

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff, it was determined that the facility failed to ensure residents were on time to scheduled dialysis treatment to received their full prescribed time. The facility also failed to ensure an adequate supply, and appropriate maintenance of Dialysis Chairs (Supplied by the [NAME] Lake Healthcare at Glen [NAME], and used for transport to Dialysis). This was found to be evident in 6 (#10, #127, #140, #197, #47, #175) of 17 residents reviewed for dialysis. 1. On 5/7/2026 at approximately 10:00AM, the Surveyor observed the dialysis Registered Nurse (RN #17) send a dialysis chair to the 2nd floor Gateway Unit. Unit Secretary (US #25) retrieved chair and placed it outside Resident #10's room for transport to [dialysis company] on the 1st floor of the building (East Building). During an interview with Resident #10 on 5/7/2026 at approximately 10:05AM, the resident appeared frustrated. The Surveyor asked if the resident was getting ready to go to dialysis and the resident responded, I guess so. I don't know what's going on. I'm just waiting. The resident was lying in bed with the head of the bed elevated and a Hoyer lift sling underneath him/her for mechanical transfer. On 5/7/2026 at 10:24AM, the resident was still in bed and the dialysis chair remained outside the room. An interview with Registered Nurse (RN #26) confirmed that the resident was getting ready to go to dialysis. The Surveyor observed the resident's green dialysis communication binder at the nurses' station. RN #26 reviewed the resident's dialysis communication binder with the Surveyor and stated that the required documentation has been completed on the sheet for today's dialysis session except the weight had not yet been documented. On 5/7/2026 at 10:28AM, Resident #10 was observed in bed and the dialysis chair still waiting outside the room. On 5/7/2026 at 12:25PM, an interview with RN #17 revealed that Resident #10 was upset because he/she arrived late to his/her dialysis treatment today. RN #17 informed the Surveyors that residents are late for their scheduled dialysis appointments daily due to transport issues. On 5/7/2026 at 1:17PM, the Surveyors expressed the concerns regarding residents arriving late to dialysis treatment sessions with the NHA. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/7/2026 at 2:45PM, a review of the Tuesday, Thursday, Saturday dialysis schedule, posted at the Gateway Unit nurses' station, revealed that Resident #10 was scheduled for dialysis treatment at 10:00AM. 2. During an interview on 5/4/26 at 9:22AM, Resident #127 reported concern to the surveyor that they were late to their dialysis appointment and their treatment had been cut short due to facility nursing staff not timely assisting them to go to their appointments. Resident #127 additionally reported concern for not being timely transferred from the dialysis chair to their bed after dialysis appointments. On 5/7/26 at 11:11AM the surveyor conducted an interview of Unit Manager (UM #16) who confirmed with the surveyor that there were dialysis appointment schedules with scheduled times for Residents requiring dialysis, and the process for communication between nursing unit staff and dialysis staff was via a dialysis communication folder and utilization of a dialysis communication form. Regarding the dialysis communication form, UM #16 stated to the survey team: We do review it and put it back in the folder. During the interview, UM #16 reported to the survey team that they did not have any Residents whose dialysis sessions were cut short due to not making it to dialysis on time. On 5/7/26 at 11:25AM the surveyor conducted an interview of Geriatric Nursing Assistant (GNA #21) who confirmed with the surveyor that the Hoyer lift and assistance by two staff were utilized to transfer Resident #127 to the dialysis chair. On 5/7/26 at 12:25PM surveyors conducted an interview of Registered Nurse (RN #17) who reported that when nursing staff are tied up with another patient, staff cannot get the Hoyer lift and get Resident #127 down to dialysis on time. During the interview, RN #17 stated to surveyors that residents were late to dialysis appointments daily due to transport. Surveyors noted that the dialysis center was located on facility grounds within the main building in which residents requiring dialysis were observed to reside. Review by the surveyor of Resident #127's dialysis communication folder on 5/7/26 at 12:35PM revealed documentation on their communication form by RN #18 as late arrival shortened tx (treatment) to their dialysis