an interview with the Nursing Home Administrator (NHA), in the presence of the Director of Nursing (DON), the Surveyor expressed the concern that Resident #193 was admitted to the facility on [DATE], was identified as a current smoker, and failed to have a Smoking Safety Screen assessment completed until 5/6/2026; and Resident #192 was admitted to the facility on [DATE], identified as a current smoker, and failed to have a Smoking Safety Screen assessment completed. The NHA and DON acknowledged the Surveyor's concerns. 2b. Failure to complete quarterly smoking assessments for residents who smoke. On 5/6/2026 at 8:20AM a review of the facility's Smokers List as of 5/1/2026 included Resident #44, #55, #78, #96, #118, and #181. On 5/6/2026 at 8:30AM a review of the electronic medical record revealed the following overdue Smoking Safety Screen assessments: -Resident #44's last completed on 10/8/2025 -Resident #55's last completed on 10/8/2025 -Resident #78's last completed on 1/15/2026 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #96's last completed on 10/8/2025 -Resident #118's last completed on 10/8/2025 -Resident #181's last completed on 10/8/2025 On 5/6/2026 at 10:20AM, during an interview with the NHA, in the presence of the DON, the Surveyor expressed the concern that the facility failed to complete quarterly Smoking Safety Screen assessments for Resident's #44, #55, #78, #96, #118, and #181. The NHA and DON acknowledged the Surveyor's concerns. 2c. A Kardex is a nursing reference (electronic or paper file summary) which includes crucial information such as diet orders, mobility aids, (e.g.,lift requirements), activity level, daily routines such as assistance with meals and other activities of daily living (ADLs), and specialized safety precautions, which are essential for fulfilling daily care duties specifically for that resident. On 5/11/2026 at 9:40AM, during a review of Resident #10's electronic medical record, the Surveyor discovered the resident's Kardex under the Tasks section for Geriatric Nursing Assistants (GNAs). The Kardex contained sections which included: Bladder/Bowel, Mobility, Hygiene/Oral Care, Resident Care, Transferring, Wake up/Bedtime, Eating, Bathing/Showering, Safety, Bed Mobility, Walking, Toileting, Dressing/Splint Care, and Bathing that failed to reveal individualized care needs for Resident #10 to reflect the comprehensive care plan and clinical record. On 5/11/2026 at 9:52AM, an interview conducted with the DON, in the presence of the NHA, the Surveyor expressed the concern that Resident #10's Kardex was not individualized based on his/her specific daily care needs. The DON reviewed the resident's Kardex and confirmed the Surveyor's findings. On 5/11/2026 at 10:31AM, during a follow-up interview with the DON, the Surveyor was informed that the resident information in the Kardex should reflect the resident's care plan. The DON stated that Resident #10's care plan and Kardex will be reviewed and updated to ensure they are accurate and individualized to reflect the resident's current daily needs.