appointment on 5/2/26. Review of the dialysis appointment schedule by the surveyor revealed the Resident's dialysis treatment was scheduled for a duration of 3 hours and 30 minutes. Review by the surveyor of the dialysis documentation revealed the Resident's treatment was cut short by 1.5 hours. On 5/7/26 at 12:41PM the surveyor conducted an interview of RN #18 who reported to the surveyor regarding 5/2/26: Something went wrong that day and other Residents were late to their dialysis appointments also. On 5/7/26 at 12:58PM Resident #127 was observed laying in their bed and reported in an interview to the surveyor that there was not enough quantity of dialysis chairs and that the facility has to buy the chairs. Resident #127 reported that there were defective chairs that were unsafe and wobbly and (continued on next page)		

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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. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 -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.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and staff interviews, it was determined that the facility failed to ensure a resident's right to formulate an Advanced Directive. This was evident for 1 (#55) out of 9 residents reviewed for Advanced Directives during the annual recertification survey. The findings include: On 5/4/26 at 12:28 PM, the surveyor conducted a resident record review. During the resident record review, the surveyor could not locate resident #55's advance directive, nor could the surveyor locate documentation indicating that Resident #55 declined the opportunity to complete an advance directive when the facility offered the resident an opportunity to complete one. On 5/7/26 at 10:07 AM, the surveyor interviewed the Nursing Home Administrator (NHA) #1. During the interview, the NHA #1 mentioned that Resident #55 does not have an advance directive in place. The surveyor asked the NHA #1 if the facility has documentation indicating that resident #55 declined to complete an advance directive when the facility offered Resident #55 an opportunity to complete one. The NHA #1 indicated that she would check Resident #55's records. On 5/7/26 at 11:39 AM, the surveyor interviewed the NHA #1. During the interview, the NHA #1 mentioned that the facility does not have documentation indicating that Resident #55 declined to complete an advance directive when the facility offered Resident #55 an opportunity to complete one.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on record reviews and interviews with staff, it was determined that the facility failed to ensure residents' rights to personal privacy. This was found to be evident for 3 (#60, #122, #141) of 4 residents residing together in a room on the Shenandoah Unit. The findings include: On 5/6/2026 at 12:20PM, the Surveyor confirmed the use of a private video monitoring device for Resident #6, installed at the request of their resident representative. Resident #6 resides in a room with Resident #60, #122, and #141. During a tour of the unit, a Surveyor observed that signage of video monitoring in the shared residents' room was not present. According to the facility's Audio/Visual Recording in Resident Rooms policy revealed that, If the resident is in a shared room, recording may not occur without written consent of the roommate and A sign will be placed on the door stating, 'Electric monitoring in progress'. On 5/7/2026 at 9:54AM, the Surveyor interviewed the Nursing Home Administrator (NHA #1) and requested documentation to verify Resident #60, #122, #141 provided written consent for the use of a video monitoring device in their room. On 5/7/2026 at 2:55PM, the NHA #1 provided the Surveyor with copies of the Roommate Virtual Monitoring Technology Consent Forms for Resident #122 and Resident #141, which were only completed by their resident representatives on 5/7/2026. Upon review, these documents were not thoroughly completed and contained contradictory signatures that both granted and withdrew consent for the use virtual monitoring technology in their room. Furthermore, the facility failed to provide written consent for Resident #60. During a subsequent tour of the unit, signage for video monitoring was observed on the residents' door. The Surveyor expressed the concern that Resident #6 had a private video monitoring device in place without the necessary prior written consent from all roommates and their resident representatives.		

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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.		

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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 &ndash; 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 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	office will now be responsible for sending these notifications via certified mail or the representative's preferred written method.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff, it was determined that the facility failed to ensure a resident's Minimum Data Set (MDS) assessments were completed and submitted in a timely manner. This was found to be evident for 1(#19) of 8 residents reviewed for accidents during the annual recertification survey. The findings include: The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. MDS assessments in Maryland should be signed and completed by the Registered Nurse (RN) Assessment Coordinator no later than 14 calendar days after the Assessment Reference Date (ARD). The signature certifies that the assessment is complete, accurate, and reflects the resident's status within the look-back period. On 5/8/2026 at 9:42AM, a review of Resident #19's Annual MDS assessment, with an ARD of 1/26/2026, revealed that the RN Assessment Coordinator signed the assessment as complete on 2/27/2026 and the assessment was accepted on 3/3/2026. Further review revealed a Discharge MDS assessment, with an ARD of 1/17/2026, signed by the RN Assessment Coordinator as completed on 2/4/2026 and was accepted on 2/6/2026. On 5/11/2026 at approximately 4:00PM, during an interview with MDS Director (MDS #33), in the presence of the Nursing Home Administrator (NHA #1), the Surveyor expressed the concern that Resident #19's Annual MDS assessment dated [DATE] and Discharge MDS assessment dated [DATE] was completed late. Section Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date) for both assessments. After review, MDS #33 acknowledged and confirmed the Surveyor's findings.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with residents and staff, it was determined that the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded to reflect the resident's status. This was evident for 5 (#12, #51, #55, #85, #139) of 19 residents reviewed for smoking and 1 (#195) of 3 residents reviewed for respiratory care during the annual recertification survey. The findings include: 1. On 5/6/2026 at 8:20AM, a review of the facility's Smokers List as of 5/6/2026 included Resident #12, #51, #55, #85, and #139 identified as current smokers. On 5/6/2026 at 10:25AM, a review of the electronic medical records for these residents, who were identified as current smokers at the time of the Annual MDS assessment revealed the following concerns with Section J 1300 Current Tobacco Use: -Resident #12- Annual MDS assessment dated [DATE] indicated No for tobacco use-Resident #51- Annual MDS assessment dated [DATE] indicated No for tobacco use-Resident #55-Annual MDS assessment dated [DATE] indicated No for tobacco use-Resident #85-Annual MDS assessment dated [DATE] indicated No for tobacco use-Resident #139-Annual MDS assessment dated [DATE] indicated No for tobacco use On 5/6/2026 at 12:34PM, during an interview conducted with MDS Director (MDS #33) and MDS Coordinator (MDS #34), in the presence of the Nursing Home Administrator (NHA #1), the Surveyor was informed that Section J1300 Current Tobacco Use is assessed during the comprehensive admission, annual, and significant change MDS assessments. Information to code that section should be gathered from observation, interview with the resident, and/or record review. The Surveyor expressed the concern that Residents #12, #51, #55, #85, and #139, identified as current and prior smokers, were inaccurately coded as No for tobacco use on their most recent annual MDS assessment. MDS #33, MDS #34, and the NHA #1 acknowledged the Surveyor's concerns and that these findings were made in error. MDS #33 and MDS #34 stated they would review the list of smoking residents to ensure J1300 for tobacco use reflects the resident's current status. 2. On 5/4/2026 at 9:45AM and 5/5/2026 at 2:05PM, the Surveyor observed Resident #195 receiving oxygen therapy via nasal cannula. On 5/6/2026 at 1:00PM, a review of Resident #195's electronic medical record revealed that the resident was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure and dependence on supplemental oxygen. A review of the Baseline Care Plan dated 4/24/2026, under the Health Conditions section, revealed oxygen therapy at 3 liters. Further review of the admission MDS assessment completed on 4/30/2026, Section O C1, failed to indicate the use of Oxygen therapy for the resident. On 5/11/2026 at approximately 4:00PM, during an interview with MDS Director (MDS #33), in the presence of the Nursing Home Administrator (NHA #1), the Surveyor expressed the concern that Resident #195 was admitted to the facility on oxygen therapy and oxygen therapy was not coded on the admission MDS assessment dated [DATE]. After review, MDS #33 acknowledged and confirmed the Surveyor's findings.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview with staff, it was determined that Preadmission Screening and Resident Review (PASARR) was not re-evaluated and updated to reflect a resident's current diagnosis of serious mental illness. This was found to be evident for 1 (#19) of 2 residents reviewed for PASARR during the annual recertification survey. The findings include: Preadmission Screening and Resident Review (PASARR) is a federal program that screens individuals applying to or residing in Medicaid-certified nursing facilities for serious mental illness (SMI) or intellectual disability (ID). The purpose is to ensure these individuals receive the most appropriate and least restrictive care setting and services. On 5/7/2026 at 11:40AM, a review of Resident #19's most recent PASARR dated 8/14/2024 showed no diagnosis of serious mental illness. However, a review of the resident's electric medical record at 12:00PM revealed the resident had been diagnosed with major depressive disorder on 12/16/2025. On 5/7/2026 at 12:55PM, during an interview with Social Worker (SW #9) and the Nursing Home Administrator (NHA #1), the Surveyor expressed the concern that Resident #19's most recent PASARR was not updated to reflect the resident's current diagnosis of major depressive disorder. After a review of the PASARR dated 8/14/2024, SW #9 and the NHA #1 acknowledged and confirmed the Surveyor's concern. The Surveyor informed the NHA #1 that Social Work Director (SW #35) completed and submitted a new PASARR for the resident which included the updated diagnosis.		

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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 observation, interview and record review it was determined the facility failed to ensure a follow up medical appointment recommendation was followed and timely scheduled. This was evident for 1 (#27) out of 4 Residents reviewed for care planning during the facility's recertification survey. The findings include: During the surveyor's initial tour of the facility on 5/4/26 at 9:16AM Resident #27 expressed to the surveyor that they were concerned regarding their medical care which included an enlarged area present on their body and they did not know what the plan was for the medical care of it. Review of Resident #27's medical record by the surveyor on 5/8/26 at 1:06PM revealed diagnoses and medical history which included liver cell carcinoma, malignant ascites, and included documentation of an area having been identified on 3/17/26 as an aggressive osseous lesion on the Resident's hospital Discharge summary dated [DATE], prior to the Resident's admission to the facility on 3/25/26. Further review by the surveyor of Resident #27's hospital Discharge summary dated [DATE] revealed recommendations which included the following: Follow up with patient oncologist at JHH next available. On 5/8/26 at 1:08PM the surveyor requested to the facility Administrator to provide documentation of Resident #27's oncology follow-up appointment. On 5/11/26 at 9:34AM the surveyor conducted an interview of the Director of Nursing (DON) who after surveyor intervention, acknowledged and provided documentation of Resident #27's oncology appointment having been made on 5/8/26 at 2:10PM. The DON confirmed with the surveyor that the follow up appointment was not made until 5/8/26, and was made by Unit Clerk (#27). At this time, the surveyor shared the concern with the DON. On 5/11/26 at 9:52AM the surveyor conducted an interview of the facility Administrator who reported that Unit Clerk #27 was waiting on the Resident's wife to provide the name of the oncologist that they wanted the Resident to see, and they could not get the exact name, and reported there was no documentation of the conversation with the wife. When the surveyor inquired to the facility Administrator as to if the Resident's wife had decision making capacity for the Resident, they reported that they did not know. On 5/11/26 at 11:15AM the surveyor conducted an interview of Unit Clerk #27 who reported that they try to look at the discharge summary, and did not see information as to where the Resident was to go for the oncology follow up appointment. Unit Clerk #27 observed the discharge recommendation for the Resident to follow up at JHH documented in the discharge summary, and confirmed that they did see the discharge summary, but did not see that it included the place for the Resident to go for the follow up appointment. Review of the medical record of Resident #27 by the surveyor on 5/11/26 at 10:10AM revealed Resident #27 had certification of capacity for decision making dated 3/27/26 by Physician #28. Review of the medical record by the surveyor revealed there was no power of attorney or completed advanced directive observed to be present. Review by the surveyor of Resident #27's consult order history revealed two medical orders placed for the oncology consult for hepatocellular carcinoma, one dated as beginning 4/13/26, and one dated as beginning 5/6/26. On 5/11/26 at 11:21AM the surveyor shared the concern with the facility's Administrator, DON, and Unit Clerk #27, who acknowledged the surveyor's concern. On 5/11/26 at 11:34AM the surveyor conducted an interview of Physician #28 and inquired as to why the Resident's oncology appointment was not timely scheduled, to which they replied: I don't know. On 5/11/26 at 3:40PM the surveyor reviewed all concerns with the facility's Administrator and Director of Nursing who acknowledged the concerns.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview with staff, it was determined that the facility failed to ensure a resident was properly assessed for the safe use of side rails and develop and implement a person-centered care plan. This was found to be evident for 1 (Resident #194) out of 2 resident reviewed for side rails during the annual recertification survey. The findings include: Bed rails, also known as side rails, are adjustable bars that attach to the bed. They vary in size, including full, half, and quarter lengths depending on their intended purpose. They can be used to prevent falls, help assist residents with movement, and provide a feeling of security. Bed rails also have potential risks associated with them, such as suffocation, entrapment, and psychological risks. On 5/4/2026 at 9:10AM, during an initial tour of the Gateway Unit, Resident #194 was observed sitting up in bed with the head of the bed elevated about 75 degrees and 1/4 size side rails raised on both sides of the bed. On 5/6/2026 at 11:06AM, during a review of Resident #194's electronic medical record the Surveyor discovered that the resident was admitted to the facility on [DATE]. An Assist Bar/Side Rail assessment completed on 4/27/2026 failed to document an evaluation of appropriate alternatives attempted prior to use of side rails and how these alternatives failed to meet the resident's assessed needs. Additionally, there was no documentation indicating that the risks and benefits of side rails were discussed with the resident and resident representative. A continued review of Resident #194's electronic medical record failed to contain a resident specific care plan developed and implemented for the use of side rails. On 5/7/2026 at 1:21PM, the Surveyor reviewed Resident #194's Assist Bar/Side Rail assessment with the Director of Nursing (DON). The DON acknowledged the Surveyor's findings. On 5/11/2026 at 2:37PM, the Surveyor requested documentation of a care plan for side rails for Resident #194. At the time of exit on 5/11/2026, the facility was unable to provide the required care plan documentation.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and interview it was determined the facility failed to ensure yearly performance evaluations of geriatric nursing assistants. This was evident for 72 out of 75 geriatric nursing assistants during the surveyor's review of the staffing task during the facility's recertification survey. The findings include: On 5/4/26 at 11:20AM the surveyor conducted an interview of the facility's Director of Nursing (DON) who reported to the survey team that they had been in their role for seven months and each nursing unit has a unit manager who performs the performance evaluations every year of nursing assistants. During the interview, the DON stated to surveyors that they review the evaluations with the unit managers. On 5/5/26 at 10:17AM the surveyor requested complete employee personnel files for Geriatric Nursing Assistants (GNA) #22, #23, and #24 from the facility Administrator. On 5/5/26 at 11:22 AM the surveyor conducted a review of the complete employee personnel files for GNA #22, #23, and #24 which revealed inconsistent documentation for yearly performance reviews. On 5/5/26 at 12:32PM the surveyor shared the concern with the facility Administrator and requested documentation of yearly performance evaluations to be provided for GNA #22, #23, and #24. On 5/6/26 at 10:45AM the surveyor conducted another interview of the facility's DON and inquired as to how often the performance evaluations were being done to which they replied: It should be yearly. When the surveyor inquired to the DON as to if the GNA performance evaluations were being performed yearly they stated: I have to check on that because the Unit Managers do that. When the surveyor further inquired to the DON as to the process for yearly performance evaluations, the DON stated to surveyors: I started on 9/15/25 and HR initiates the process and Unit Managers perform the evaluations. When the surveyor inquired to the DON as to how the evaluations were documented and if they were on paper, the DON stated: I have to get back to you on that, at this point I have to get back to you. At this time the surveyor shared the concern with the DON and Administrator. The facility Administrator confirmed with the surveyor that they did not know what process was used for documentation of yearly performance evaluations of Geriatric Nursing Assistants and stated: I have to follow up on it, I understand, I'll get with HR and find out. On 5/6/26 at 1:36PM the surveyor conducted an interview of the facility Administrator who informed the survey team that they had looked into this surveyor's questions regarding yearly performance reviews and found that there is a failed process and that some staff had yearly performance reviews and some staff did not. The Administrator reported that the evaluations were to occur yearly on each employee's hire date, however, the dates were not kept tracked and up to date. The facility Administrator stated to the survey team: I will correct this process to get back on track, the HR (human resources) personnel is new. The facility Administrator confirmed that the evaluation is on a paper document in the employee personnel file and reported that the employee records this surveyor reviewed very well may not have the performance reviews done. Review by the surveyor of GNA #22's complete employee personnel file on 5/6/26 at 2:14PM revealed their most recent employee hire date of 5/29/24 and no evidence of a yearly performance evaluation. Review by the surveyor of GNA #23's complete employee personnel file on 5/6/26 at 2:14PM revealed a hire date of 9/4/24 and no evidence of a yearly performance evaluation. Review by the surveyor of GNA #24's complete employee personnel file on 5/6/26 at 2:14PM revealed a hire date of 1/20/22 and one employee evaluation form with an incomplete date range which was documented as: 1/20/22 to / / and signed by GNA #24 on 9/18/24. On 5/7/26 at 11:11AM the surveyor conducted an interview of Unit Manager (UM) #16 who reported having been employed by the facility for six months. During the interview, the surveyor inquired to UM #16 as to how many performance reviews they had conducted for staff, at which time (continued on next page)		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they reported they had only conducted one performance evaluation which was performed in response to the Administrator informing them of it and was documented on a paper form. On 5/7/26 at 2:55PM the surveyor conducted an interview of the facility's Administrator who, after surveyor intervention, reported: A facility staff audit was conducted and only three staff had received yearly performance evaluations, so we started doing them yesterday. The facility Administrator further reported that twenty-five performance reviews of staff had been completed so far. Surveyor review of the staff list audit provided by the facility Administrator revealed there were seventy-two GNA's listed as employed by the facility. On 5/11/26 at 3:23PM the facility Administrator confirmed with the survey team and provided documentation that a total of 75 GNA's were currently employed by the facility. On 5/11/26 at 3:40PM the surveyor reviewed all concerns with the facility's Administrator and Director of Nursing who acknowledged the concerns.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview it was determined that the facility failed to ensure daily staffing information was current and displayed in a prominent location. This was evident for 1 out of 1 staffing sheet observed to be present during the surveyor's initial tour of the facility. The findings include: On 5/4/26 at 8:19AM surveyors observed the front desk of the facility's main building at which time a plastic container was observed prominently displayed with staffing information which was dated 5/1/26. Upon further tour of the main areas of the facility's main building, no other posting with all required staffing information was observed to be present. On 5/4/26 at 8:48AM the surveyor shared the concern with Front Desk Staff #4 who observed and acknowledged the concern and reported to the surveyor that the displayed staffing information was supposed to be over on a table in a side hallway and not at the front desk. Updated staffing information was then observed displayed on a side hallway table with the date of 5/4/26 present, and the front desk staffing information was removed by Front Desk Staff #4. After surveyor intervention, on 5/5/26 at 9:49AM the surveyor observed updated staffing information located at the front desk prominently displayed with the date of 5/5/26. On 5/5/26 at 1:38PM the surveyor shared the concern with the facility's Administrator who acknowledged and confirmed understanding of the concern and reported that staff had let them know of the concern and confirmed that the staffing information should be updated and at the facility's main front desk in a prominent location. On 5/11/26 at 3:40PM the surveyor reviewed all concerns with the facility's Administrator and Director of Nursing who acknowledged the concerns.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on an interview and record review conducted during the annual survey, it was determined that the facility staff failed to promptly provide or obtain routine dental care and treatment. This was found to be evident for 1 (# 8) out of 8 residents reviewed for dental services during an annual survey. The findings include: During an initial screening conducted on 05/04/26 at 11:37 AM, Resident #8 reported experiencing aching in their back teeth. This resident also expressed uncertainty regarding their dental history at this facility and whether they have previously seen a dentist here. Resident #8 was able to answer questions appropriately and made his/her needs known. A record review conducted on 05/08/26 regarding Resident #8 revealed that the resident was admitted to this facility on 08/21/25 with diagnoses of left stroke resulting in hemiplegia, dysarthria, and type 2 diabetes. The admission orders signed by Physician #28 on 08/21/25 specify that a dental consultation should be conducted annually and as necessary. Additionally, the functional status assessment indicates that Resident #8 is unable to clean their teeth without assistance. Interview, on 05/8/26 at 11:39AM, Nurse #29 stated that they were aware of Resident #8's dental issues but did not follow up to ensure care was provided. During interview, on 05/8/26 at 11:55 AM, the Administrator confirmed that while all long term care residents are eligible for annual dental visits, the facility failed to schedule an appointment for Resident #8.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, medical record reviews, and interviews, it has been determined that the facility failed to honor resident preferences and provide consistent meal selections. This was evident for 1 (#8) of 8 residents reviewed for food preferences during an annual survey. The findings include: On 05/04/26 at 12:30 PM, Resident #8 pointed out that they were served fish. A review of the meal tray and ticket confirmed the fish entree was served and listed, and the resident noted receiving fish or pork multiple times previously. On 05/06/26 at 12:45 PM, an observed revealed that the resident's lunch meal ticket indicated a restriction for No Pork only. Additionally, floor staff stated that this resident would not eat fish. A record review conducted on 05/08/26 regarding Resident #8 revealed that the resident was admitted to this facility on 08/21/25 with diagnoses of left stroke resulting in hemiplegia, dysarthria, and type 2 diabetes. Physician #28's order dated 08/21/25 indicated regular diet. Notes from Dietitian #30 dated 02/11/26 showed that this resident consumed 50% or less for two or more meals. There were no mentions of food preferences. During an interview on 05/08/26 at 2:01 PM, Dietitian #30 stated that all resident food preferences should be obtained within 48 hours after the admission. However, she could not explain why Resident #8's specific dislike for fish was missing from the dislike/preference list, she added that the kitchen system should have updated. Further interview with the Administrator and shared above findings. She agreed that Resident #8's food preferences should have been clearly documented and acknowledged this as a practice deficiency. She was to follow up with her facility staff.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/11/2026
NAME OF PROVIDER OR SUPPLIER Autumn Lake Healthcare at Glen Burnie		STREET ADDRESS, CITY, STATE, ZIP CODE 7355 Furnace Branch Road East Glen Burnie, MD 21060	
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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with a resident and staff, it was determined that the facility failed to ensure a resident had the opportunity to communicate food preferences upon admission. This was evident for 1 (Resident #192) out of 3 residents reviewed for food concerns during the annual recertification survey. The findings include: On 5/5/2026 at 8:40AM, during an interview with Resident #192, the Surveyor was informed that he/she did not get any meat on their tray for breakfast. The Surveyor observed eggs, a piece of coffee cake, a bowl of hot cereal, milk, and juice. The resident appeared frustrated. On 5/6/2026 at 12:55PM, Resident #192 was observed eating lunch. The resident informed the Surveyor that he/she did not receive enough food for breakfast. The resident stated, They gave me 2 small pancakes, as he/she demonstrated the size of the pancakes with his/her hands. The resident appeared frustrated. On 5/7/2026 at 12:28PM, during a follow-up interview, the resident expressed the concern that he/she was not given enough food on his/her meal trays and is still hungry afterwards. The Surveyor asked the resident if a representative from the dietary services or the Registered Dietitian had come to speak to him/her about their diet, alternatives, and food preferences (e.g. likes and dislikes). The resident reported that no one from dietary services has come to speak with him/her since their admission on [DATE]. On 5/7/2026 at 1:45PM, during an interview with the Kitchen Account Manager #31, in the presence Certified Dietary Manager (CDM) #32, the Surveyor was informed that the expectation is for new admissions to be visited by dietary staff within 24 hours of admission to discuss the menu for the week, the always available menu for alternatives, substitutes, the meal process, and preferences including likes and dislikes. Staff #31 was unable to provide documentation that Resident #192 was seen at all. On 5/7/2026 at 2:00PM, an interview with Registered Dietitian (RD) #30 revealed that they visit new admissions within 5-7 days after admission. At that time, the resident should have been seen by dietary services within 72 hours of admission. RD #30 stated that Resident #192 was on their schedule for today. The Surveyor mentioned that Resident #192 has expressed concern that the portion of food that he/she receives is insufficient. RD #30 stated that they would assess the resident and address his/her concerns. On 5/8/2026 at 2:05PM, the Surveyor's concern that the resident was admitted on [DATE] and remained unseen by dietary staff until 5/7/2026 was discussed with the Nursing Home Administrator.		